Global Health Promotion

When the worldwide response to the COVID-19 pandemic is done without health promotion

Linda Cambon[1,2], Henri Bergeron[3], Patrick Castel[3], Valéry Ridde[4] and François Alla[1,2]

More than a year after the first reported cases of COVID-19, the world is still submerged in the doldrums of the pandemic. Wave after wave, measures taken to stem the epidemic are being repeated, failing to contain the phenomenon in most countries. The world is struggling against SARS-CoV-2; its pulse beating to the rate of the mediatised number of cases, hospitalisations, and deaths. Doesn't this continuous and massive publicity of the COVID-19 figures constitute one of the key problems of the crisis policy? By relentlessly making these specific epidemiological data salient and visible, the risk is taken of rendering invisible other problems, disorders and diseases, at least as serious; this risk is all the more worrying as the crisis becomes chronic.

Public policies have mobilized, not always effectively, the classic tools for responding to acute epidemic phenomena: detecting, isolating and, henceforth, vaccinating. But COVID-19 is not just an epidemic, it is a syndemic (1). It is asymptomatic or minimally severe for a very large majority of the population and is only aggravated by other factors of vulnerability, notably the combination of age, morbidity and social conditions. It has socially stratified effects and certain populations, because of their living, employment and housing conditions, are particularly vulnerable (2). In this respect, universal measures have barely been adapted to the peculiarities of different contexts, whether geographical, cultural, political, etc. (3). In the panic, a total, universal and centralised approach was chosen almost everywhere in the world: closure of living and teaching areas, physical distancing and general confinement. The determinants of living together have been frozen over a very long period in an attempt to limit the spread of the virus and avoid hospital saturation in intensive care.

For what results? COVID-19 has killed nearly 3.2 million people, almost exclusively over the age of 65 and/or already sick (4). It is currently difficult to know to what extent this rate has been affected by the measures decided upon. Studies highlight the effectiveness of certain measures on the spread of the virus under certain conditions (5), while others show that they either do not influence, or negatively influence the death rate in the population (6). On the other hand, data are now available showing the consequences of these measures on the health of the population: 100 million new people in extreme poverty (7), doubling of the unemployment rate in OECD countries (8), increased mental disorders and anxiety (9–12), lack of care for chronically ill patients and slower prevention activities (vaccination, screening) (13). Worse still is the toll for children: 142 million have been plunged into poverty (14), 463 million who have not been able to access distance education will experience learning delays (15) and subsequent health problems (16), worsening mental health problems (17,18) with probable consequences for the growth and development of younger children (19). There are fears of a collapse of decades of progress in child health, the consequences of dramatically disrupted immunisation and antenatal care policies (20,21) and policy-induced malnutrition (22). Finally, confinement measures overexposed children to domestic violence in a context of weakening child protection services (23,24). This observation, which is striking in its scale, its gravity and its victims, the youngest and the most vulnerable, calls out to the principles of beneficence to which public health interventions should refer (25). How

1. Inserm U1218, BPH, Bordeaux, France.
2. CHU Bordeaux, France.
3. Sciences Po, CSO, CNRS, Paris, France.
4. CEPED, IRD, France et ISED/UCAD Dakar, Sénégal.

Correspondence to: Linda Cambon, Inserm U1218, BPH, Bordeaux, France. Email: linda.cambon@u-bordeaux.fr

Global Health Promotion 1757-9759; Vol 28(2): 3–6; 1015129 DOI: 10.1177/17579759211015129 journals.sagepub.com/home/ghp

could we have forgotten that the social determinants of health are interdependent, that health is rooted in social fact and that, therefore, in the long term, such measures can only be destructive (26)?

The answer could be quite simple: the method used. Let us recall a fact that those involved in health promotion know perfectly well. Health proceeds from a process of empowerment, namely the capacity of individuals and groups to act on the social, economic, political or ecological conditions they face. In the context of COVID-19 (7), to be able to act, those affected must have the opportunity to participate, own and adjust the response. However, in many countries, all public communication on the epidemic has been deployed intensely without engaging in dialogue with civil society or health promotion professionals. The main objective seemed to be that of eliciting support for government measures by focussing communication on the individual responsibility of people and by mobilising worn out registers of fear and guilt (27). However, political science has shown this for a long time: what the governor believes to gain in autonomous decision capacity, by centralisation and monopolisation of the decision, he loses in implementation capacity (28). In addition, the limits of this anxiety-inducing strategy have long been known, especially when it is not shared and, consequently, the communities cannot play the role of moderator, resource or support (29–32): strategies of avoidance or withdrawal into oneself, anxiety and defensive behaviors, even pathological, linked to induced chronic stress. This deleterious combination of 'pandemic fatigue' (33) is observed worldwide, weakening the population and therefore the fight against COVID-19. To fight against this phenomenon, the World Health Organisation (7) nevertheless calls for modifying the method around four principles: (a) facilitating community responses by improving the quality and consistency of approaches; (b) basing actions on the mobilization of evidence, but also on the specificities of the contexts, capacities, perceptions and behaviors of the community; (c) strengthening local capacities and solutions by facilitating the skills and competencies of communities and the participatory evaluation of measures; and (d) favoring collaboration and mobilization of common interests between groups, structures and territories in the effort to respond to COVID-19. These four principles, good and well-established health promotion practices, refer directly to the need to combine expertise, disciplines and sectors. And this is the second weakness of the method used so far.

By favoring a biomedical approach where it is a question of suppressing or containing a virus rather than studying its encounter with a population forming a system (34), prevention and health promotion professionals, researchers in the human and social sciences, and citizens were excluded. However, how is it possible to embark hundreds of millions of individuals in a collective dynamic that directly concerns only a fraction of them, to choose the right communication in the long term, to adjust measures to territories, to vulnerabilities, without the achievements of these specialties? For 50 years, the guides in this field have been spangled from charter to charter, from consensus conference to consensus conference, to recall that 'the coordinated action of all those concerned' is necessary because 'the programs and strategies for health promotion must be adapted to the possibilities and local needs of countries and regions and take into account the various social, cultural and economic systems' (35). Principles endorsed by most of the nations concerned today, principles that have not been applied, are undoubtedly unknown to the rulers and experts mobilised in the management of this crisis.

In the approach as in the method, in its results as in its impacts, the management of the COVID-19 pandemic can only appeal to health promotion professionals. Why are they not heard? Certainly we had prepared for a sprint and it is a marathon that we are going through. Admittedly, the virus is agile, devious because it is silent and opportunistic, as always. Of course, hospitals are drained from years of neoliberal reforms. But while surprise, even astonishment, could excuse the initial choices of those in power, stubbornness and/or blindness to their consequences are not allowed. Continuing to sacrifice many segments of the population, in the name of universal measures, when measures proportionate to the vulnerability of territories and people could be put in place, is no longer permitted. If the advocacy mission is central to health promotion, it has never been more important than today when the world stumbles on SARS-CoV-2 generating multiple social, territorial, generational and community divides and where the expertise mobilised so far is conscious of its limits (36).

References

1. Horton R. Offline: COVID-19 is not a pandemic. Lancet. 2020; 396: 874.
2. Bambra C, Riordan R, Ford J, Matthews F. The COVID-19 pandemic and health inequalities. J Epidemiol Community Health. 2020; 74: 964–968.
3. Damme WV, Dahake R, Delamou A, et al. The COVID-19 pandemic: diverse contexts; different epidemics—how and why? BMJ Glob Health. 2020; 5: e003098.
4. Omori R, Matsuyama R, Nakata Y. The age distribution of mortality from novel coronavirus disease (COVID-19) suggests no large difference of susceptibility by age. Sci Rep. 2020; 10: 16642.
5. Haug N, Geyrhofer L, Londei A, Ingelbeen B, Wouters E, Vanham G. Ranking the effectiveness of worldwide COVID-19 government interventions. Nat Hum Behav. 2020; 4: 1303–1312.
6. Rice K, Wynne B, Martin V, Ackland GJ. Effect of school closures on mortality from coronavirus disease 2019: old and new predictions. BMJ. 2020; 371: m3588.
7. COVID-19 global risk communication and community engagement strategy. 2020 [cited 2021 Feb 9]. Available from: https://www.unicef.org/documents/covid-19-global-risk-communication-and-community-engagement-strategy
8. OECD Employment Outlook 2020. Facing the jobs crisis. 2020 [cited 2021 Feb 9]. Available from: http://www.oecd.org/employment-outlook/2020
9. Vindegaard N, Benros ME. COVID-19 pandemic and mental health consequences: systematic review of the current evidence. Brain Behav Immun. 2020; 89: 531–542.
10. Globalization and Health. Prevalence of stress, anxiety, depression among the general population during the COVID-19 pandemic: a systematic review and meta-analysis. 2020 [cited 2021 Feb 9]. Available from: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-020-00589-w?fbclid=IwAR1IsBbTX9f8g1bMRjVR2hoscN6QQEGuPK0IQNaqBht80gi0hQ_9KtuAXTA
11. Krishnamoorthy Y, Nagarajan R, Saya GK, et al. Prevalence of psychological morbidities among general population, healthcare workers and COVID-19 patients amidst the COVID-19 pandemic: a systematic review and meta-analysis. Psychiatry Res. 2020; 293: 113382.
12. Serafini G, Parmigiani B, Amerio A, Menon V. The psychological impact of COVID-19 on the mental health in the general population. QJM Int J Med. 2020; 113: 531–537.
13. Rapid assessment of service delivery for NCDs during the COVID-19 pandemic. 2020 [cited 2021 Feb 9]. Available from: https://www.who.int/publications/m/item/rapid-assessment-of-service-delivery-for-ncds-during-the-covid-19-pandemic
14. UNICEF DATA. Children in monetary poor households and COVID-19. 2020 [cited 2021 Feb 9]. Available from: https://data.unicef.org/resources/children-in-monetary-poor-households-and-covid-19/
15. UNICEF DATA. Impact of COVID-19 on multidimensional child poverty. 2020 [cited 2021 Feb 9]. Available from: https://data.unicef.org/resources/impact-of-covid-19-on-multidimensional-child-poverty/
16. Christakis DA, Van Cleve W, Zimmerman FJ. Estimation of us children's educational attainment and years of life lost associated with primary school closures during the coronavirus disease 2019 pandemic. JAMA Netw Open. 2020; 3: e2028786.
17. Golberstein E, Wen H, Miller BF. Coronavirus disease 2019 (COVID-19) and mental health for children and adolescents. JAMA Pediatr. 2020; 174: 819.
18. Phelps C, Sperry LL. Children and the COVID-19 pandemic. Psychol Trauma Theory Res Pract Policy. 2020; 12(S1): S73–S75.
19. Araújo LA de Veloso CF, Souza M, de C, Coelho de Azevedo JM, Tarro G. The potential impact of the COVID-19 pandemic on child growth and development: a systematic review. J Pediatr. Epub ahead of print September 2020. DOI: 10.1016/j.jped.2020.08.008.
20. Roberton T, Carter ED, Chou VB, Stegmuller AR, Jackson BD, Tam Y, et al. Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study. Lancet Glob Health. 2020; 8: e901–e908.
21. Worldwide measles deaths climb 50% from 2016 to 2019 claiming over 207,500 lives in 2019. 2020 [cited 2021 Feb 9]. Available from: https://www.unicef.org/press-releases/worldwide-measles-deaths-climb-50-2016-2019-claiming-over-207500-lives-2019
22. COVID-19 and maternal and child food and nutrition insecurity: a complex syndemic - Pérez-Escamilla - 2020 - Maternal & Child Nutrition. Wiley Online Library. 2020 [cited 2021 Feb 9]. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/mcn.13036
23. Parental burnout and child maltreatment during the COVID-19 pandemic. SpringerLink. 2020 [cited 2021 Feb 9]. Available from: https://link.springer.com/article/10.1007/s10896-020-00172-2
24. Combatting COVID-19's effect on children. OECD. 2020 [cited 2021 Feb 9]. Available from: http://www.oecd.org/coronavirus/policy-responses/combatting-covid-19-s-effect-on-children-2e1f3b2f/
25. Éthique et santé publique. Enjeux, valeurs et normativité | Raymond Massé | Société, cultures et santé. Presse de l'Université Laval. 2003 [cited 2021 Feb 22]. Available from: https://www.pulaval.com/produit/ethique-et-sante-publique-enjeux-valeurs-et-normativite
26. Paul E, Brown GW, Ridde V. COVID-19: time for paradigm shift in the nexus between local, national and global health. BMJ Glob Health. 2020; 5: e002622.

27. Witte K, Allen M. A meta-analysis of fear appeals: implications for effective public health campaigns. Health Educ Behav Off Publ Soc Public Health Educ. 2000; 27: 591–615.
28. Bergeron H, Borraz O, Castel P, Dedieu F. Covid-19 : une crise organisationnelle. Presses de Sciences Po; 2020 [cited 2021 Feb 22]. Available from: https://www.cairn.Info/covid-19-une-crise-organisationnelle–9782724626650.htm
29. Lazarus RS. Psychological stress and the coping process. New York, NY: McGraw-Hill; 1966.
30. Wray RJ, Becker SM, Henderson N, Jupka K, Middleton S, Henderson C, et al. Communicating with the public about emerging health threats: lessons from the pre-event message development project. Am J Public Health. 2008; 98: 2214–2222.
31. Aldao A, Dixon-Gordon KL, De Los Reyes A. Individual differences in physiological flexibility predict spontaneous avoidance. Cogn Emot. 2016; 30: 985–998.
32. Movius HL, Allen JJB. Cardiac vagal tone, defensiveness, and motivational style. Biol Psychol. 2005; 68: 147–162.
33. WHO Regional Office for Europe. Pandemic fatigue: reinvigorating the public to prevent COVID-19: policy considerations for Member States in the WHO European Region. 2020 [cited 2021 Feb 12]. Available from: https://apps.who.Int/iris/handle/10665/335820
34. Rajan D, Koch K, Rohrer K, et al. Governance of the Covid-19 response: a call for more inclusive and transparent decision-making. BMJ Glob Health. 2020; 5: e002655.
35. World Health Organization. Ottawa Charter for Health Promotion. Geneva: WHO; 1986.
36. Atlani-Duault L, Lina B, Chauvin F, Delfraissy JF, Malvy D. Immune evasion means we need a new COVID-19 social contract. Lancet Public Health 2021; 6: e199–e200.

‘Back to better’: amplifying health equity, and determinants of health perspectives during the COVID-19 pandemic

Sume Ndumbe-Eyoh, Pemma Muzumdar, Claire Betker and Diane Oickle

Abstract

Introduction: Equity and social justice have long been key tenets of health promotion practice, policy and research. Health promotion foregrounds the pertinence of social, economic, cultural, political and spiritual life in creating and maintaining health. This necessitates a critical structural determinants of health perspective that actively engages with the experiences of health and wellbeing among diverse peoples. The inequitable impacts of pandemics are well documented, as are calls for improved pandemic responses. Yet, current pandemic and emergency preparedness plans do not adequately account for the social and structural determinants of health and health equity.

Methods: Through five one-hour online conversations held in April 2020, we engaged 13 practice, policy, research and community leaders on the intersections of COVID-19 and gender, racism, homelessness, Indigenous health and knowledge, household food insecurity, disability, ethics and equitable futures post-COVID-19. We conducted a thematic analysis of speaker and participant contributions to investigate the impacts and influence of COVID-19 related to the structural and social determinants of health. We analyzed which policies, practices and responses amplified or undermined equity and social justice and identified opportunities for improved action.

Findings: Analysis of the COVID-19 pandemic revealed four broad themes:

- oppressive, unjust systems and existing health and social inequities;
- health and social systems under duress and non-responsive to equity;
- disproportionate impacts of COVID-19 driven by underlying structural and socioeconomic inequity; and
- enhanced momentum for collective mobilization, policy innovations and social transformation.

Discussion: There was a strong desire for a more just and equitable society in a post-COVID-19 world, going ‘back to better’ rather than ‘back to normal.’ Our analysis demonstrates that equity has not been well integrated into pandemic planning and responses. Social movement and systems theories provide insight on ways to build on existing community mobilization and policy openings for sustained social transformation.

Keywords: determinants of health, equity / social justice, systems, policy / politics, community action

National Collaborating Centre for Determinants of Health, Antigonish, Nova Scotia, Canada.

Correspondence to: Sume Ndumbe-Eyoh, National Collaborating Centre for Determinants of Health, PO Box 5000, Antigonish, Nova Scotia, B2G2WG, Canada. Email: seyoh@stfx.ca

(This manuscript was submitted on 13 July 2020. Following blind peer review, it was accepted for publication on 16 February 2021.)

Global Health Promotion 1757-9759; Vol 28(2): 7–16; 1000975 DOI: 10.1177/17577592211000975 journals.sagepub.com/home/ghp

Introduction

Structural determinants of health are the economic, cultural, political and social structures that shape the distribution of material and symbolic power and resources. In tandem with concerns for the health of the planet and ongoing legacies of colonialism and racism, these 'structural drivers' shape public policies across sectors creating predictable inequities in health and health-promoting resources across and between nations and communities (1–5). The social gradient in health illustrates that those with more relative advantage experience better health than those with less advantage.

During the 2009 influenza pandemic in England, age and sex-standardized mortality was three times higher for those in the most socioeconomically deprived areas (6). First Nations, Inuit and Métis peoples in Canada were disproportionately affected by both waves of the 2009 H1N1 pandemic (7). For example, First Nations, Inuit and Métis peoples represented 27.8% of hospital admissions during the first wave even though they made up about 4.3% of the Canadian population (7). In the United States, H1N1 led to 4 to 4.5 times higher hospitalization rates for Hispanics, Blacks and Asian/Pacific Islanders (8) than for Whites, and higher mortality for American Indians/Alaska Natives compared with other racial/ethnic groups (9). Others have documented similar disproportionate impacts of pandemics by gender (10) and disability (11).

Core health promotion values of equity and social justice foreground the pertinence of social, economic, cultural, political and spiritual life for health (12). These relationships and values are relevant to pandemics (13–15). What's more, the inequitable impacts of pandemics are well documented, as are calls for improved responses (16–19). Yet, these core values are not integrated into current pandemic and emergency preparedness plans or responses, evidenced in the lack of intentional consideration for the social and structural determinants of health and health equity. In the Canadian context, equity is seldom named in pandemic preparedness plans (20) and the initial description of who was considered 'vulnerable' in the early days of the COVID-19 pandemic failed to engage equity and structural determinants of health perspectives (21).

With a goal to rapidly identify, generate and share equity-focused impacts and responses to the COVID-19 pandemic, we organized a series of online conversations for the public health community and others. We sought to answer the following questions: As the COVID-19 pandemic took hold across the globe, was the intersecting relationship between social determinants of health embodied in public health and policy responses? What were the emerging impacts of COVID-19 on social and health inequities?

Methods

Five one-hour online facilitated conversations engaged 13 practice, policy, research and community leaders including: Indigenous elders and knowledge keepers, policy and decision makers, practitioners, and researchers from health and non-profit sectors. Speakers explored the manifestations and experiences of COVID-19 at the intersections of multiple structural and social determinants of health. Over 1600 participants registered for the series, representing disciplines and roles across public health as well as other sectors. Participants were largely from Canada with a small proportion from other countries.

Conversation themes were: 1) Health equity, determinants of health, and COVID-19, 2) Community impact and responses to COVID-19 (focus on gender, racism, homelessness), 3) Indigenous perspectives on COVID-19, 4) Community impacts and responses (focus on household food insecurity, disability and ethics), and 5) Equitable futures in a post-COVID-19 world (22). Participants contributed questions, lived experience and resources during the conversations and as part of session registration. The conversations were recorded and are posted online for public access.

We conducted a thematic analysis (23) of the content explored during the conversations guided by three research questions:

- What is the impact of COVID-19 on health equity and the social and structural determinants of health?
- Which policies, practices and responses amplify or undermine equity and social justice?
- What are the opportunities for improved action?

We adapted the six phases presented by Braun and Clarke (23) and refined by Nowell *et al.* (24) for our analysis. First, all authors attended the conversations and/or listened to the recordings, taking field notes on

what themes initially emerged during the dialogues. We transcribed the recorded conversations and collated participants' contributions after each session. We then coded data from the five conversations using tags developed from initial themes (e.g. 'community mobilization,' 'collaboration'). We mapped data in tables, identifying relevant quotes from speakers and participants. Mid-way in the process, we presented a preliminary set of themes to a group of public health leaders with recent experience with the COVID-19 pandemic for validation and augmentation, and incorporated feedback in the next phase of distilling, scoping and theming. We used illustrative quotes to enrich the findings.

Speakers verbally consented to the recording and sharing of the conversation recordings. The information from the conversations is publicly available online. For that reason, we did not seek research ethics approval. Direct quotes have been anonymized. However, given that this information is in the public domain we cannot guarantee confidentiality or anonymity (25).

Findings

Analysis of the COVID-19 pandemic revealed four broad themes:

1) oppressive, unjust systems and existing health and social inequities;
2) health and social systems under duress and non-responsive to equity;
3) disproportionate impacts of COVID-19 driven by underlying structural and socioeconomic inequity; and
4) enhanced momentum for collective mobilization, policy innovations and social transformation.

1) Oppressive, unjust systems and existing health and social inequities

Speakers and participants situated the pandemic as a multi-purpose device: part flashlight, part hammer, and part crystal ball.

a. COVID-19 as a flashlight, that illuminates existing inequities

The pandemic shone light on intersecting structures and systems that drive inequitable health and social outcomes. The direct and indirect impacts of COVID-19 made visible structural drivers of inequity, including colonization, white supremacy, racism, patriarchy, capitalism and a frail social safety net (e.g. health, employment insurance, welfare):

> *COVID-19 is an example of that sort of a biophysical phenomenon and social phenomenon that's filtered through systems in which some of our lives are deemed more essential or more valuable than others.* [S1]

More specifically, COVID-19 made systemic inequities more visible to those who experience social and economic privilege.

> *What we are seeing is an emergence into the consciousness and space of the non-poor, or the non-marginalized, of some of the issues that many of us had been working on for a very long time.* [S2]

This heightened awareness of inequities within the public consciousness presented an opportunity for public health to engage with intersectoral partners and community groups, and advocate for shifts in social and economic policy.

> *One of the things that COVID has done, moving forward, is that we are conscious now of some of these realities and how we have been impacted by it ..., and that's painful, and that can be very challenging, but our responsibility in public health is to sustain consciousness.* [S14]

b. COVID-19 as a hammer, that applies further stress and intensifies inequities

Participants and speakers depicted the pandemic as a hammer, dealing blows to existing points of stress and intensifying inequities.

> *[COVID-19] is reinforcing the existing structural inequities that are deepened in a pandemic ... hitting marginalized and disadvantaged groups the hardest. It's like there is two COVID-19 realities. There's those who can't quarantine, and they are serving the rest of us who can afford to quarantine, and that's called quarantine privilege.* [S13]

They described avoidable and unfair systems that led to even worse outcomes for those already experiencing marginalization. Outcomes included increased susceptibility to COVID-19 infection, income inequity, food and housing insecurity, and challenges for people who use substances.

> *Indigenous peoples statistically have high rates of respiratory and heart disease, due to a variety of longstanding determinants of health stemming from continued colonization. These conditions make a person especially vulnerable to COVID-19.* [P1]

c. COVID-19 as a crystal ball for future planetary health disruptions

Speakers framed inequities caused and exacerbated by COVID-19 as a cautionary crystal ball, indicative of what would happen during disruptions due to massive ecological change. They drew connections between the emergence of COVID-19, the state of planetary relationships, and the need for justice, solidarity, and a sustainable future:

> *And I think this situation is a test of our global solidarity. And we need it, because it's from a global health or global justice perspective. And what we're in right now is also a dress rehearsal for climate change.* [S11]

Calling for intersectional approaches and drawing links to past movements, a speaker noted that addressing racism and sexism is essential to create a sustainable future:

> *Sustainable for whom is my first question ... it's like the women's movement, you know. Quickly we realize, okay, ... 'Woman of colour' is really not included in this so-called women's movement. ... So there's a core piece around equity. There's anti-Black racism, Indigenous racism ... [if] we don't really articulate those and make sure they're included in all this other work, we end up with improvement and widening inequities.* [S12]

2) Health and social systems under duress and non-responsive to equity

COVID-19 responses exposed that health and social systems were under duress, ill-prepared:

> *... the old system never prepared us for a global pandemic. We knew the old system was reinforcing inequities and leaving people behind. And we also knew that there was a better way forward. We are seeing how the old social safety net was too frayed to really rise to the occasion.* [S13]

> *The time to think about ethics in an emergency situation is before the situation itself. And when we're talking about equity, equity has to be built into things beforehand and not on the fly.* [S11]

The erosion of public health and social systems limited the extent to which core public health functions could be fulfilled. Redeployment of existing public health resources to the COVID-19 response resulted in little or no resources left to attend to significant public health issues and health equity issues.

There was not a strong equity focus in planning, and responses did not apply past learnings about who was most likely to be impacted:

> *Look at who is catching the virus, who is dying, who got the training and the protective gear and when. Long-term care, group homes, congregate living for people with mental and physical disabilities and the staff that provided care came after. We should focus on where we know the spread will occur. There isn't anybody in public health, in regional planning, that didn't know after SARS and H1N1 that care settings were our priorities, and yet they did not get priority.* [S12]

Measures taken did not account for those experiencing structural disadvantage. For example, physical distancing guidelines were difficult to apply in the shelter system.

The closure of supportive services and programs (e.g. daycares, schools, libraries, public spaces, businesses) significantly impacted structurally disadvantaged communities, who rely on these services for various reasons (e.g. access to food, shelter, digital connections).

Participants and speakers noted that the pandemic increased the visibility of both public health and the public's health, and identified opportunities to improve weaknesses in health and social systems:

- Address racism, colonialism, and unfair economic structures as part of emergency preparedness planning, response and recovery.
- Develop and implement public policies, guidelines and frameworks that consider the health and social impacts of pandemics.
- Engage in proportionate universalism to account for health outcomes along a social gradient.
- Before, during, and after the emergency, strategize with community members and intersectoral providers as to how to mitigate impacts for populations experiencing social injustice (e.g. those who experience homelessness, low income, food insecurity etc).
- Apply ethical principles such as transparency and accountability when engaging with communities and intersectoral partners.

3) Disproportionate impacts of COVID-19 driven by underlying structural and socioeconomic inequity

COVID-19, and public health and policy responses to the virus, disproportionately impacted multiple communities. Due to the social and structural determinants of health, communities experienced specific and unequal impacts, described below.

a. Indigenous peoples

Jurisdictional conflicts, inadequate housing, and lack of access to clean water, all rooted in colonization, impacted the experience of COVID-19 for Indigenous peoples. Food access and supply chain issues were present for remote Indigenous communities. In some settings there were barriers to following public health measures, and guidance was not tailored for Indigenous communities. Additionally, resources for Indigenous people in hospitals were diverted to COVID-19 testing, leading to compromised care.

b. Black and racialized communities

Systemic racism manifested in inequities in the social determinants of health like housing, education, income, employment and health care access. The health system did not account for the impact of systemic racism on COVID-19 infections, treatment and mortality, and there was a lack of race-based data. Black communities were not referred to testing, denied care and had their symptoms minimized. Black and racialized people were over-represented in jobs deemed as essential, putting them at increased exposure to COVID-19, and did not always have access to technology to access information. Overt acts of racism and stigma, often directed to members of the Chinese community, increased interpersonal violence. Black and Indigenous communities experienced state-sanctioned violence, due to the disproportionate enforcement of public health guidelines.

c. Gender

Women and gender diverse people had increased exposure to COVID-19 due to overrepresentation in health, social and service sector jobs deemed as essential. Exposure was heightened for racialized women, including newcomers over-represented in low-income, temporary positions without the benefits necessary to protect workers. COVID-19 increased gender-based violence, with intimate partner violence as a hidden crisis within the pandemic for women isolating at home. As crowded shelters were unable to provide support, women were exposed to further harm.

d. Precariously employed

People in precarious employment, and those who were unable to work at home, experienced job and income loss. Precariously employed workers were more likely to have challenges maintaining physical distancing in their work. Many were unable to access benefits or relief supports. Women and racialized people were over-represented in part-time and essential positions without paid sick leave and less likely to have resources to manage the financial and emotion burden of working from home, performing childcare duties, and self-isolating.

e. Food insecure

People on social assistance and in low-wage precarious jobs experienced household food insecurity. Due to limited internet and/or or credit access, low-income communities could not always engage with the virtual solutions created to comply with public health measures (e.g. ordering food online, contactless payment, etc).

f. Housing insecure

People experiencing homelessness faced increased exposure to COVID-19 in shelters. Housing inadequacy worsened as shelters closed.

g. People with disabilities

Young women and girls with disabilities experienced greater COVID-19 exposure risk, lack of access to basic necessities and benefits, increased vulnerability in institutional care settings, uncertain availability of supports, lack of personal protective equipment and screening, and slowed or discontinued home care. Physical distancing resulted in heightened feelings of invisibility, isolation, exclusion, and lack of importance to government and society. Information was not adapted for people with intellectual and physical disabilities. People with disabilities experienced stigma and discrimination in public and professional settings through overt comments, the de-prioritization of resources, loss of income, and ableist approaches to triage for health system resources like intensive care unit beds and ventilators.

h. Mental health

COVID-19 significantly impacted the mental health of practitioners, essential workers and community members including anxiety, stress and community trauma.

4) Enhanced momentum for collective mobilization, policy innovations and social transformation

a. Community mobilization and organizing

Community responses rapidly emerged to meet the distinct needs of intersectional communities even as they were being deeply impacted by COVID-19. Community-based organizations were well positioned to provide services and supports, credited to the close relationships with communities, governance by community members, and strong networks:

> *So these frontline organizations are already community governed, they're run by and for communities, and so that means we can tap into those networks of staff, of peer workers, of board members, of volunteers in the community and clients, to continue to give advice through the networking structures that we already have, to help make sure that we're making decisions that are reflective of what the community needs and wants, and what their current circumstances are.* [S2]

'Care mongering' at the community-level played a critical role to fill gaps left by fractured health and social systems. These self-organized schemes like mutual aid groups were largely led by equity-seeking communities who provided their communities with basic necessities. Indigenous-specific responses emerged as communities protected elders by restricting entry into their Nations. Programs like virtual traditional dancing were delivered to counteract isolation stemming from physical distancing and to maintain cultural practices. Traditional food systems, medicines and practices enhanced community wellbeing.

b. Policy innovations on the social determinants of health

The COVID-19 pandemic opened an unprecedented opportunity for policy change and innovations. These innovations represented years of on-the-ground research, advocacy and activities to shift policy. The speed at which policies were implemented actively challenged notions of change as incremental, an approach often implored in policy circles. Faced with the urgency of the pandemic and the hypervisibility of harm and inequities, governments moved more expediently than previously seen:

> *I've been talking to a number of public policy advocates who have said that the amount of changes we've seen in public policy in the last 20 days has surpassed the changes that many people have seen in the last 20 years ...* [S5]

Sector-specific policies responded to the direct and indirect impacts of COVID-19. Early policy innovations were already being implemented in April 2020 to improve the social determinants of health by different levels of government. At the federal level, for example, the Canada Emergency Response Benefit was implemented to replace lost income due to COVID-19 (26). At the municipal

level, innovations in housing were observed whereby hotels were used to provide safe housing for people experiencing homelessness. Coupled with the provision of food, medical aid, mental health supports and a drug supply, this showed positive benefits:

> *... folks having their own safe space ... their own bathroom ... their own lock on the door ... we're seeing many of the folks who are being placed into these hotels and motels having quite good outcomes ... improvement on health ... positive improvement on social outcomes as well.* [S7]

Policy approaches, such as increased funding to food banks as a charity-based solution to food insecurity and Canada Emergency Response Benefit (CERB) were critiqued for failing to address and restructure power relations, leading to calls for social transformation that went beyond sector-specific reforms.

c. Igniting social transformation for health and social equity

Social transformation was articulated in spiritual, political, social, economic and cultural terms. Drawing on Indigenous spirituality and knowledge, one speaker stated:

> *I was always told of the Seventh Fire, the Seventh Fire of people awakening themselves, and we're in it, we're in the midst of the Seventh Fire. And I really thought to myself that my children's children wouldn't have to deal with this, right. But now it's staring us in the face so it's kinda woken me up, right.* [S8]

Accordingly, transformation was inevitable given the existing policy windows and the 'enormous ... abyss' between pre-pandemic social safety nets and the systems required to promote good health and a good life:

> *I think in terms of this idea of coming back to status, quo, we can't. CERB, as it's set up right now, is actually way more money than those who rely on social assistance and disability benefits, so that speaks to the enormous gap, abyss, whatever you want to call it that is very ableist in how we determine people's worth and the lives that they live. So going back to status quo is not an option.* [S9]

d. Power reasserts itself

Despite the potential for policy innovations and social transformation, there was skepticism of realizing a 'better normal.' This was grounded in the knowledge that social transformation is difficult, lack of trust in governments based on historical experiences and the contention that power seeks to reassert itself.

> *I think because this is a matter of privilege and power, I do believe that the urge is going to be to restore that power, and so institutions and individuals, communities with privilege, are going to want to protect their privilege, and institutions are going to cater to that.* [S14]

Antidotes to a return to the status quo surfaced such as courage, persistent organizing, engaging those with influence, productive conflict and accountability:

> *... working together to find leaders to make these move right now I think would be really helpful. Identifying what's working and what isn't working. And trying to identify and make the most of windows that are open or the doors that are open when they're open, and not letting up when things calm down.* [S11]

To ignite social transformation, speakers and participants offered bold visions to address persistent inequities in pandemic planning and recovery, and beyond:

- Recognize the interconnectedness of all planetary elements
- Invest in the ecological and social determinants of health for all communities in government policies
- Apply intersectoral policy approaches resourced by wellbeing budgets
- Transform health and social systems to better account for equity for example, collect race and equity data and implement appropriate programs and services

- Develop alternative social, economic and political systems and approaches grounded in an ethic of care, compassion, trust-building and togetherness

So when you start to look at pandemics like COVID-19, we start to understand that it's not just human beings in this world, that the plants, the animals, the birds, the fish, the land, the soil, the water, it's all connected so we start to heal Mother Earth, we can start to heal people as well. [S1]

Discussion

COVID-19 was declared a global pandemic by the World Health Organization on 13 March 2020. This declaration was rapidly followed by the implementation of public health measures by different levels of governments across the world. In Canada, lockdown and physical distancing measures were implemented by federal, provincial/territorial and regional governments. Our findings support that COVID-19 and the subsequent public health responses had unique and deep impacts on health that followed lines of existing structural inequities.

Despite past recommendations on integrating equity and health promotion principles into pandemic planning and preparedness (17–19) and notwithstanding warnings of future pandemics resulting from significant ecological changes (18,27), our findings support that governments and health and social systems did not adequately prepare and plan for equity. Further, the early responses to COVID-19 strongly suggest that governments were ill-prepared, and that health and social systems did not apply core health promotion principles and approaches in pandemic planning. Where equity was addressed, it appears to have been through later responses, as an afterthought rather than an initial driver or part of the emergency preparedness planning.

For equity-oriented researchers, practitioners and communities, the negative impacts did not come as a surprise. Instead they were experienced as a reverberation of generations of activism, advocacy, research and ongoing attempts to transform inequitable and oppressive social structures. Our findings emphasize that precarity was already built into the societal fabric. As a result, the existing social and health systems were destined to fail many parts of society, with communities at the margins bearing more than their fair share of the burdens brought on by COVID-19.

Community organizing and mobilization played a protective role. The inherent resilience of communities filled gaps left by frail and toxic health and social systems which were slow or unresponsive. The capacity of communities to mobilize, however necessary, does not meet the need for widespread social support and protection, nor does it absolve governments from their responsibility to ensure the health and wellbeing of all people.

Equity and social justice are manifestations of an ethic of care (28) and communitarian perspectives (29). If ethical principles and values are to be applied to pandemic preparedness and responses, we need to be attentive to questions of implementation and structural inequities (13). This will require a stronger engagement between health promotion scholars and practitioners, and infectious diseases and emergency preparedness specialists (30).

Speakers and participants consistently expressed a strong desire to move toward a more just and equitable society, going 'back to better' rather than 'back to normal' in a post-COVID-19 world. Stronger critiques of public health practice and public policy that draw on critical health promotion principles are needed to inform pandemic responses, so they reflect a better normal. Critiques should offer up bold visions of how to reorganize society for better health and wellbeing. Health promotion principles coupled with other approaches to social, political and economic change offer a path forward. This raises the questions: Are the current mobilizations and policy innovations expressions of a moment, or can they serve as the basis for social transformation, growing into a sustained movement for health and health equity? Can increased public consciousness be sustained beyond the pandemic and transformed into political action to improve health equity?

Social movement (31–34) and systems theories (35–37) offer vital insights on how health promotion research, practice and policy can contribute to current momentum to move toward a better normal. Systems theory tells us that systems are deeply connected and offer different points of leverage for action (35). Social movement theory explicitly accounts for conflict and calls for mobilizing structures, resonant frames and political opportunities. COVID-19 has opened up

political opportunities which, if fully exploited, can lead to significant social transformation for health beyond pandemic planning and responses. Together, both theoretical approaches speak to the pertinence of narrative practices that shift the fundamental assumptions that underpin systems. These narratives, coupled with new and existing mobilizing structures, can be directed to planetary health disruptions and building health-promoting socioeconomic and political systems (5,38). Concretely this means:

- Apply a 'whole community' approach that engages individuals and organizations in public health emergency planning to strengthen community capacity during response and recovery (39) and allow for inclusion of community-based risks and lived experiences (40).
- Strategize with non-health sector partners to design a just and sustainable future.
- Act with non-health sector partners to disrupt oppressive systems and invest in healthy communities.
- Engage in effective message framing and media advocacy to maintain these equity issues, and their solutions, in the public consciousness.

Acknowledgements

We are grateful to all speakers and participants who shared their knowledge and expertise during the online conversations. Speakers included Samiya Abdi, Nelly Bassily, Claire Betker, Trish Hennessy, Michael Keeling, Yoav Keynan, Angela Mashford-Pringle, Kate Mulligan, Camille Orridge, Abe Oudshoorn, Clay Shirt, Louis Sorin, Anjum Sultana and Valerie Tarasuk. The conversations were moderated by Sume Ndumbe-Eyoh. Our thanks to Jaime Stief and Danielle MacDonald for supporting the planning and delivery of the conversations. We are also grateful to Jean Lederer who assisted with components of the thematic analysis.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: All authors work for the National Collaborating Centre for Determinants of Health which is funded by the Public Health Agency of Canada.

ORCID iD

Sume Ndumbe-Eyoh https://orcid.org/0000-0002-0605-0143

References

1. Greenwood M, de Leeuw S, Lindsay NM (eds). Determinants of Indigenous Peoples' Health in Canada: Beyond the Social. Toronto: Canadian Scholars' Press; 2015.
2. Paradies Y, Ben J, Denson N, Elias A, Priest N, Pieterse A, et al. Racism as a determinant of health: a systematic review and meta-analysis. PLoS One. 2015; 10: e0138511.
3. Navarro V, Shi L. The political context of social inequalities and health. Soc Sci Med. 2001; 52: 481–491.
4. Pan American Health Organization. Just Societies: Health Equity and Dignified Lives. Executive Summary of the Report of the Commission of the Pan American Health Organization on Equity and Health Inequalities in the Americas [Internet]. Revised ed. Washington, DC: Pan American Health Organization; 2019 [cited 2020 July 13]. Available from: https://iris.paho.org/handle/10665.2/51570
5. Raphael, D., Bryant, T., Mikkonen, J., & Raphael, A. (2020). Social determinants of health: The Canadian facts [Internet]. Oshawa, ON: Ontario Tech University Faculty of Health Sciences and Toronto, ON: York University School of Health Policy and Management. Available from: http://www.thecanadianfacts.org/
6. Rutter PD, Mytton OT, Mak M, Donaldson LJ. Socio-economic disparities in mortality due to pandemic influenza in England. Int J Public Health. 2012; 57: 745–750.
7. National Collaborating Centre for Aboriginal Health. The 2009 H1N1 Influenza Pandemic Among First Nations, Inuit and Métis Peoples in Canada: Epidemiology and Gaps in Knowledge. Prince George, BC: NCCAH; 2016.
8. Centers for Disease Control and Prevention. 2009 pandemic influenza A (H1N1) virus infections—Chicago, Illinois, April–July 2009. MMWR Morb Mortal Wkly Rep. 2009; 58: 913–918.
9. Centers for Disease Control and Prevention. Deaths related to 2009 pandemic influenza A (H1N1) among American Indian/Alaska natives—12 states, 2009. MMWR Morb Mortal Wkly Rep. 2009; 58: 1341–1344.
10. Klein SL, Passaretti C, Anker M, Olukoya P, Pekosz A. The impact of sex, gender and pregnancy on 2009 H1N1 disease. Biol Sex Differ. 2010; 1: 5.
11. Campbell VA, Gilyard JA, Sinclair L, Sternberg T, Kailes JI. Preparing for and responding to pandemic influenza: implications for people with disabilities. Am J Public Health. 2009; 99: S294–S300.
12. World Health Organization; Health and Welfare Canada; Canadian Public Health Association. Ottawa: Charter for Health Promotion [Internet].

1986 [cited 2020 July 13]. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/services/health-promotion/population-health/ottawa-charter-health-promotion-international-conference-on-health-promotion/charter.pdf/
13. DeBruin D, Liaschenko J, Marshall MF. Social justice in pandemic preparedness. Am J Public Health. 2012; 102: 586–591.
14. Kayman H, Ablorh-Odjidja A. Revisiting public health preparedness: incorporating social justice principles into pandemic preparedness planning for influenza. J Public Health Manag Pract. 2006; 12: 373–380.
15. Plough A, Bristow B, Fielding J, Caldwell S, Khan S. Pandemics and health equity: lessons learned from the H1N1 response in Los Angeles County. J Public Health Manag Pract. 2011; 17: 20–27.
16. National Advisory Committee on SARS and Public Health. Learning from SARS: Renewal of Public Health in Canada. Ottawa: Health Canada; 2003.
17. Khan Y, Fazli G, Henry B, de Villa E, Tsamis C, Grant M, et al. The evidence base of primary research in public health emergency preparedness: a scoping review and stakeholder consultation. BMC Public Health. 2015; 15: 432.
18. Stephen C. Rethinking pandemic preparedness in the Anthropocene. Healthc Manage Forum. 2020; 33: 153–157.
19. Tam T. Fifteen years post-SARS: key milestones in Canada's public health emergency response. Can Commun Dis Rep. 2018; 44: 98-101.
20. Canadian Pandemic Influenza Preparedness: Planning Guidance for the Health Sector [Internet]. Ottawa, ON: Government of Canada; 2018 [cited 2020 July 13]. Available from: https://www.canada.ca/en/public-health/services/flu-influenza/canadian-pandemic-influenza-preparedness-planning-guidance-health-sector.html
21. Public Health Agency of Canada. Vulnerable Populations and COVID-19 [Internet]. Ottawa, ON: Public Health Agency of Canada; 2020 May 28 [cited 2020 July 13]. Available from: https://www.canada.ca/en/public-health/services/publications/diseases-conditions/vulnerable-populations-covid-19.html/
22. National Collaborating Centre for Determinants of Health. Conversation Series: Health Equity, Determinants of Health and COVID-19 [webcast]. Antigonish, NS: National Collaborating Centre for Determinants of Health; 2020 [cited 2020 July 13]. 5 videos. Available from: https://nccdh.ca/index.php?/workshops-events/entry/COVID-19-webinar-conversation-series
23. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006; 3: 77–101.
24. Nowell LS, Norris JM, White DE, Moules NJ. Thematic analysis: striving to meet the trustworthiness criteria. Int J Qual Methods. 2017; 16: 1609406917733847.
25. Stevens G, O'Donnell VL, Williams L. Public domain or private data? Developing an ethical approach to social media research in an inter-disciplinary project. Educ Res Eval. 2015; 21: 154–167.
26. Government of Canada [Internet]. Canada Emergency Response Benefit (CERB). Ottawa, ON: Government of Canada; 2020 [cited 2020 July 13]. Available from: https://www.canada.ca/en/services/benefits/ei/cerb-application.html/
27. Canadian Public Health Association. Global Change and Public Health: Addressing the Ecological Determinants of Health [Internet]. Ottawa, ON: Canadian Public Health Association; 2015 [cited 2020 Jan 12]. Available from: https://www.cpha.ca/sites/default/files/assets/policy/edh-discussion_e.pdf/
28. Falk-Rafael A, Betker C. Witnessing social injustice downstream and advocating for health equity upstream: "the trombone slide" of nursing. ANS Adv Nurs Sci. 2012; 35: 98–112.
29. MacDonald M. Introduction to Public Health Ethics 3: Frameworks for Public Health Ethics. Montréal, QC: National Collaborating Centre for Healthy Public Policy; 2015.
30. Van den Broucke S. Why health promotion matters to the COVID-19 pandemic, and vice versa. Health Promot Int. 2020; 35: 181–186.
31. Brown P, Zavestoski S. Social movements in health: an introduction. Sociol Health Illn. 2004; 26: 679–694.
32. Morris AD, Mueller CM. Frontiers in Social Movement Theory. New Haven, CT: Yale University Press; 1992.
33. Touraine A. An introduction to the study of social movements. Soc Res. 1985; 52: 749–787.
34. Roundtable on Population Health Improvement; Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities; Board on Population Health and Public Health Practice; Institute of Medicine. Supporting a Movement for Health and Health Equity: Lessons from Social Movements: Workshop Summary. Washington, DC: National Academies Press; 2014.
35. Carey G, Crammond B. Systems change for the social determinants of health. BMC Public Health. 2015; 15: 1–10.
36. Pauly B, Shahram SZ, van Roode T, Strosher HW, MacDonald M. Reorienting Health Systems Towards Health Equity: The Systems Health Equity Lens (SHEL). Victoria, BC: The Equity Lens in Public Health (ELPH) Research Project; 2018.
37. Xia S, Zhou X, Liu J. Systems thinking in combating infectious diseases. Infect Dis Poverty. 2017; 6: 1–7.
38. National Collaborating Centre for Determinants of Health. Common Agenda for Public Health Action on Health Equity. Antigonish, NS: National Collaborating Centre for Determinants of Health; 2016.
39. Ramsbottom A, O'Brien E, Ciotti L, Takacs J. Enablers and barriers to community engagement in public health emergency preparedness: a literature review. J Community Health. 2018; 43: 412–420.
40. Khan Y, O'Sullivan T, Brown A, Tracey S, Gibson J, Généreux M, et al. Public health emergency preparedness: a framework to promote resilience. BMC Public Health. 2018; 18: 1344.

Original Article

Individual, social and national coping resources and their relationships with mental health and anxiety: A comparative study in Israel, Italy, Spain, and the Netherlands during the Coronavirus pandemic

Adi Mana[1], Sabina Super[2], Claudia Sardu[3], Dolors Juvinya Canal[4], Neuman Moran[5] and Shifra Sagy[6]

Abstract: Employing the salutogenic model, we asked how individuals in different countries cope with the COVID-19 crisis and stay healthy. We were interested in exploring the individual (i.e. sense of coherence) as well as the social and national resources (i.e. social support, sense of national coherence, and trust in governmental institutions) that could explain levels of mental health and anxiety during the outbreak of the pandemic. Data collection was conducted via convenience sampling on online platforms, during the end of March and the beginning of April 2020. The data included four samples: 640 Israeli participants (319 males), 622 Dutch participants (177 males), 924 Italian participants (338 males) and 489 Spanish participants (117 males); age range of 18–88 years. The questionnaires included standard tools (MHC-SF, GAD-7, SOC, SONC). Several questions were adapted to the context of coronavirus and measured levels of exposure to COVID-19, trust in governmental institutions, and social support. The results significantly confirmed the suggested salutogenic model regarding the contribution to individual and national coping resources to anxiety levels and mental health. The patterns of the coping resources in explaining anxiety and mental health were similar in the four samples, and SOC was the main predictor these outcomes. Despite these similarities, a different pattern and also different magnitudes of the predictive value of the coping resources were found for the two different reactions: anxiety vs. mental health. While SOC and situational factors (like financial threat) were significant in explaining anxiety levels, the SOC and national resources were found as significant in explaining mental health levels. The findings support the salutogenic approach in studying reactions during pandemic time. They also shed some light on the difference between pathogenic and salutogenic measures in studying psychological reactions to stressful situations.

Keywords: Social support, stress, sense of coherence, sense of national coherence, trust, COVID-19, mental health, anxiety

1. School of Behavioral Sciences, Peres Academic Center, Israel.
2. Health and Society Group, Wageningen University, Netherlands.
3. The Department of Medical Sciences and Public Health of the University of Cagliari, Italy.
4. Health Promotion Chair, Research Group Health and Healthcare, University of Girona, Spain.
5. The Department of Education, Ben-Gurion University of the Negev, Beer Sheva, Israel.
6. Martin Springer Center for Conflict Studies, Ben-Gurion University of the Negev, Beer Sheva, Israel.

Correspondence to: Adi Mana, School of Behavioral Sciences, Peres Academic Center, Rehovot, 76120, Israel. Email: manna.adi@gmail.com

(This manuscript was submitted on 3 August 2020. Following blind peer review, it was accepted for publication on 14 January 2021.)

Global Health Promotion 1757-9759; Vol 28(2): 17–26; 992957 DOI: 10.1177/1757975921992957 journals.sagepub.com/home/ghp

Introduction

The COVID-19 pandemic has affected the lives of millions worldwide, causing great uncertainty and anxiety. In addition to severe physical health consequences, the pandemic is also having an impact on the general population in terms of mental health and well-being (1). Former studies have indicated that the virus's spread over a given territory or the level of actual health event were not the only factors that predicted mental health and anxiety levels (2). Moreover, differences in the responses to the pandemic could be observed between and within countries, as individuals and nations differ in their resources to cope with such a crisis (3). Thus, it seems valuable to study which resources play a role in coping with a pandemic in a health-promoting way and to compare the pattern of these resources in promoting mental health and reducing anxiety levels across countries.

Our study employs the salutogenic approach (4) that, in contrast to pathogenesis, focuses on the study of the origins of health, illuminates salutary factors that promote health, reduces distress reactions, and explains successful coping with stress (5).

While the COVID-19 pandemic is a global phenomenon, it appears that each nation has developed its own way of managing it (1,6). Thus, the first aim of our study was to compare levels of mental health and anxiety in four countries that differ in their situation and management of the pandemic in its first stage. Both measures are commonly used as indicators of psycho-physiological distress. However, anxiety is usually considered a pathological construct while mental health is a salutogenic one (7). Our second purpose relates to the differential patterns of coping resources in explaining these two measures.

Emotional reactions

Various psychological vulnerability factors may play a role in anxiety levels, including individual differences of intolerance of uncertainty, perceived vulnerability to disease, and anxiety proneness (3). We hypothesized that general anxiety will be explained mainly by state related variables, such as level of health or financial threat due to the pandemic situation (8).

Our second measure of mental health refers to a subjective evaluation of one's state of wellbeing (7). It is not merely the absence of anxiety, but it also relates to the presence of positive feelings, positive functioning in individual and community life, and life satisfaction (9). We expected the level of mental health to be explained less by the situational variables of the pandemic risk and more by one's coping resources (8,9).

Coping resources as explanatory factors

Our main research question relates to the influence of individual, social, and national coping resources on the emotional reactions to acute stress situations.

On the individual level we included the sense of coherence (SOC) (4), as a core salutogenic construct. SOC is defined as a global orientation in life which enables people to view life as comprehensible, manageable, and meaningful (4). People with a stronger SOC are better able to understand the stressor (comprehensibility), are better capable to select an appropriate strategy and available resources to deal with the stressor (manageability), and have a stronger feeling that engaging with the stressor is a meaningful process (meaningfulness). A strong SOC has been found in research to be associated with better quality of life, reduced anxiety, and better mental health (4,5).

However, when people face collective stressors, the resources of the group are also crucial (4). Therefore, we also explored social and national coping resources. Social support was found to act as a buffer against adverse life events and to support mental health in times of crisis. Social support and SOC were found to have significant independent and shared contributions to explained variance on the mental health index (10).

On a national level various coping resources are available that allow individuals and communities to cope well under stress. In this study we focus on two resources: the sense of national coherence (SONC) and trust in governmental institutions. The salutogenic concept of SONC (11) reflects an enduring tendency to perceive one's national group as comprehensible, meaningful, and manageable. Strong SONC was found to be an important factor for resilience especially in conflict areas (12).

Similarly, trust in governmental institutions can mitigate the impact of a pandemic on mental health,

as has been suggested previously during the COVID-19 epidemic (3, 6). Loss of trust in the aftermath of a disaster was found as a potential factor in worsening health problems (13).

The context of the study

Our study investigated these measures across four different countries: Israel, the Netherlands, Italy, and Spain. In each country, the pandemic situation was different during the period of data collection. Based on the database of OurWorldInData (14), during that period (19 March–24 April 2020), Israel was significantly lower as compared to the Netherlands, Italy, and Spain in the spread and the damage of the pandemic. The strategy of the governments to deal with the pandemic was also different at this stage (14,15,16). In Israel, Italy, and Spain the government imposed a complete lockdown. Schools and commercial activities with the exception of essential ones were closed, and restrictions were imposed on leaving home, except for certain justified reasons. In the Netherlands, however, the national measures were implemented in what the government called 'an intelligent lockdown', allowing most shops to remain open and allowing people to go outside for recreational purposes (17). Moreover, a range of emergency financial schemes for employers and self-employed people were in place, while in Israel, Italy, and Spain the governmental financial support during this period was not clear. On this background, we expected to find different levels of reactions and patterns of coping resources in the four samples as follows.

***The study hypotheses*:**

1. Depending on the pandemic situation, levels of the reactions will be different among the four countries. Higher levels of anxiety and lower levels of mental health were expected in Italy and Spain than in the Netherlands and Israel.
2. Based on the salutogenic approach, a similar pattern of coping resources was expected to explain levels of anxiety and mental health in the four countries.
3. Different patterns of factors, however, were expected to explain mental health vs. anxiety. Mental health would be explained more by personal, social, and national coping resources, while anxiety response would be explained more by the situational risk factors.

Method

Participants

Data collection took place from 19 March–24 April 2020. Recruitment of participants was conducted via an online survey platform and social media networks. The current data analysis included four samples: participants from Israel, the Netherlands, Italy, and Spain (the following data and results will be presented according to this order): 619 Israelis (303 males, 48.9 %), with an age range of 18–75 years (mean = 38.61, SD = 13.11); 622 Dutch (177 males, 29.3 %), with an age range of 19–88 (mean = 44.71, SD= 18.02); 924 Italians (338 males, 36.6 %), with an age range of 18–86 (mean = 41.67, SD = 16.84); and 489 Spanish (117 males, 23.9 %), with an age range of 18–80 (mean = 48.32, SD = 13.86).

Very few participants in the four samples reported that they had been diagnosed with Coronavirus (3 (0.5%), 1 (0.2%), 4 (0.4%), 25 (5.1%)). About a quarter of the participants reported that they are in a high-risk group because of their age or health status 110 (17.8%), 155 (25.6%), 198 (21.4%) and 129 (26.4%). Some of the participants reported that they were or had been in quarantine 53 (8.6%), 70 (11.6%), 294 (31.8%) and 94 (19.2%). Most of the Israeli and Italian participants estimated that they would suffer financially from COVID-19 crisis 466 (75.2%), 563 (60.9%), while smaller numbers estimated so in Spain 204 (41.7%), and only 68 (11.2%) of the Netherlands participants estimated that they would suffer financially.

Instruments

The study instrument comprised structured and self-reported questionnaires that were back translated (18) from English to Hebrew, Dutch, Italian, and Spanish.

The Generalized Anxiety Disorder (GAD-7, Spitzer, Kroenke, and Löwe, 2006)

The seven items of this scale enquired about the degree to which the participant has been bothered

by feeling nervous, anxious, worried, restless, annoyed, and afraid during the two weeks prior to answering the questionnaire. Each item was scored on a four-point Likert scale (0–3), with total scores ranging from 0 to 21 where higher scores reflect greater severity of anxiety. Internal consistency of the questionnaire was estimated at 0.89 (19) and in the current study α = 0.91, 0.85, 0.88, 0.90.

Mental health continuum (MHC-SF, Lamers, Westerhof, Bohlmeijer, ten Klooster, and Keyes, 2011)

The scale includes 14 items measuring the three components of well-being: emotional, social, and psychological. The questionnaire was adapted to the current context and based on the experiences the participants had over the last two weeks (never, once in these two weeks, about once a week, two or three times a week, almost every day, or every day). Internal consistency of the questionnaire was estimated at 0.89 (7) and in the current study α = 0.90, 0.89, 0.91, 0.94.

Sense of coherence (SOC-13, Antonovsky, 1987)

The 13 items, on a seven-point Likert scale, explore the participants' perceptions of the world as comprehensible, meaningful, and manageable. The Italian SOC version was distributed to the Italian sample (20). The α values in former studies using SOC-13 range from 0.70 to 0.92 (21) and in this study the α = 0.79, 0.85, 0.81, 0.82.

Sense of national coherence (SONC, Mana, Srour, and Sagy, 2019)

The eight items on a seven-point Likert scale (1 = totally agree, 7 = totally disagree) explore the participants' perceptions of his/her own society as comprehensible, meaningful, and manageable. Internal consistency of the questionnaire was estimated at 0.80 (11) and in the current study α = 0.84, 0.70, 0.77, 0.81.

Trust in governmental and other institutions

A seven-item questionnaire regarded level of trust in relevant institutions (i.e. media, prime minister, police, government, ministry of finance, ministry of health, health-care workers, and hospitals) on a five-point Likert scale (1 = very much, 5 = not at all). Internal consistency was α = 0.77, 0.85, 0.85, 0.86.

Social support

Three items explored feelings of support that the participant feels he/she receives from family members, from the community in the neighbourhood or settlement, and from virtual communities (i.e. social networks, Twitter, Facebook), on a five-point Likert scale (1 = very much, 5 = not at all).

Socio-demographic variables

Demographic information (gender, age, marital status) was collected.

Level of risk and exposure to COVID-19

We explored both health and financial risk by asking if the participant: 1) was part of a risk group because of his/her age and/or medical condition; 2) had been in quarantine; and 3) had been diagnosed with COVID-19. We also explored the participant's estimation of financial risk: To what extent do you think you will suffer financially from the Coronavirus crisis? (1 = very low, 5 = very high).

Procedure

Prior to data collection, we obtained approval from the ethics committees of the participating institution in each county. In Israel, the data were collected via a nonprobability, general population panel (Midgam panel) and in the other countries we used a nonprobability snowball sampling via social media networks (using Qualtrics or other online tools). To reduce the sample selection problem, the invitation letter was distributed among a large variety of social networks and the participants were asked to help in further distributing the link to the questionnaire. In this letter we explained that the research objective was to understand the participant's experience during the period of Coronavirus. The anonymity of the participants was guaranteed, and no identifying data were collected in the questionnaire. Data were analyzed using SPSS Statistics. Descriptive data were compared using ANOVA. Separated hierarchical regressions were

Table 1. Means, standard deviations and one-way analyses of variance in mental health, anxiety and coping resources in Israel, the Netherlands, Italy and Spain.

Measure	*Israel*		*The Netherlands*		*Italy*		*Spain*		*Sig F*	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*		
Mental health	3.95	1.05	4.40	0.87	4.04	0.99	4.18	1.12	.010	3.934
Anxiety	7.46	5.65	5.57	3.79	8.29	4.96	7.72	5.17	.005	4.776
SOC	4.54	0.84	4.97	0.90	4.41	0.95	4.80	0.91	.000	7.613
SONC	4.08	1.16	4.61	0.75	3.55	1.03	3.22	1.09	.000	141.887
Trust	3.24	0.78	3.89	0.52	3.89	0.75	2.53	0.78	.000	233.758
Family support	4.23	1.05	4.07	0.92	4.08	1.01	4.65	0.64	.000	34.995
Community Support	3.05	1.37	2.86	1.22	2.80	1.19	3.72	1.20	.000	45.896
Virtual Support	3.32	1.32	3.06	1.33	2.91	1.28	3.60	1.26	.000	27.684

calculated to examine the contribution of coping resources to mental health and anxiety.

Results

Preliminary analysis

An ANOVA tested the differences in the levels of the research variables (mental health, anxiety, SOC, SONC, trust, and social support of family, neighbourhood, and virtual community) between the four research groups (Israel, the Netherlands, Italy, and Spain – the results will be presented in that order). As the assumption of homogeneity of variance was not met, we used the Welch's adjusted F ratio, which was significant at the .01 alpha levels for mental health, .005 for anxiety, and at the .001 alpha for the other variables (see Table 1). Games-Howell Post hoc tests revealed that the levels of SOC, SONC, and trust among the Dutch participants were significantly higher as compared to the other participants, while levels of trust and SONC were the lowest among the Spanish participants. However, levels of family, community, and virtual community were higher among the Spanish participants as compared to the others. As for our first hypothesis, the results revealed that the Dutch participants, as predicted, reported lower levels for anxiety and higher level of mental health as compared to the Italian and the Spanish participants. However, no significant differences in level of anxiety were found between the Israeli participants and the other three samples, and their level of mental health was lower compared to the Netherlands participants. Therefore, the first hypothesis was not confirmed.

Hierarchical regression

Separate hierarchical regressions were calculated to test the second and the third hypotheses. Demographic variables of age and dummy variables of belonging to a risk group, financial risk, and being in quarantine were controlled for in the model. In the first step, control variables were entered. In the second step, SOC, SONC, trust, and social support were added. Table 2 shows the final step of the regression model.

Mental health. At Step 1, age, gender, and health and financial risk variables predicted approximately 4%, 11%, 9%, and 3% of the variance in mental health scores in the Israeli, Dutch, Italian, and Spanish samples. At this step, financial risk and age scores were significant predictors among the all the Israeli, Dutch and Italian samples, while in Spain only financial risk was significant. Belonging to a health risk group was a significant predictor only among the Dutch sample.

The inclusion of the coping resources at Step 2 led to a significant increase in the variance accounted for by the model. SOC was a significant predictor among all the samples and it was the main significant predictor. Family support was significant in all the samples, while community support was a significant predictor in the Israeli, Dutch, and Italian samples, and support from the virtual community was significant among Spanish and Dutch participants. Levels of SONC significantly predicted mental health in the Israeli, Dutch, and Italian samples.

Table 2. A summary of the hierarchical regression analysis between health and economic risk factors, gender, SOC, SONC, trust and social support mental health and anxiety.

Mental Health																
Country	*Israel*				*The Netherlands*				*Italy*				*Spain*			
Variables	*B*	*SE B*	β	*t*	*B*	*SE B*	β	*t*	*B*	*SE B*	β	*t*	*B*	*SE B*	β	*t*
Model 1																
Gender	−0.02	0.09	−0.01	−0.18	0.07	0.08	0.04	0.83	0.12	0.08	0.06	1.51	−0.08	0.13	−0.03	−0.64
Health risk group	−0.18	0.13	−0.07	−1.46	−0.21	0.10	−0.11	−2.14	−0.05	0.10	−0.02	−0.55	−0.18	0.13	−0.07	−1.39
Quarantine	0.11	0.16	0.03	0.66	−0.19	0.11	−0.07	−1.73	−0.09	0.08	−0.04	−1.08	0.15	0.14	0.05	1.07
Age	0.01	0.00	0.15	3.14	0.02	0.00	0.31	6.02	0.02	0.00	0.24	5.69	−0.00	0.00	−0.07	−1.31
Economic risk	−0.14	0.04	−0.16	−3.72	−0.17	0.05	−0.15	−3.80	−0.10	0.03	−0.12	−3.23	−0.13	0.05	−0.12	−2.46
Model 2																
Gender	0.01	0.07	0.00	0.13	0.06	0.07	0.03	0.91	0.12	0.06	0.06	2.02	0.05	0.11	0.02	0.41
Health risk group	−0.01	0.10	−0.01	−0.13	−0.06	0.08	−0.03	−0.77	0.02	0.07	0.01	0.28	−0.19	0.11	−0.07	−1.71
Quarantine	0.18	0.13	0.05	1.45	−0.02	0.09	−0.01	−0.18	−0.00	0.07	−0.00	−0.03	0.12	0.12	0.04	1.05
Age	−0.00	0.00	−0.03	−0.84	0.00	0.00	0.04	0.92	0.01	0.00	0.09	2.65	0.00	0.00	−0.02	−0.45
Economic risk	−0.03	0.03	−0.03	−1.00	−0.07	0.04	−0.06	−1.86	0.01	0.02	0.01	0.21	−0.02	0.05	−0.02	−0.51
SOC	0.57	0.05	0.46	11.86	0.44	0.04	0.45	11.76	0.49	0.03	0.47	14.31	0.41	0.06	0.33	7.29
SONC	0.20	0.03	0.22	5.86	0.12	0.05	0.11	2.65	0.09	0.04	0.10	2.69	0.01	0.05	0.01	0.23
Trust	0.02	0.05	0.02	0.49	0.03	0.07	0.02	0.39	0.15	0.05	0.11	3.17	0.23	0.07	0.16	3.40
Family support	0.10	0.04	0.10	2.69	0.08	0.03	0.09	2.42	0.13	0.03	0.14	4.32	0.31	0.08	0.18	3.71
Community support	0.07	0.03	0.09	2.15	0.10	0.03	0.14	3.55	0.14	0.03	0.17	5.49	0.06	0.04	0.06	1.26
Virtual Support	0.05	0.03	0.06	1.48	0.08	0.02	0.13	3.55	0.02	0.02	0.02	0.77	0.15	0.04	0.17	3.88
Anxiety																
Model 1																
Gender	−1.73	0.46	−0.15	−3.75	−1.27	0.36	−0.15	−3.55	−1.16	0.40	−0.11	−2.96	−0.72	0.60	−0.06	−1.19
Health risk group	0.82	0.65	0.06	1.26	0.49	0.44	0.06	1.11	0.69	0.50	0.06	1.42	−0.66	0.60	−0.07	−1.11
Quarantine	−1.21	0.85	−0.06	−1.43	1.20	0.48	0.10	2.51	1.10	0.43	0.10	2.56	−0.66	0.63	0.06	1.18

(Continued)

Table 2. (Continued)

Mental Health																
Country	*Israel*				*The Netherlands*				*Italy*				*Spain*			
Variables	*B*	*SE B*	β	*t*	*B*	*SE B*	β	*t*	*B*	*SE B*	β	*t*	*B*	*SE B*	β	*t*
Age	−0.04	0.02	−0.10	−2.17	−0.05	0.01	−0.25	−4.97	−0.02	0.01	−0.07	−1.70	0.01	0.01	0.06	0.90
Economic risk	1.30	0.19	0.28	6.73	0.66	0.20	0.13	3.29	0.78	0.15	0.19	5.03	0.92	0.24	0.19	3.82
Model 2																
Gender	−1.49	0.41	−0.13	−3.61	−0.91	0.32	−0.11	−2.86	−0.87	0.35	−0.08	−2.47	−0.29	0.54	−0.02	−0.53
Health risk group	0.29	0.57	0.02	0.51	0.03	0.40	0.00	0.09	0.46	0.43	0.04	1.09	−0.59	0.53	−0.05	−1.09
Quarantine	−1.33	0.74	−0.06	−1.81	0.66	0.43	0.06	1.53	0.44	0.38	0.04	1.15	0.56	0.56	0.04	1.01
Age	0.02	0.02	0.05	1.28	−0.01	0.01	−0.04	−0.82	0.02	0.01	0.05	1.37	0.00	0.01	0.02	0.42
Economic risk	0.78	0.17	0.17	4.52	0.28	0.18	0.06	1.55	0.43	0.14	0.11	3.09	0.43	0.22	0.09	1.96
SOC	−3.48	0.28	−0.52	−12.35	−2.16	0.18	−0.50	−12.00	−2.31	0.20	−0.44	−11.64	−2.74	0.27	−0.48	−10.25
SONC	0.02	0.20	0.00	0.10	−0.23	0.22	−0.05	−1.06	0.03	0.20	0.01	0.15	−0.18	0.24	−0.04	−0.77
Trust	−0.04	0.29	−0.01	−0.13	0.48	0.32	0.06	1.50	−0.46	0.28	−0.07	−1.65	0.62	0.33	0.10	1.92
Family support	−0.16	0.22	−0.03	−0.74	0.04	0.17	0.01	0.22	−0.29	0.18	−0.06	−1.62	−0.44	0.40	−0.06	−1.10
Community support	0.30	0.18	0.07	1.69	−0.08	0.13	−0.03	−0.62	−0.44	0.15	−0.11	−2.88	−0.22	0.21	−0.05	−1.02
Virtual Support	0.00	0.19	0.00	0.02	0.23	0.11	0.08	2.04	0.28	0.14	0.07	2.08	0.37	0.19	0.09	1.96

Note: Mental health- Model 1 $F(5,536) = 4.82$, $p = .000$; $F(5,543) = 13.55$, $p = .000$; $F(5,649) = 13.42$, $p = .000$; $F(5,402) = 2.35$, $p < .05$. Model 2 R2 change = 0.40; F change = 62.24, $p = .000$, $F(11,530) = 37.64$, $p = .000$; R2 change = 0.40; F change = 82.19, $p = .000$, $F(11,654) = 55.51$ $p = .000$; R2 change = 0.33; F change = 51.46, $p = .000$, $F(11,548) = 37.66$ $p = .000$; R2 change = 0.32; F change = 31.84, $p = .000$, $F(11,402) = 18.93$, $p = .000$. Anxiety- Model 1 $F(5,541) = 13.04$, $p < .001$; $F(5,548) = 15.53$, $p < .001$; $F(5,654) = 11.25$, $p < .001$; $F(5,402) = 4.03$, $p < .005$. Model 2 R2 change = 0.23, F change = 30.41, $p < .001$, $F(11,541) = 24.47$ $p = .000$; R2 change = 0.21; F change = 27.41, $p < .001$, $F(11,548) = 24.07$ $p = .000$; R2 change = 0.23; F change = 35.48, $p < .001$, $F(11,654) = 26.10$ $p = .000$; R2 change = 0.25, F change = 22.91, $p < .001$, $F(11,402) = .14.94$, $p = .001$. Israel, The Netherlands, Italy, and Spain accordingly.

Gender and age were significant predictors only among the Italian sample and trust was significant among the Italian and Spanish samples. Levels of the overall regression model predicted approximately 44%, 49%, 44%, and 35% of the variance in mental health scores.

Anxiety. At Step 1, age, gender, and health and financial risk variables predicted approximately 11%, 13%, 8%, and 4% of the variance in anxiety scores in the Israeli, Dutch, Italian, and Spanish samples. At this step, financial risk was a significant predictor among all the samples. Gender was a significant predictor among Israeli, Dutch, and Italian samples. Age was a significant predictor only among the Israeli and the Dutch samples. Having been in quarantine was a significant predictor only in the Italian and the Dutch samples.

The inclusion of the coping resources at Step 2 led to a significant increase in the variance accounted for by the model. SOC was the main predictor among all the samples. Gender was also a significant predictor among the Israeli, Italian, and Dutch samples. At this step, financial risk was a significant predictor among Israeli, Italian, and Spanish participants. Support of virtual community was significant in the Italian and Dutch samples, and community support was significant only in the Italian sample. The overall regression model predicted approximately 34%, 33%, 31%, and 30% of the variance in general anxiety scores in Israel, the Netherlands, Italy and Spain.

The results confirmed the second hypothesis, as similar pattern of coping resources in explaining mental health and anxiety were found in the four samples. However, the third hypothesis was only partly confirmed. In all the samples, the coping resources better explained mental health as compared to anxiety, and the situational factors better explained anxiety than mental health, however, SOC explained anxiety levels better than situational factors.

Discussion

The study employed a salutogenic perspective and explored the contribution of coping resources to the explanation of anxiety and mental health during the first wave of COVID-19.

First, we found that the levels of emotional responses were quite different in the four samples. As expected, the participants in the Netherlands reported higher mental health scores and lower levels of anxiety as compared to the participants in Italy and Spain. These results can be explained by the lower spread of the pandemic in the Netherlands compared to Italy and Spain. In Israel, however, the levels of anxiety were relatively high, and the levels of mental health were low, despite the low spread of the pandemic at this stage. It seems that the lack of stability of the political and economic systems in Israel, as compared to the Netherlands, could explain the greater vulnerability of the Israeli participants to the global crisis, as compared to the Dutch participants.

As the research samples were not representative, and significantly different in several demographic variables, we must relate to these findings carefully and with strict caution. Nevertheless, the results are consistent with previous studies, indicating that the actual level of virus damage and its spread were not the only factors that predicted stress responses (2, 22). It seems that as COVID-19 was highly covered by the social media all over the world, psychological responses towards the unknown effects of the pandemic appeared among people in different countries, without direct correlation to the levels of the actual risk of infection (22,23). Moreover, psychological responses to a crisis could be related to a variety of factors like the socio-cultural atmosphere of one's community, gender patterns of expressing feelings of fear, and other factors, more than to the 'objective' situation of the specific crisis (2,3). The sociological and cultural explanations of these results, however, are beyond the scope of this report.

Our main research question focused on the contribution of coping resources in explaining the participants' levels of mental health and anxiety. The findings mainly confirmed our hypothesis. Coping resources indeed contributed to the predictions of both anxiety and mental health, and SOC was found to be the main predictor of these two reactions. Moreover, as expected, the situational factors (state of health and financial threat) were better predictors of anxiety, while SOC and other coping resources were more dominant in explaining mental health. These findings could be explained by the situational characteristic of the anxiety measure

versus the more habitual regular orientation in the life of the mental health measure (8). It appears that one's personal ability to view life as comprehensive, manageable, and meaningful in the chaotic reality of a global pandemic is the most important coping resource in different national and social contexts. This finding supports similar results related to the important role of SOC in the time of COVID-19 (23) and cumulative research from over 30 years that confirms the salutogenic hypothesis (5): a strong sense of coherence (SOC) in the face of hardship enables and advances successful coping and results in less anxiety and better mental health. Understanding the role of coping resources, especially SOC, in promoting mental health during a crisis can lead to a more holistic and salutogenic health care system.

Different patterns were found regarding the predictive value of the national resources for anxiety and mental health: SONC significantly predicted levels of mental health (but not levels of anxiety) in three of the four samples. A previous study revealed that SONC was related to voting patterns (11) and that levels of SONC and mental health were found to be significantly lower among voters for opposition parties (13). It appears that more attention should be paid to the concept of SONC as a potentially significant national resource in coping with the crisis. Despite the global nature of COVID-19, nationality appeared to be a significant factor in dealing with the stressful situation (3). Further research is needed to understand the recent phenomena during the last decade of strengthening national feelings in many countries in the Western world. This seems to be especially significant against the background of a global crisis.

Our study has some limitations that need to be carefully considered. First, the samples are based on a nonprobability convenience sampling. Moreover, the differences found among the four samples in relevant socio-demographic variables limited our ability to conduct accurate comparisons. Therefore, we have no possibility for generalizing the findings on global or national populations. However, internet-based research has many advantages, mainly in terms of timeliness, response rates, and costs (24), and this is especially true in the time of a global pandemic, when the rapid global changes in the pandemic situation required quick responses, and the regulations of social distancing limited the options for other strategies of data collection. Although in the time of the pandemic there was increasing openness and dependency on the internet among a variety of groups, the main challenge of internet-based studies is the non-representability of groups who had no access to an electronic survey. More studies are needed in order to explore the experiences of those specific groups like minorities, immigrants, underprivileged and elderly populations.

Despite these limitations, the findings still point to some theoretical suggestions. First, the similar patterns of coping resources that appeared in such different contexts is very significant and sheds light on the importance of the salutogenic approach in the research of a global pandemic. Understanding the role of coping resources, especially SOC and SONC, in promoting mental health during a crisis can lead to a more holistic and salutogenic health care system. Moreover, based on our findings of the main role of SOC in predicting the mental health of the global population, we suggest exploring SOC in on-going international public health and social surveys.

Second, our findings support the value of a meaningful distinction between the two different responses that were examined in this study: mental health as a salutogenic response and anxiety as a more pathogenic one. We need to understand better, by further research using a mixed methods design, the type of emotional reactions, as well as the patterns of coping resources relevant to study during stressful situations in general, and specifically during a global dramatic pandemic in different contexts.

Understanding the importance of the salutogenic approach view by health systems and leaders, could lead to new directions in health assessment and inform interventions in the pandemic crisis.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iDs

Adi Mana https://orcid.org/0000-0001-7733-7937

Dolors Juvinya Canal https://orcid.org/0000-0002-8749-7800

References

1. Xiong J, Lipsitz O, Nasri F, et al. Impact of COVID-19 pandemic on mental health in the general population: A systematic review. J Affect Disord. 2020; 277: 55–64.
2. Ren SY, Gao RD, Chen YL. Fear can be more harmful than the severe acute respiratory syndrome coronavirus 2 in controlling the corona virus disease 2019 epidemic. World J Clin Cases. 2020; 8.
3. Jetten J, Reicher SD, Haslam SA, Cruwys T. Together apart: The psychology of COVID-19. Sage Publications; 2020.
4. Antonovsky A. Unraveling the mystery of health. How people manage stress and stay well. San Francisco: Jossey-Bass, 1987.
5. Mittelmark MB, Bauer GF. The meanings of salutogenesis. In: Mittelmark MB, Sagy S, Eriksson M, et al. (eds). The Handbook of salutogenesis. Cham: Springer, 2017; 7–13.
6. Žižek S. Pandemic! Covid-19 shakes the world. New York: OR Books, 2020.
7. Lamers SMA, Westerhof GJ, Bohlmeijer ET, et al. Evaluating the psychometric properties of the mental health Continuum-Short Form (MHC-SF). J Clin Psychol. 2011; 67: 99–110.
8. Sagy S. Moderating factors explaining stress reactions: comparing chronic-without-acute-stress and chronic-with-acute-stress situations. J Psychol. 2002; 136: 407–419.
9. World Health Organisation. Wellbeing measures in primary health care: the DepCare project. Report on a WHO meeting, Stockholm, Sweden, 12–13 February 1998, WHO Regional Office for Europe, 1998.
10. Srensen T, Klungsyr O, Kleiner R, Klepp OM. Social support and sense of coherence: independent, shared and interaction relationships with life stress and mental health. Int J Ment Health Prom. 2011; 13: 27–44.
11. Mana A, Srour A, Sagy S. A sense of national coherence and openness to the "other's" collective narrative: the case of the Israeli- Palestinian conflict. Peace and Conflict. J Peace Psychol. 2019; 25: 226–233.
12. Sarid A, Srour A, Sagy S. Sense of national coherence and willingness to concile In: Ferrari F, Leiner M (eds) Encountering the Suffering of the Other. Transdisciplinary Perspectives from the DFG Project. "Hearts of Flesh-not Stone". Gottingen, Germany. Vandenhoeck and Ruprecht. In Press.
13. Mana A, Sagy S. Brief report: can political orientation explain mental health in the time of a global pandemic? Voting patterns, personal and national coping resources, and mental health during the coronavirus crisis. J Soc Clin Psychol. 2020; 39: 187–193.
14. Roser M, Ritchie H, Ortiz-Ospina E, Hasell J. Coronavirus pandemic (COVID-19) [Internet]. 2020 [cited 2020 Mar 19]. Available from: https://ourworldindata.org/coronavirus
15. Ministero della Salute. Covid-19 weekly monitoring report 2020.
16. The Israel National Institute for Health Policy Research. Research Corona Policy [Internet]. 2020 [cited 2020 Mar 19]. Available from: http://israelhpr.org.il/research-corona-policy/
17. RIVM. Hoe reageren mensen in Nederland op het nieuwe coronavirus? Bilthoven: National Institute of Public Health and the Environment; 2020.
18. Tyupa S. A theoretical framework for back-translation as a quality assessment tool. New Voices Transl Stud. 2011; 7: 35–46.
19. Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Inter Med. 2006; 166: 1092–1097.
20. Sardu C, Mereu A, Sotgiu A, et al. Antonovsky's sense of coherence scale: cultural validation of SOC questionnaire and socio-demographic patterns in an Italian population. Clin Prac Epidemiol Ment Health. 2012; 8: 1–6.
21. Eriksson M, Mittelmark MB. The sense of coherence and its measurement. In: Mittelmark MB, Sagy S, Eriksson M, et al. (eds). The handbook of salutogenesis.Cham: Springer; 2017, pp. 97–106.
22. Kinsman J. "A time of fear": local, national, and international responses to a large Ebola outbreak in Uganda. Globalization Health. 2012; 8: 15.
23. Barni D, Danioni F, Canzi E, Ferrari L, Ranieri S, Lanz M, et al. Facing the COVID-19 Pandemic: The Role of Sense of Coherence. Front. Psychol. 2020; 11: 3027.
24. Fricker RD, Schonlau M. Advantages and disadvantages of internet research surveys: evidence from the literature. Field Methods. 2002; 14: 347–367.

Health promotion preparedness for health crises – a 'must' or 'nice to have'? Case studies and global lessons learned from the COVID-19 pandemic

Diane Levin-Zamir[1,2], Kristine Sorensen[3], Tin Tin Su[4], Tetine Sentell[5], Gillian Rowlands[6], Melanie Messer[7], Andrew Pleasant[8], Luis Saboga Nunes[9], Shahar Lev-Ari[10] and Orkan Okan[11]

Abstract: The current COVID-19 pandemic has exposed missing links between health promotion and national/global health emergency policies. In response, health promotion initiatives were urgently developed and applied around the world. A selection of case studies from five countries, based on the Socio-Ecological Model of Health Promotion, exemplify 'real-world' action and challenges for health promotion intervention, research, and policy during the COVID-19 pandemic. Interventions range from a focus on individuals/families, organizations, communities and in healthcare, public health, education and media systems, health-promoting settings, and policy. Lessons learned highlight the need for emphasizing equity, trust, systems approach, and sustained action in future health promotion preparedness strategies. Challenges and opportunities are highlighted regarding the need for rapid response, clear communication based on health literacy, and collaboration across countries, disciplines, and health and education systems for meaningful solutions to global health crises.

Keywords: health literacy, health-promoting schools, equity/social justice, health-promoting healthcare, vulnerable groups, migrant health, mental health literacy

Introduction

The COVID-19 pandemic has exposed missing links between health promotion and national/global emergency policies. Health promotion, by enabling people to increase control over their health, is essential when health crises such as COVID-19 emerge. Throughout the course of the pandemic, the role of the public in mitigating the crisis has been emphasized, as health promotion needs emerged, including:

- maintaining healthy lifestyles during periods of lockdown/curfew (1)
- empowerment and self-care for all, while healthcare and educational systems rapidly

1. Clalit, Tel Aviv, Israel.
2. School of Public Health, University of Haifa, Haifa, Israel.
3. Global Health Literacy Academy, Urmond, Netherlands.
4. Monash University, Bandar Sunway, Malaysia.
5. Office of Public Health Studies, University of Hawai'i at Mānoa, Hawaii, United States.
6. Newcastle University, Newcastle upon Tyne, United Kingdom.
7. APOLLON Hochschule der Gesundheitswirtschaft (University of Applied Sciences), Bremen, Germany.
8. Health Literacy Media, United States.
9. University of Education Freiburg, Freiburg im Breisgau, Baden-Württemberg, Germany.
10. Tel Aviv University Sackler Faculty of Medicine, Tel Aviv, Israel.
11. Bielefeld University, Bielefeld, North Rhine-Westphalia, Germany.

Correspondence to: Diane Levin-Zamir, Clalit, 101 Arlozorov, Tel Aviv, Israel. Email: diamos@zahav.net.il

(This manuscript was submitted on 13 July 2020. Following blind peer review, it was accepted for publication on 4 February 2021.)

Global Health Promotion 1757-9759; Vol 28(2): 27–37; 998639 DOI: 10.1177/1757975921998639 journals.sagepub.com/home/ghp

shifted orientation to digital navigation, COVID-19 prevention and care (2)
- mental health challenges across the lifespan (3)
- coping with the infodemic (4).

Vulnerable populations were left behind due to lack of attention given by authorities to health literacy (5), language or cultural needs, and/or limited access to health promotion services and opportunities (6). These are not the sole factors leading to the known health inequalities in risks of contracting, and dying from, COVID-19; rather, they compound other structural inequalities in health, such as poor housing, residential density, and a higher likelihood of holding low-paid occupations requiring in-person contact (7). Without clear-cut contingency plans, health promotion action was not the initial focus in many countries. As the pandemic spreads, subsides and reappears, people have been challenged by uncertainty, and with the understanding that individual needs should service collective needs (8). Among the essential tools recognized for containing and mitigating COVID-19, accessible, trustworthy, understandable, culturally appropriate, and timely information addressing health literacy needs (9) is recognized as a condition for achieving positive health behavior change. As prevention and prediction are now key words that flood the public discourse, lack of health literacy erodes support for strong public engagement (10).

As health promotion is essential for overcoming the pandemic and changing health behavior (11), initiatives have been urgently developed and immediately applied globally during the outbreak. A selection of case studies from regions across the world are presented here to exemplify challenges and 'real-world' action for health promotion practice, research and policy as described by health promotion/health literacy experts during the COVID-19 pandemic. The aim was not to provide a comprehensive overview, but rather to illustrate different contexts, settings, national and local policies and varying guidelines aimed at reducing the risk of infection and/or transmission. Health promotion and health literacy are interdisciplinary (12) and international fields, reflected in the case studies chosen. The actions range from individual intervention through action focused on family, community, healthcare, public health and media systems, health promoting settings and policy. These cases and this special issue highlight a bright light emerging from the pandemic, which is that rapid response, communication, and collaboration across nations, disciplines, and perspectives can build successful solutions to an unprecedented global health crisis. Health promotion efforts are often constructively considered within the context of the socio-ecological model (SEM) (13). This model provides a framework that situates individual health outcomes, knowledge, and behaviors in the context of influence from *individual, interpersonal, organizational, community*, and *policy-level* factors (14). Each layer of influence on health behavior change may be exemplified thusly:

> **Individual**: knowledge, attitudes, self-efficacy, health literacy skills, values, personal psycho/social/demographic attributes;
>
> **Interpersonal**: people with close relationships to the individual: immediate family, relatives, close friends and co-workers, peer network;
>
> **Organizations**: agencies, social institutions, public/private partnerships;
>
> **Community**: schools, workplaces, neighborhoods, places of worship, community primary care;
>
> **Policies:** national healthcare organizations, governmental ministries, mandates, laws.

This model also offers opportunity to explore cross-level interventions in the socio-environmental context. Figure 1 provides a visual of these contexts based on the following cases presented. Our purpose is to showcase needs across the lifespan, best practices exemplified through the SEM, lessons learned and conclusions regarding the application of health promotion practice during the pandemic.

Case 1: interpersonal focus — older people coping with COVID-19 (Germany)

The needs

In March 2020, two months after the first reported case in Germany, nationwide public health measures were announced, including contact restrictions, closure of public facilities, and even stay-at-home orders issued by some federal states. The measures

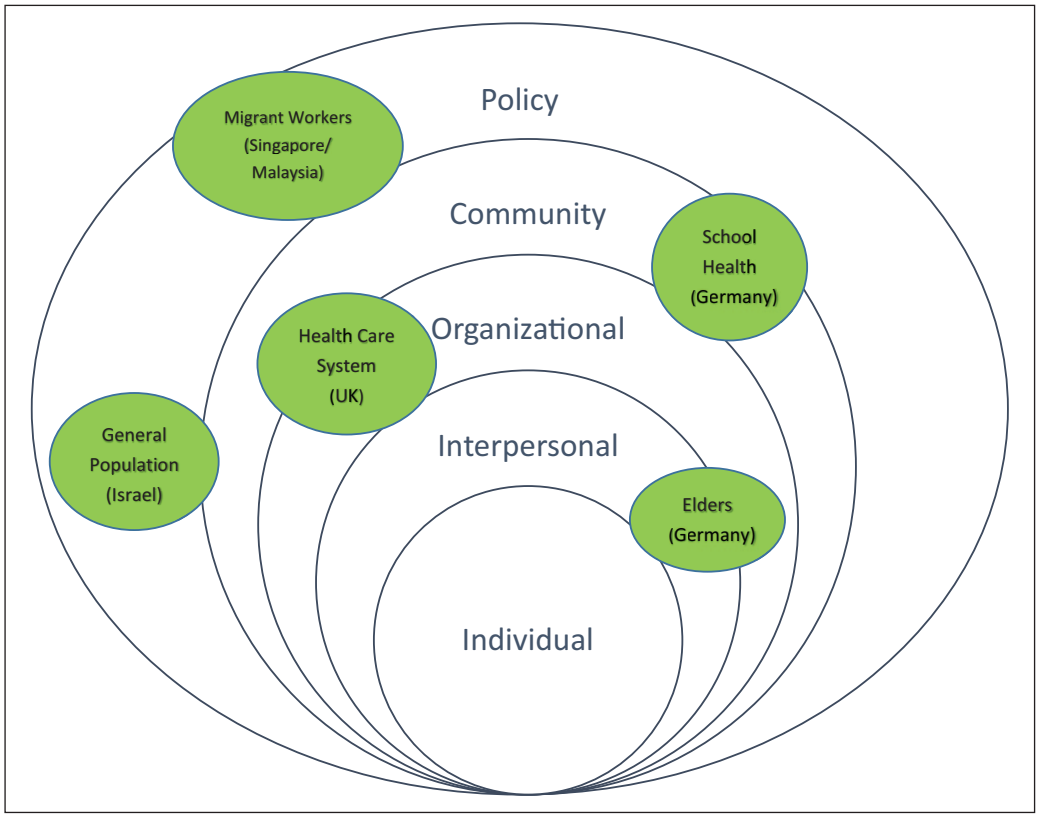

Figure 1. Cases in the context of the social-ecological model.

were intended to contain the epidemic, increase the capacity of the healthcare system to treat COVID-19, and protect vulnerable populations, in particular older people and people with pre-existing conditions (15). Yet, more specific action was needed to meet the needs of the elderly.

The actions

Several laws were amended to enable the health sector to respond to epidemics (15). Early after the outbreak, federal health authorities implemented nationwide public health campaigns and promoted health-related media communication. Messages called for solidarity within society (e.g. 'Together against Corona,' promoting shopping for older neighbors), mutual support and adherence with official recommendations. While early in the pandemic, health information was general in nature, by April 2020, health authorities released more specific health information, tailored to the needs of older people (16).

Primary care providers introduced temporary measures such as telephone and video-based consultations, suspended mandatory check-ups and disease management programs, and allowed refunds of postal charges for medical prescriptions (17). Precautions to protect older people living at home included stay-at-home recommendations and limited family contact (e.g. restricting grandchildren's visits). Older people living in nursing home facilities were strictly isolated, by banning visits, canceling group activities, and forbidding residents to leave the facility (15,18). Measures addressed residents, their relatives, service providers (e.g. hairdressers), and health professionals (18). Additionally, health authorities introduced specific health recommendations for long-term care (19).

Notably, temporary measures were applied to safeguard citizens' economic situation, including protection against eviction for tenants, and to support nursing care and care by relatives.

Lessons learned

Systematic public evaluation and robust data analysis are not available yet. At the federal state and local levels, evaluation and readjustments of measures and laws are ongoing. The Federal Public Health Institute presents daily situation reports (19), supported by the scientific community providing evidence, analysis of healthcare, and recommendations.

Adverse effects of social isolation and loneliness on older people's health, and barriers to healthcare for people with chronic conditions are severe and have been documented (18,20). Crisis hotlines for immediate counseling reported twice the number of calls in April (21). The main concerns of the callers were loneliness, psychological stress, family crises, and fear of inadequate care. Once a considerable decrease in doctor visits was noted, people were urged not to delay or postpone critical visits. The importance of relatives, home care services, and nursing homes for prevention and containing the spread of infection, and for ensuring proper support and care of older people, became evident. Furthermore, earlier support measures were adapted and strict isolation measures in nursing homes were relaxed. Early in the pandemic, measures were dominantly aimed at increasing patient safety. Yet, as the pandemic progresses, measures need to shift toward specific patient-centered health promotion, community health support, and appropriate health information interventions based on the health literacy needs of older people. New measures should also help to improve living and working conditions, enable social participation and quality-of-life for older people, and empower all involved to better cope with the changing pandemic situations.

Case 2: organizational focus — mental health and the view from primary care (UK)

The needs

Between the first COVID-19 case in the United Kingdom in January 2020, and when the country went into a strict lockdown in March, anxiety increased about the possibility of severe illness and death. There was deep concern about overwhelming health services and not having sufficient facilities to care for people if they became ill. More than two-thirds of adults reported feeling worried about the effect of COVID-19, with over half reporting stress and anxiety (22).

Health services increasingly focused on providing intensive and critical care and on diagnosing COVID-19. Hospital and other specialist services were scaled back or even stopped. Access to mental health services for people with pre-existing conditions was 25% lower than before the pandemic (23), and likely even lower for people without pre-existing mental conditions. Some health services, such as General Practice (GP) remained fully available, albeit with consultations largely virtually or by phone. However, because the public assumed that GPs were not available, many did not access the service. This resulted in a stressed and anxious population without access to mental health advice and support, placing especially at risk those with low access to digital information, such as the socioeconomically deprived.

The actions

The importance of supporting mental health during the pandemic was initially championed by mental health charities such as the Mental Health Foundation (24), MIND (25), and the Royal Family; the Duke of Cambridge, in particular, has a longstanding interest in mental health (26). The National Health Service made mental health advice available online (27). The public was reassured that non-COVID health services such as GP were still available for advice and support for conditions, including mental health. Efforts were made to ensure information was easy to access, understand and use, although inequality in access to online information persisted.

Lessons learned

Weekly national evaluation of the epidemic's social impact continues. The latest available findings at the time of writing show that the proportion of the population worried about the effect of COVID-19 on their life remains high at 70%, but fewer people are feeling stressed and anxious, as lockdown

eases and life starts to return to a 'new normal' (28). Yet, the proportion of people feeling stressed and anxious remains much higher than before the pandemic (29). The pandemic exacerbated existing mental health inequalities; populations whose mental health is at greatest risk include those with existing mental health problems, people with long-term physical conditions, women and children experiencing violence and abuse, and Black, Asian, and minority ethnic (BAME) communities (30).

The pandemic also increased opportunities to discuss mental health, and hence increased mental health literacy. More than two-thirds of the population feel able to express feeling worried about the effect of the pandemic, with more than half describing stress and depression. This demonstrates a shift from previous stigmas creating barriers to admitting, discussing, and seeking care for mental health problems. Recognition of the need to promote mental health in parallel with physical health (6) has increased. Efforts should be made to maintain this momentum in both the short and the long term. Increased mental health resilience will become especially important in the 'second wave' of the pandemic.

Mental health resources must target those most at risk, focusing on building skills among the least advantaged, including applying health literacy approaches. The current monitoring systems must continue to ensure that mental health improves and inequalities are reduced. Healthcare organizations working in partnership especially with mental health-focused advocacy groups can continue to share the message from their organizational perspectives to change community and interpersonal norms and understanding about mental healthcare access and stigma.

Case 3: community focus — school health promotion and COVID-19 (Germany)

The needs

Germany's first reported case of COVID-19 was on 27 January 2020 (15). In Germany, there are about 13.6 million children under 18 years of age. Children and schools were long neglected by the public health system (31,32). Schools in Germany are critical settings for socialization and health promotion for children (33), especially those vulnerable and disadvantaged, who may experience adverse health consequences when confronted with abrupt changes. In particular, social and educational development in the children involved may suffer long-lasting effects. The turmoil caused by the COVID-19 pandemic, potentially damaging to children, must be carefully addressed during and in the aftermath of this crisis (31,32).

The actions

Only in mid-March 2020 did the conference of ministers of education begin discussing school closures to support infectious disease strategies (34). All education institutions were closed nationwide for about 2 months. Due to the federal system and state responsibility for education and health, each state implemented its own reopening strategy. Most reopened as early as 20 April 2020 for critical exams and transition grades (35) and fully reopened just after the 2020 summer holidays.

During school closures, children did not receive the benefits of school health promotion, including high-quality learning and educational opportunities, guidance from teachers and health professionals, access to digital infrastructure, meals, physical/sports activities, and social/cultural capital in terms of the school community and peer contact. As experience and evidence from other countries show (36) regarding schools during COVID-19 or past epidemics (37), adverse health effects are associated with closures, especially among socioeconomically disadvantaged children.

COVID-19 policies may have exacerbated pre-existing inequities, impacting healthy child development (32). Many children lack the necessary resources to ensure participation in distance learning, namely computers, internet access, and supporting adults. The education system and policy administration failed to systematically roll-out distance learning infrastructure, as teachers were not equipped to design, teach and support virtual learning.

Lessons learned

COVID-19 impacted education institutions and fundamental interactions between school children and teachers (33,36,38). The German education system is not well prepared to respond to a pandemic,

requiring a need to rethink and redesign the education system, to provide a more inclusive and health-literate system equipped to include health promotion. Working parents may not have the time and resources to support their children. With school closures, digital communication and learning has been the only option for education and school health promotion. Children therefore must be provided with the necessary digital infrastructure and skills to engage with this new form of virtual learning; all families should have capacities at their disposal, and teachers should receive the necessary training, including an emergency strategy for education. New educational approaches are needed, introducing more practical methods, adapted to real-world needs, and keeping health promotion activities effective (32,38).

Case 4: policy focus — vulnerable groups-migrant workers (Singapore and Malaysia)

The needs

Singapore and Malaysia are popular destinations for migrant workers from South and Southeast Asia. During the initial outbreak of COVID-19, while confirmed cases in Singapore were relatively low, the number of cases rose drastically in early April 2020, particularly among migrant workers (39). By mid-June, 39,223 cases (94.3%) of the total confirmed cases (41,615) in Singapore were migrant workers (40). Crowded dormitories and sharing of common facilities were identified as the root causes of the COVID-19 spread.

During the second week of March 2020, Malaysia became the worst COVID-19-hit country in Southeast Asia. The Malaysian government declared a Movement Control Order (MCO) on 18 March (41). The number of confirmed cases and community spread gradually decreased after the implementation of the MCO. In contrast, a marked escalation in new COVID-19 cases among migrant workers occurred since May 2020. By mid-June 2020, there were approximately 610 confirmed cases among documented migrant workers — 7.1% of 8535 cases in Malaysia (41).

Immediate actions

The Singapore government quarantined 24 migrant worker dormitories, began COVID-19 testing, segregation of healthy and infected workers, and daily checks of fever/symptoms (39). Health authorities encouraged dormitory operators to maintain hygiene on their premises, non-governmental organizations (NGOs) provided meals, fruits and essential items, and temporary housing, such as vacant public housing flats, military camps, exhibition centers and floating hotels, was provided to enable physical distancing (39).

The Malaysian government enforced compulsory COVID-19 screening among migrant workers, financially covered by SOSCO (Social Security Organization) (42). NGOs collaborated with the government to provide food and essential supplies, and launched COVID-19 funds for marginalized groups, including migrant workers. The Malaysian Ministry of Health provides free testing and medical care for non-Malaysian citizens who have COVID-19 symptoms and their close contacts (41).

The Borderless Healthcare Group (BHG) implemented a total wellness program for migrant workers in several countries including Malaysia and Singapore. This online platform provides an opportunity for two million migrant workers to join the multi-lingual interactive COVID-19 education program and mental health support in their own language (43). In addition, the migrant workers from Bangladesh and Myanmar were allowed to consult doctors from their home countries free of charge via the online BHG platform (44).

Long-term actions

The Singapore government announced that new dormitories with better facilities for migrant workers will be built to enhance physical distancing and hygiene practice (45). The Malaysian government also implemented a new law requiring employers to provide proper accommodation for the migrant workers to prevent the spread of COVID-19 (46).

Lessons learned

Policies promoting health promotion messages on physical distancing, using personal protection equipment, particularly masks, and good hygiene were implemented during the COVID-19 outbreak. However, for migrant workers, poor living conditions and environment prevented them from practicing proper preventive measures. This is aligned with the

recommendation of Lieberman *et al*. (47) to focus on policy and environmental changes rather than individually orientated health promotion programs. To support individual behavior change, it is critical to implement policies for enabling environments, supporting health literacy across all populations, especially those who are marginalized and most vulnerable (48).

Case 5: cross-cutting SEM levels — intervention for the general population (Israel)

The needs

Israel's first reported case of COVID-19 was in February 2020, with a national lockdown declared in March 2020. As in-person health promotion programs were canceled to comply with stay-at-home guidelines (49), it became apparent that a national health promotion plan for emergency preparedness was lacking. Thus, health promotion experts from the national healthcare system set out to 1) learn about the needs of the public, including special populations, and 2) take decisions regarding appropriate action.

The actions

The primary health promotion challenge focused on health literacy efforts to provide evidence-based information to the public, encouraging all to adopt behavioral measures for the individual and common good. The following topics received special attention during the outbreak, based on public interest: self-care in pregnancy/breastfeeding (50), smoking cessation, care for the elderly (51) and people with chronic disease, physical activity during home quarantine, and managing children's media exposure. Language/cultural needs received attention, as information both printed and digital was provided in Hebrew and Arabic, and adjusted for the ultra-orthodox Jewish population. Additionally, at the peak of the first wave, the major religions in Israel celebrated major holidays (Passover, Ramadan and Easter). Recommendations promoted alternative ways in which these special holidays could be observed, without the ritual family gatherings, in order to maintain physical distancing. New health-promoting settings emerged, such as converted hotels for housing people with COVID-19 but who did not require hospitalization, where activities on dealing with stress, sexual health, healthy lifestyle, and more were implemented.

As digital healthcare solutions were rapidly developed during the pandemic, likewise safe and protected digital health promotion platforms were developed. Clalit Health Services, Israeli's largest healthcare organization, allocated resources to digitally continue health promotion efforts. Virtual group workshops were launched on smoking cessation, healthy lifestyles for people with diabetes, nutrition/weight management for adults, birth preparation and breastfeeding. To date, following the second wave of the COVID-19 pandemic, over 600 virtual group sessions have been conducted, reaching over 800 people throughout the country.

A unique multidisciplinary research project, led by the Tel Aviv University Department of Health Promotion, in collaboration with the Collective IL Academia, produced a position paper entitled *TIME TO MOVE: urgent need to promote physical activity during the corona period*, emphasizing the devastating physical and mental consequences of physical activity restriction and advocating for promoting regular physical exercise. Recommendations for individuals, communities, media systems, and policy interventions were submitted to an Israeli parliament (Knesset) special committee convened in April 2020 to discuss the consequences of limiting physical activity, and whether to extend or lift restrictions on physical activities/sports (52).

Lessons learned

Online consensus conferences were conducted throughout the outbreak among health promotion/public health professionals. Among the lessons learned and recommendations made were the need for a national and consistent voice during the outbreak, recognized and trusted by the public. Public participation was lacking in expressing the needs and recommending solutions for health promotion health literacy. The Collective IL Academia framework provided policy makers with reliable research for decision making in vital aspects of the pandemic, promoting transparency, trust, collaboration and public responsibility.

As Israel was confronted with a severe second wave of the pandemic, insights from the first wave were applied, yet still lacking is a national policy on

Table 1. Summary of cases across various dimensions.

Country	*Life course focus*	*Area focus*	*SEM focus*	*Health literacy needs identified*	*Implications: research, practice and policy*
Germany	Elders	Web of health/social needs	Interpersonal, including community and patient–provider relationships	Critical health literacy, including messages for solidarity/mutual support. Access to personal healthcare, including digital solutions.	Elders and other vulnerable populations can thrive during pandemics in supportive environments.
UK	Adults	Primary care/ mental health	Organizational linked to policy to provide access to mental health advice and support	Mental health literacy and healthcare: understanding access to care options, reducing stigma for seeking care.	Primary care healthcare organizations are critical partners in improving access to mental healthcare and promoting mental health literacy.
Germany	Children	Schools	Community: school as hub for health-promoting relationships with families/children/ teachers	Building holistic health literacy from school-based health promotion.	Highlights valuable role of schools for all children's health needs; including digital solutions.
Singapore/ Malaysia	Working-age adults	Migrant workers	Policies to mitigate COVID-19 with culturally-sensitive solutions addressing practical and social needs	Access to culturally relevant health information and structural support (food, safe shelter, access to in-language healthcare).	Environmental support for actions across all populations and culturally relevant resources.
Israel	Adult	General population	A national health promotion plan crossing SEM	Public health literacy, across language/ cultural needs, offering digital solutions.	Underscores need for effective strategies to build public trust.

health promotion preparedness for a health crisis, including health literacy interventions, public participation, and partnership.

Discussion

These cases across diverse locations and health and education systems highlight challenges, recommendations, and solutions during the pandemic across various stages in the lifespan and levels of the SEM. We acknowledge that an individual-level focus only is not sufficient for sustainable behavior change, whereas a focus on interpersonal, organizational, community, policy or cross-cutting efforts are critical given the multilayered challenges in COVID-19. Struggles include coping with mental health, stress, loss of service accessibility, social connectivity and the needs of vulnerable populations. The cases provide researchers, practitioners and policy makers brief but rich examples highlighting multi-sectoral approaches across the levels of the SEM. Table 1 provides a

summary of focal areas, health literacy needs identified, and lessons learned.

Key themes emerging from these cases directed especially at policy makers include:

- **Equity.** Addressing the needs of vulnerable populations in the appropriate language and cultural context is key. Efforts must meet people where they are, with what they need to stay healthy, while considering the inherent challenges of physical distancing. The needs of the hidden groups must be acknowledged, such as people with mental health challenges who refrain from seeking care, and children remaining at home, disconnected from technology whose family's strife or hunger is often invisible.
- **Trust.** Transparency and clear communication are necessary to inform and build trust. This is vital during a pandemic, especially when its course is constantly changing, lingering longer than expected. Trust is built by acknowledging that guidelines reflect the best knowledge accrued to date, but may change as the science and study of the pandemic unfolds, especially to ensure patients' understanding and meeting their needs. It is important to note that information collected through mass media and crowd sourcing may not be systematic nor accurate, and may amplify the detrimental infodemic.
- **Systems approach.** As seen in the cases presented, COVID-19 is not only an individual health issue but also engages caregivers, families, extended social networks, neighborhoods, communities, health systems and organizations, and governing/political systems. Structural changes in health promotion are requisite to sustain health during the COVID-19 and future pandemics.
- **Sustained action.** Existing health promotion policies during a crisis should not be ignored. A strong health promotion infrastructure must be maintained to meet both immediate and long-term needs. Ongoing programs such as routine vaccination, smoking prevention/cessation, and mammograms, must be sustained and resources must not be diverted elsewhere when addressing a health crisis such as COVID-19. The immediate and long-term effects of this pandemic on individual health, community well-being, and health systems are still emerging. While some nations remain in active crisis, nearly all are in a new normal with changes likely to stay, especially the shift to digital communication, interventions, and healthcare.

The current challenges include:

- building best practices and investing resources in health promotion focusing on health literacy, health education, accessible and appropriate health information, and healthcare, especially in a new technological age with social media and telehealth, during a pandemic;
- the need for valid and reliable data and evidence regarding health promotion/health literacy solutions for equitably improving and sustaining health for all, during an emergency;
- preparing for expected future challenges such as vaccine resistance and supporting those chronically disabled by COVID-19.

It is important to adopt community engagement strategies in the process of developing and maintaining relationships among the stakeholders to work together and promote well-being for long-term positive outcomes, based on trust, respect, and a sense of shared purpose. These relationships span all levels, from the micro (individual) to the meso (groups) to the macro (systems and institutions).

The pandemic is a call for humanity to remove inequities that divide, and engage in solidarity. Equity is the lighthouse to drive decision making, replacing survival of the fittest to face the pandemic with empowerment and support for people across the globe.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

ORCID iDs

Diane Levin-Zamir https://orcid.org/0000-0001-8852-5554
Kristine Sorensen https://orcid.org/0000-0002-6179-7004
Gillian Rowlands https://orcid.org/0000-0001-7388-7771
Orkan Okan https://orcid.org/0000-0003-1714-4783

References

1. Hall G, Laddu DR, Phillips SA, Lavie CJ, Arena R. A tale of two pandemics: how will COVID-19 and global trends in physical inactivity and sedentary behavior affect one another? Prog Cardiovasc Dis. Epub ahead of print April 2020. DOI: 10.1016/j.pcad.2020.04.005.
2. Levin-Zamir D, Bertschi I. Media health literacy, Ehealth literacy, and the role of the social environment in context. Int J Environ Res Public Health. 2018; 15: 1643.
3. Galea S, Merchant RM, Lurie N. The mental health consequences of COVID-19 and physical distancing: the need for prevention and early intervention. JAMA Intern Med. 2020; 180: 817–818.
4. Zarocostas J. How to fight an infodemic. Lancet. 2020; 395: 676.
5. Abdel-Latif MMM. The enigma of health literacy and COVID-19 pandemic. Public Health. 2020; 185: 95–96.
6. Smith JA, Judd J. COVID-19: vulnerability and the power of privilege in a pandemic. Heal Promot J Aust. 2020; 31: 158–60.
7. Public Health England. Disparities in the risk and outcomes of COVID-19 [Internet]. 2020 [cited 2020 July 1]; 89. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf
8. Abel T, McQueen D. Critical health literacy and the COVID-19 crisis. Health Promot Int. 2020; 35: 1612–1613.
9. Okan O, Sorensen K, Messer MM. COVID-19: a guide to good practice on keeping people well informed [Internet]. The Conversation. 2020 [cited 2020 July 1]. Available from: https://theconversation.com/covid-19-a-guide-to-good-practice-on-keeping-people-well-informed-134046
10. Harzheim L, Lorke M, Woopen C, Jünger S. Health literacy as communicative action — a qualitative study among persons at risk in the context of predictive and preventive medicine. Int J Environ Res Public Health. 2020; 17: 1–27.
11. Van den Broucke S. Why health promotion matters to the COVID-19 pandemic, and vice versa. Health Promot Int. 2020; 35: 181–186.
12. Sentell T, Vamos S, Okan O. Interdisciplinary perspectives on health literacy research around the world: more important than ever in a time of covid-19. Int J Environ Res Public Health. 2020; 17: 1–13.
13. Mcleroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. Heal Educ Behav. 1988; 15: 351–377.
14. Eaton LA, Kalichman SC. Social and behavioral health responses to COVID-19: lessons learned from four decades of an HIV pandemic. J Behav Med. 2020; 43: 341–345.
15. Federal Ministry of Health. Aktuelle Informationen zum Coronavirus [Internet]. 2020 [cited 2020 July 1]. Available from: https://www.bundesgesundheitsministerium.de/coronavirus.html
16. Federal Centre for Health Education (BZgA). Ältere Menschen und Corona [Internet]. 2020 [cited 2020 July 1]. Available from: https://www.bzga.de/presse/pressemitteilungen/2020-04-03-aeltere-menschen-und-corona/
17. Kassenärztliche Bundesvereinigung. Coronavirus: informationen für Ärzte, Psychotherapeuten und Praxisteams 2020 [Internet]. 2020 [cited 2020 July 1]. Available from: https://www.kbv.de/html/coronavirus.php#content45248
18. Dichter MN, Sander M, Seismann-Petersen S, Köpke S. COVID-19: it is time to balance infection management and person-centered care to maintain mental health of people living in German nursing homes. Int Psychogeriatr. 2020; 32: 1157–1160.
19. Robert Koch Institut. COVID-19 (Coronavirus SARS-CoV-2) [Internet]. 2020 [cited 2020 July 1]. Available from: https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronavirus/nCoV.html
20. Shrappe M, François-Kettner K, Gruhl M, Hart D, Knieps D, Pfaff H, et al. 3.0. Die Pandemie durch SARS-CoV-2/Covid-19 - eine erste Bilanz [Internet]. 2020 [cited 2020 July 1]. Available from: https://www.socium.uni-bremen.de/uploads/thesenpapier_3.pdf
21. Richter C. Psychische Probleme in Corona-Krise; Telefonseelsorge am Anschlag [Internet]. 2020 [cited 2020 July 1]. Available from: https://www.deutschlandfunk.de/psychische-probleme-in-corona-krise-telefonseelsorge-am.886.de.html?dram:article_id=475273
22. Davies R. Coronavirus and the social impacts on Great Britain data - Office for National Statistics. OnsGovUk [Internet]. 2020 [cited 2020 July 1]; 1–14. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandthesocialimpactsongreatbritain/5june2020
23. Charlesworth A, Watt T, Thorlby R. Early insight into the impacts of COVID-19 on care for people with long-term conditions [Internet]. Health Foundation. 2020 [cited 2020 July 1]. Available from: https://www.health.org.uk/news-and-comment/blogs/early-insight-into-the-impacts-of-covid-19-on-care-for-people-with-long-term
24. How to look after your mental health during the coronavirus outbreak: the Mental Health Foundation [Internet]. 2020 [cited 2020 July 4]. Available from: https://www.mentalhealth.org.uk/coronavirus
25. MIND. Coronavirus and your wellbeing [Internet]. 2020 [cited 2020 July 1]. Available from: https://www.mind.org.uk/information-support/coronavirus/coronavirus-and-your-wellbeing/
26. BBC News. Coronavirus: royal couple say lockdown "stressful" on mental health [Internet]. 2020 [cited 2020 July 1]. Available from: https://www.bbc.co.uk/news/uk-52308863
27. NHS. Every mind matters [Internet]. 2020 [cited 2020 July 1]. Available from: https://www.nhs.uk/oneyou/every-mind-matters/
28. Statistics O for N. Coronavirus and the social impacts on Great Britain: 3 July 2020 [Internet]. 2020 [cited 2020 July 4]. Available from: https://www.ons.gov.uk/

peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandthesocialimpactsongreatbritain/3july2020#indicators-of-well-being-and-finances
29. Fancourt D, Bu F, Mak H, Steptoe A. Covid-19 Social Study: Results Release 11. London: UCL; 2020 [cited 2020 July 1]. Available from: https://www.centreformentalhealth.org.uk/sites/default/files/2020-06/CentreforMentalHealth_CovidInequalities_0.pdf.
30. Centre for Mental Health. Understanding Inequalities in Mental Health During the Pandemic [Internet]. 2020 [cited 2020 July 1]. Available from: https://www.centreformentalhealth.org.uk/sites/default/files/2020-06/CentreforMentalHealth_CovidInequalities_0.pdf
31. Saboga-Nunes L, Levin-Zamir D, Bittlingmayer UH, Contu P, Pinheiro P, Ivassenko V, et al. A health promotion focus on COVID-19: keep the Trojan horse out of our health systems: promote health for ALL in times of crisis and beyond! [Internet]. 2020 [cited 2020 July 1]. Available from: http://www.iuhpe.org/images/IUHPE/Advocacy/COVID19_HealthPromotion.pdf
32. Pinheiro P, Bauer U. From at risk to as risk and back again: children and adolescents during COVID-19. Transform Soc [Internet]. 2020 [cited 2020 July 1]. Available from: http://www.transformingsociety.co.uk/2020/05/25/from-at-risk-to-as-risk-and-back-again-children-and-adolescents-during-covid-19/
33. Bauer U, Hurrelmann K. Sozialisation in Krisenzeiten. Der Lockdown offenbart die Defizite des deutschen Schulsystems. In: Egbers J, Himmelrath A (eds). Das Schuljahr nach Corona. Was sich nun ändern muss. Bern, Schweiz: Hep-Verlag; 2020, 14–27.
34. KMK. Zum Umgang mit dem Corona-Virus [Internet]. 2020 [cited 2020 July 1]. Available from: https://www.kmk.org/presse/pressearchiv/mitteilung/zum-umgang-mit-dem-corona-virus.html
35. ARD und MDR. Lockerungen nach Corona. Wann öffnen Schulen und Kitas wieder? [Internet]. 2020 [cited 2020 July 1]. Available from: https://www.mdr.de/brisant/schulen-kitas-oeffnen-bundesland-100.html
36. Viner RM, Russell SJ, Croker H, Packer J, Ward J, Stansfield C, et al. School closure and management practices during coronavirus outbreaks including COVID-19: a rapid systematic review. Lancet Child Adolesc Health. 2020; 4: 397–404.
37. Jackson C, Vynnycky E, Hawker J, Olowokure B, Mangtani P. School closures and influenza: systematic review of epidemiological studies. BMJ Open. 2013; 3: 1–10.
38. Jourdan D, Marmot M, Gray N. Coronavirus: there is an urgent need to re-open schools - this is how to make it happen [Internet]. 2020 [cited 2020 June 28]. Available from: https://theconversation.com/coronavirus-there-is-an-urgent-need-to-re-open-schools-this-is-how-to-make-it-happen-137818
39. Koh D. Migrant workers and COVID-19. Occup Environ Med. 2020; 77: 634–636.
40. Singapore TM of H. 19 June 2020 Daily Report on COVID-19 [Internet]. 2020 [cited 2020 July 1]. Available from: https://www.moh.gov.sg/docs/librariesprovider5/2019-ncov/situation-report—19-jun-2020.pdf
41. Shakirah MS, Ang ZY, Anis Syakira Jailani, Cheah KY, Kong YL, Selvarajah S, et al. The COVID-19 Chronicles of Malaysia. Setia Alam, Selangor: National Institutes of Health; 2020.
42. Anis MN and Bedi RS. Swab tests for foreign workers to start in KL, Selangor - May 6, 2020 [Internet]. 2020 [cited 2020 July 4]. Available from: https://www.thestar.com.my/news/nation/2020/05/06/swab-tests-for-foreign-workers-to-start-in-kl-selangor
43. Adilla F. Borderless Healthcare's total wellness programme for workers, students stranded overseas [Internet]. 2020 [cited 2020 July 4]. Available from: https://www.nst.com.my/business/2020/05/592491/borderless-healthcares-total-wellness-programme-workers-students-stranded
44. Yusof A. Singapore's Doctor Love launches online platform for migrant workers to consult doctors in their home countries [Internet]. 2020 [cited 2020 July 4]. Available from: https://www.channelnewsasia.com/news/asia/singapore-doctor-love-migrant-workers-covid-19-12734764
45. Phua R. Singapore to build new dormitories with improved living standards for migrant workers [Internet]. 2020 [cited 2020 July 4]. Available from: https://www.channelnewsasia.com/news/singapore/covid-19-singapore-new-dormitories-foreign-workers-conditions-12792538
46. Sivanandam H and Lai A. Employers to provide accommodation for all workers, says HR Ministry [Internet]. 2020 [cited 2020 July 4]. Available from: https://www.thestar.com.my/news/nation/2020/05/27/employers-to-provide-accommodation-for-foreign-workers-says-hr-ministry
47. Lieberman L, Golden SD, Earp JAL. Structural approaches to health promotion: what do we need to know about policy and environmental change? Health Educ Behav. 2013; 40: 520–525.
48. Lai A, Tang A. Suffering from a lack of awareness. Sunday Star. 2020 November [cited 2020 July 4]. Available from: https://www.thestar.com.my/news/nation/2020/11/08/suffering-from-a-lack-of-awareness
49. Bodas M, Peleg K. Self-isolation compliance in the COVID-19 era influenced by compensation: findings from a recent survey in Israel. Health Aff (Millwood). 2020; 39: 936–941.
50. Taubman–Ben-Ari O, Chasson M, Abu Sharkia S, Weiss E. Distress and anxiety associated with COVID-19 among Jewish and Arab pregnant women in Israel. J Reprod Infant Psychol. 2020; 38: 340–348.
51. Horesh D, Kapel Lev-Ari R, Hasson-Ohayon I. Risk factors for psychological distress during the COVID-19 pandemic in Israel: loneliness, age, gender, and health status play an important role. Br J Health Psychol. 2020; 25: 925–933.
52. Rosen L, Jacobovitz R, Levin-Zamir D, Apple N, Wolf-Meron R, Berman T, et al. Time to move (in Hebrew) [Internet]. 2020 [cited 2020 July 1]. Available from: https://fs.knesset.gov.il/23/Committees/23_cs_bg_569922.pdf

Original Article

The power that comes from within: female leaders of Rio de Janeiro's *favelas* in times of pandemic

Nilza Rogeria De Andrade Nunes

Abstract: This paper aims to present how the female leaders of the *favelas* of Rio de Janeiro/Brazil have been protagonists in coping with the demands arising from COVID-19. The city has approximately 2 million residents living in 763 *favelas*. There is no strategic planning on the part of the government with coordinated actions related to the specificities of these territories — producing an escalation of demands due to the living and health conditions of the residents. It is in this multifaceted reality, with urgencies and emergencies, that we highlight the role of community by strengthening the local support networks that are built like webs inside the *favela* and beyond. Our statement is based on a qualitative study involving 111 such women, distributed across 105 *favelas*. Correlating their practices, 97% say they support health promotion through the strengthening of popular participation towards community development and defense of rights, and mobilization of health services to meet these populations' needs, among other actions. With the presence of public agents in these places restricted in times of pandemic, these women often take up the duties of the local authorities to ensure food security, good communication among local residents on health standards, hygiene measures, assistance to the most vulnerable, etc. Perceived by community members as replacing the role of government agencies, they develop a particular way of doing politics. Calling upon resistance and solidarity, they transform this micro-power into effective changes to cope with the inequities and in benefit of citizenship and the other residents of the *favelas* where they live.

Keywords: women, favela, community-based organization, COVID-19, Brazil

Introduction

The COVID-19 pandemic affects the rich and the poor, but its brutal aggression and spread finds much more fertile ground when it affects groups that are in more precarious conditions of life and health. Social isolation as a coronavirus control strategy — for those, the street is the only space beyond their houses; hand washing and personal hygiene for those who do not have regular access to water; protecting hands, mouth, nose and eyes, for those who do not have any source of income or dignified means of survival; among many other weaknesses — exposes the inequities to which the residents of *favelas* and peripheral areas of Rio de Janeiro are subjected.

It is in this context that it is shown how women in the *favelas* are responding to this as leaders, the purpose of this paper being to document their practices and attitudes in coping with the pandemic. Being a woman, being black, and living in a *favela* in Rio de Janeiro is to be subject to triple discrimination, since the stereotypes generated by sexism, racism, and social status put such women in a position of inferiority. Thus, we see a confluence of oppressions that fall upon the women who live in the *favelas*. The factors of gender, race, and class that lead us to

Pontificia Universidade Catolica do Rio de Janeiro, Rio de Janeiro, Brazil.

Correspondence to: Nilza Rogeria De Andrade Nunes, Pontificia Universidade Catolica do Rio de Janeiro, Rua Marquês de São Vicente, 225, Gávea, Rio de Janeiro, 22451-900, Brazil. Email: nr.nunes@puc-rio.br

(This manuscript was submitted on 12 July 2020. Following blind peer review, it was accepted for publication on 25 January 2021.)

Global Health Promotion 1757-9759; Vol 28(2): 38–45; 994690 DOI: 10.1177/1757975921994690 journals.sagepub.com/home/ghp

the notion of intersectionality, a term coined by Kimberlé Crenshaw (1), are addressed in this paper.

Based on certain theorists of black feminism (2–7), it can be affirmed how structural oppressions are interconnected in a domination matrix that influences all levels of social relations permeating individual and collective plans — and how these structures are visible and permeable when women from *favelas* are referred to. However, we also show that some of them subvert this order and push the limits of the envelope imposed by the current social structure.

Women, popularly appointed as community leaders or social activists, have been building and consolidating their place of speech (8) and public recognition across diverse agendas since the 1980s — gaining momentum and visibility in the 1990s. They subvert the order that has, historically, made them invisible, and developed their own particular way of conducting politics.

The protagonists here on the scene are geopolitically located in the socio-spatially segregated territories that are called *favelas* in Rio de Janeiro — permeating the urban fabric of the city of Rio de Janeiro, these 'ghettos' are constituted and expressed in a mosaic of violence and rights violations. Due to their negative image, synonymous with insecurity and violence, their existence has historically been denied. But despite all this, they play an essential geographical, economic, social, and political (9–11) role in the city.

This homogenizing view of the *favela*, associated with a discourse aimed almost exclusively at what is lacking, coincides with the constructed concept of not recognizing the *favela* resident as an active agent, inserted within the time and space of the city, and thus a citizen with rights. Defined by physical and symbolic borders, they form areas of separation and contact for socio-spatial practices that are drawn in the landscape. They mark and individualize places and forms of belonging and appropriation of the urban space (10).

Even though these places are strongly demarcated by visible borders, women have been affirming their existence and showing resistance. They manage territorial networks (12–14) that are built like webs within and beyond the *favela* territory and they are engaged in the search for transformation of a collective that transcends their personal relationships, but calls out to everyone within and to all those around them.

In the exercising of this local power, they push against the limits demarcated by colonialism (15–17) and racism (7,18). We are talking about poor black women who carry in their bodies multiple expressions of a society marked by oppression, patriarchy, and inequality (19). Alongside this, we incorporate white women who are equally poor inhabitants of popular locations and are also subjugated under such conditions of oppression. Thus, our reflections are anchored mainly in the references to black feminism (2,20,21), decolonial studies (15,16,22), and the concept of *favela* as a geopolitical space (9,23,24) — demarcated not only by a sociability that is established within the contradictions between unmet needs and violence, but also by the presence that is established through solidarity and neighborhood ties.

The recommendations made by the World Health Organization (WHO) can hardly be adopted by this huge population contingent, considering the conditions in which they live. How does one protect one's own health and that of one's family when one needs to put food on the table every single day? There is a considerable number of unemployed, informal workers, small traders, housekeepers earning by the hour — all involved with job and income-generation activities that are crucial to the survival of these communities, whose vulnerability has been sharply intensified by the pandemic.

Clearly, the pandemic has exposed Brazil as an extremely unequal country with an inadequate social protection system (25–27) — the worsening of the economic crisis has punished the poorest much more and the COVID-19 outbreak and its mortality rate finds more favorable conditions for transmission in the agglomerations within *favelas*.

The lack of public policies related to infrastructure, such as housing, basic sanitation, digital access, among others, explains the worsening of the situation for people who are deemed less important, especially if one considers that it is the poor and blacks who mostly inhabit popular spaces. The public authorities did not develop a specific contingency plan for the *favelas* to face the pandemic — which can be considered another form of violence perpetrated by the State.

The physical distancing during the pandemic is a challenge in *favelas*, since the use of the street as a shared space for meeting and leisure becomes an extension of the home, most of which are very small — with six to nine people per square meter. This is where workers are found, who, when not unemployed or underemployed, work in essential

services so that the middle and upper classes can isolate themselves and carry out their activities in the comfort of their privileged locations.

Poor women, who are mostly black or self-declared as black, face unemployment or immersion in the risk of contamination, since Brazilian women are the ones who are most active in the informal work sector and in activities related to the act of caring. Interestingly, the first lethal victim of COVID-19 in Rio de Janeiro was a 63-year-old domestic worker infected in the employer's home. This detail is symbolic — as it exposes the structural racism (28) perpetrated against women. Considering these initial reflections and the challenges arising from them, we focus on women from *favelas* (29), known leaders recognized for their local activism. The day-to-day construct of this woman and her place of social and political prominence is shaped by practices and attitudes revealing that there is a power that derives from these popular spaces, exercised by women, that involves unique experiences of exclusion, but does not abandon the struggle.

Locating these women

When we relate the performance of these women to a force that emerges from within the *favela*, we speak of it as the 'multiplicity of power relationships that are immanent to the domain in which they perform and are constitutive of their organization (30)'. Thus, we understand power as multidimensional and this stance encourages a look at everyday connections and power relations on all scales.

The knowledge of these women is grounded in their daily experiences and this is how they acquire learning — confirming the need to recognize that popular culture comes from the knowledge of the people (31). The protagonism these women perform is focused on their engagement in struggles for social justice and citizenship.

Our arguments are based on qualitative research that has so far interviewed 111 women.[1] The aim of the paper is to make visible the leadership these women exercise in populated areas. To that end, we chose to identify these women using *Snowball sampling* or *Snowball methodology* (32–34). The initial participants suggest new participants and so on (35,36). This is a non-probabilistic sampling technique that uses reference chains, in a kind of network (32,33,37).

The active search for female leaders in *favelas* was made through contacts, approaches, recommendations and participation in places where these women are found (civil society forums and community networks, among others) and where they are notably recognized for their socio-political performance, without delimitation of the study locus, considering that this search points us to interlocutors who come from all parts of the city of Rio de Janeiro. Semi-structured interviews were conducted through direct contact with participants, using an electronic questionnaire via mobile phone, all recorded in a database in the *Statistical Package for the Social Sciences* (SPSS). The research interviews began before the pandemic, with the aim of increasing the visibility of women's leadership in popular areas, relating their experiences to the social determinants of health. As COVID-19 unfolded we resumed contact with research participants to better understand and make visible their leadership in the emerging pandemic context.

Who are the other Marielles?

A black woman, daughter and mother, a woman from the *favela*, Marielle Franco was a sociologist, feminist, activist in defense of human rights and a Brazilian politician — a city councilor — who was assassinated in 2018. The questions about what motivated her murder and who ordered the crime are still awaiting answers.

A woman performing an active militant role, Marielle's path intersects with those of many others and also with the other women referred to here. Her story emphasizes her social and political role, her connections with militancy for the guaranteeing of rights and her permanent struggle against various forms of segregation, violence, and oppression. So, Marielle is a symbol to the female leaders of the *favelas*.

The women represented here in our interviews narrate and portray a new form of political praxis. They transform their concerns into bridges (orchestrating and connecting different possibilities for action) and themselves and their collective into a virtuous movement for social change (38). To describe this process in the face of the COVID-19 pandemic, we will present their profile, portraying them as spokespersons who embody a sense of individual and collective struggle and resistance.

Our interlocutors are mostly black, corresponding to 90% of the interviewees; 80% are mothers; 44%

completed a higher education diploma, 18% are currently attending higher education; 47% are married or live with a partner; and 65% are under 55. In Rio de Janeiro, several community-based organizations have emerged since the 1990s. They have been focused on the need for the social recognition of these women, since they represent the absolute majority in these places, and were set up as a result of the prominent demands for the mobilization of public resources to promote effective improvements in the living conditions within their territories. In this respect, 70% are linked to a community-based organization and 96% participate in collective activities (social movements, networks, collectives, and others). They work on several fronts, such as social assistance, health, education, culture, environment, among others, and it is important to note that 96% state that they work to promote community health. Networking (whether within the *favela* itself or outside it), participation in social movements, and the struggle for public policies that address needs — individual and collective — demonstrate the imperative visibility of what these women have been doing.

In view of the lack of coordinated action by the public authorities to confront COVID-19 in *favelas* and recognizing that social inequalities have a greater impact on mortality, we have sought to identify and monitor the set of strategies adopted by these women to deal with the pandemic. It is a time that calls for joint action to attend the urgencies of the vulnerable people who inhabit popular locations.

The state of play: possible paths

In the context of the pandemic, the leaders — in full exercise of their micro-power — develop strategies to provide immediate responses to local emergencies. They mobilize different resources within civil society, activate public authorities, and map out different strategies to face the moment of crisis in public health. 'We chase up, liaise, develop strategies. We can't just cross our arms', Rita from the Rocinha tells us.

> We form a team, specifically to complement the actions: synthesis of laws related to the benefits and guidance on the flows and procedures to derive them; analysis of information revealing the fake news that so distresses the population; availability of people to perform market, pharmacy and food purchases, especially for the elderly and people with physical limitations; calculation and forwarding of various services performed online, with no charge deliveries; telephone contacts with the elderly emphasizing dialogue; provision of resources (food, hygiene products, wheelchairs, etc.). (Catia, from *favela* Barreira do Vasco)

Given the conditions imposed by the pandemic, with regard to the need for social isolation, resulting in loss of work and/or conditions for earning an income in the *favela* context, hunger is the foremost threat. Contributing to the food and nutritional security of families (especially those headed by women in conditions of extreme poverty and vulnerability) becomes a priority. Mothers in *favelas* are the people most affected, as many have had to leave their jobs to look after their own children. Vanessa, from the Buriti Congonhas *favela*, told us, 'My first action involved two mothers who lost their jobs in the first week of the pandemic — one for being a day-worker and the other a street vendor. I needed to do something'. Due to their contacts and ability to talk to people inside and outside the *favelas*, all the women we are following began their efforts to cope with the demands arising from COVID-19 by acquiring baskets of basic grocery needs, along with hygiene and cleaning products. The strategies are diverse, ranging from support from individuals and companies and social media campaigns to birthday parties that transform the gift request into cash donations, so that they can subsidize the purchasing of essential goods. However, registering the neediest families and meeting their basic and immediate needs is not enough. The major concern over nutritional quality drives other action — campaigns carried out by several of these leaders have been launched so that they can obtain cash donations and thus purchase perishable foods such as eggs, vegetables, groceries, and fruits. Given that the basic-needs grocery baskets are rich in carbohydrates, it is also imperative to provide food products that protect the immune system, as pointed out by Pâmela, a leader in the Manguinhos *favela*. In this respect, the strengthening of this primary care reflects the role of health promotion for the sustainable well-being of the population.

The social and health conditions in the *favelas* challenge compliance with necessary prophylactic

measures, such as hand and food hygiene. In many areas there is no basic sanitation and/or regular access to water. As a way of minimizing these difficulties, several campaigns have been carried out to install public sinks in alleys, so that people can at least access water, which is so essential to the strategy of preventing COVID-19. In addition to these objective strategies, these women coordinate actions with young volunteers so that, when delivering the basic-needs grocery baskets, guidance is provided on personal and environmental care.

Community communication is another tangible factor at this time. In view of the low educational level of the Brazilians from low-income classes, these female leaders have confirmed the need to facilitate the understanding of *favela* residents regarding the essential procedures for protecting individual and collective health. Thus, the communication needs to be deployed in a way that encourages people to adopt the necessary measures and follow all the standard procedures. So, empowering people and the community to act in accordance with the necessary guidelines requires empathy and trust, as confirmed by Amanda, from Maré. 'Several strategies are being used for this purpose, such as placing banners, posters, spots with community radio stations, among other steps. It is necessary to speak the language of the *favela*'.

The *favela* breaks the rules for social distancing. The living space is generally shared by several people, making the street the extension of the house — their common space where interaction such as parties, fights, discussions, and leisure activities takes place. However, when people understand the dynamics of contagion and are encouraged in their efforts, they can feel more secure in facing the challenges posed by quarantine and social isolation measures.

Another challenge relates to commercial establishments inserted within the area of the *favela*. Due to the way they are set up, it is not practical to consider closing them. It is illusory to believe that small-scale entrepreneurs in places where the government is rarely present will adopt the criteria of other parts of the city. 'This is a matter of day-to-day survival! Imagine whether the *favela* economy can stop?' asks Lucia, from Complexo do Alemão. In the face of these specifics, it is essential to raise awareness about individual and, consequently, collective protection.

Considering the adversities to which people living in these popular locations are subjected, as well as their housing conditions, we are challenged to imagine a home with three or four children, all of whom are unable to go to school (or access online classes, since they usually have just a single mobile phone that is used by the whole family, with limited resources and often no internet access) and have to stay indoors for weeks. The proposed measures to ensure the continuity of education through virtual teaching platforms are not aimed at children and adolescents living in *favelas*. In addition to the challenges of shared space in the home and the lack of sufficient suitable equipment, the study routine requires the support of others who, in many cases, have not attended school — so this measure is not really feasible, due to the impossibility of it being implemented in the *favelas*, thus contributing to widening social inequities. Despite all this, the leaders are not bowed by the challenge and are in constant dialogue with the public authorities — acting in a network as a way of demanding action that takes into consideration the adversities presented by the moment.

The social and health conditions in the *favelas* challenge compliance with necessary prophylactic measures, such as hand and food hygiene. Julia, from Chatuba *favela*, says, 'Not everyone has basic sanitation, a bathroom, or can go outside the small rooms in which three, four, or five people live. For these people to take all the recommended precautions is a challenge'. Accompanying the elderly and most vulnerable people has also been essential at this time, as the young leader Lays (21), a resident of the Palmeirinha *favela*, tells us:

> One of our initial concerns was mental health. We, young people, have been challenged to pursue strategies. The first was to identify that they need to talk, to be heard. So, we started to visit them! (Lays, a resident of the Palmeirinha *favela*)

As the community activists are excellent orchestrators of networks inside the *favelas* and beyond, the management of volunteers in a chain of solidarity has been an important mechanism to support and give attention to the elderly. In addition, they provide care services to families who have lost their loved ones and are in dire need of emotional support. In this respect, several leaders are mediators between professionals and applied psychology services from universities that are providing voluntary care via the internet,

contributing to the efforts towards controlling anxiety and other associated symptoms. In this sense, it is believed that promoting action to protect the health and well-being of the most vulnerable people is contributing to increasing equity, an aspect that is directly related to the principles of health promotion.

From this perspective of care, we must add violence against women. Due to inequalities in power relations, in times of pandemic, women's vulnerability is even more exposed. In the face of this challenge, these leaders are sensitive and attentive and are of fundamental importance to this local protection network. In addition to taking care of battered women, they provide guidance on the system of guaranteed rights. Anazir, from Vila Aliança *favela*, says, 'We formed a chain of goodness and started to take care of each other'.

In their daily activism, they build bridges and establish partnerships with health and social assistance units, a fundamental relationship for the care of victims of COVID-19. They are able to mediate access to services and provide assistance and guidance regarding the paths to be taken that guarantee their right to health and social assistance. So, an intersectorial approach is in the sights of collaborative action, since it involves coordinating public policies, civil society organizations, and the community.

Conscious of it being a case of 'we for us' and solidarity within the *favela* space, they promote health through understanding of the social determinations. The presence of public authorities in several *favelas* in Rio de Janeiro has been marked, in the context of the pandemic, only by the security policy. The so-called 'operations' against the 'war on drugs' — alluding to the armed control of popular locations by gangs — are in place, using practices that are fueled by class and racial division and urban segregation. The community activists presented here are not silent. In a movement marked by struggle and social resistance, they keep their activities going, assisting families and those who need support and to be heard. Their struggles are translated, in this pandemic, into recognition of citizenship, the restoring of core values that guide humanity, and the developing of strategies to overcome inequalities.

Conclusion

The feminization of power is a growing phenomenon in contemporary society. However, we are interested in recognizing the participation of social activists and *favela* residents in this micro-political action involving mobilization and negotiation with different social agencies and the public authorities. These women, subject to agencies, are continually evolving repertoires to deal with the unequal structure to which they are permanently subjected. They recognize that the State does not act to deal with the conflicts caused by inequalities and consequently they seek ways to live better in *favelas*. The ability to connect and circulate within the city makes them autonomous and allows more freedom to build the paths that can lead them to resolving lives: their own, their families, and their communities — in the authentic sense that the term suggests: the place of belonging, neighborly relations, and solidarity.

The COVID-19 pandemic exposes the inequalities of Brazilian society and their consequences. Housing, sanitation, and access to health services are all offered to the poor, notably black, in a way that defines where the priorities in this class-based society lie, whose interests are based on individual desires, as opposed to collective interests. In this context, the strengthening of primary care and social and health services based on the community are essential to the role of health promotion and disease prevention.

Recognizing and ensuring social and cultural sustainability becomes a challenge to the current status quo in our society and a paradigm shift is essential — whereby competitiveness and individual interests must give way to the defense of solidarity.

The common intersectionality is an expression of gender, race, and class, associated with territorial factors, and is translated in this group as existence and resistance. The lived experience and different paths developed to deal with the pandemic reveal the importance of the struggle of these women. So, we seek in this study to identify and observe the set of strategies adopted by these women during the pandemic, confirming the important contribution offered by female leaders in the *favelas* to coping with the various problems that arose in the context of the COVID-19 pandemic. They were involved with housing, primary care, social and health services, nutritional support, community communication, and violence against women, among other local demands. It is essential to recognize their tactics, ability to organize and network, mobilization of the different resources of civil society, and development of a variety of strategies to face this moment of crisis in public

health. They seek to create better conditions for the well-being of those who inhabit the *favelas*, where inequities critically expose the fundamental social distancing in Brazilian society.

Declaration of conflicting interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Conselho Nacional de Desenvolvimento Científico e Tecnológico 408786/2018-3.

ORCID iD

Nilza Rogeria De Andrade Nunes https://orcid.org/0000-0002-2208-1054

Note

1. This research is approved by the Ethics Committee of the Catholic University of Rio de Janeiro (PUC-Rio).

References

1. Crenshaw K. Documento para o encontro de especialistas em aspectos da discriminação racial relativos ao gênero. Revista Estudos Feministas. 2002; 10: 171–188.
2. Gonzales H a L. Lélia Fala de Lélia. REF. 1994; 2: 379–379.
3. hooks bell. Ain't I a woman: Black women and feminism. 2nd ed. New York: Routledge, Taylor & Francis Group; 2015. 205 p.
4. Carneiro S. A batalha de Durban. Revista Estudos Feministas. 2002; 10: 209–214.
5. Collins PH, Collins PH. Aprendendo com a outsider within: a significação sociológica do pensamento feminista negro. Sociedade e Estado. 2016; 31: 99–127.
6. Akotirene C. Interseccionalidade. São Paulo: Pólen; 2019. 150 p. (Feminismos plurais).
7. Kilomba G, Oliveira J. Memórias da plantação: episódios de racismo cotidiano. Rio de Janeiro: Editora Cobogó; 2019.
8. Ribeiro D. O que é lugar de fala? Belo Horizonte, MG: Letramento, Justificando; 2017. 111 p. (Feminismos Plurais).
9. Silva J de S e, Barbosa JL. As favelas como territórios de reinvenção da cidade. Cadernos do Desenvolvimento Fluminense. 2013; 1: 115–126.
10. Lannes-Fernandes F. Os jovens da favela: Reflexões sobre controle e contenção socioespacial dos párias urbanos no Rio de Janeiro. Convergência. 2012; 19: 159–186.
11. Telles V da S. Favela, favelas: interrogando mitos, dogmas e representações. Revista Brasileira de Ciências Sociais. 2006; 21: 141–143.
12. Haesbaert R. O mito da desterritorialização: dos múltiplos territórios a multiterritorialidade. 2004; 20.
13. Haesbaert R. Território e multiterritorialidade: um debate. GEOgraphia [Internet]. 2007 [cited 2020 Dec 18]; 9. Available from: https://periodicos.uff.br/geographia/article/view/13531
14. da Cunha Nóbrega PR. Reflexões acerca dos conceitos de território, territorialidades e redes para o ensino de geografia. Revista de Ensino de Geografia. 2013; 4: 4–21.
15. Aníbal Q. Colonialidade do poder, Eurocentrismo e América Latina. In: Buenos Aires: CLACSO; 2005.
16. Lugones M. Rumo a um feminismo descolonial. Revista Estudos Feministas. 2014; 22: 935–952.
17. Cardoso CP. Amefricanizando o feminismo: o pensamento de Lélia Gonzalez. Revista Estudos Feministas. 2014; 22: 965–986.
18. Jurema W. Nossos passos vêm de longe! Movimentos de mulheres negras e estratégias políticas contra o sexismo e o racismo. In: Mulheres negras: um olhar sobre as lutas sociais e as políticas públicas no Brasil. Criola; 2010.
19. Sardenberg C. Caleidoscópios de gênero: gênero e interseccionalidades na dinâmica das relações sociais. Mediac Rev Cien Soc. 2015; 20: 56.
20. Collins PH. Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment. Routledge; 2002. 352 p.
21. Davis AY. Mulheres, raça e classe. São Paulo: Boitempo; 1983.
22. Maldonado-Torres N. Transdisciplinaridade e decolonialidade. Soc. Estado [Internet]. 2016 Dec 5 [cited 2020 Dec 18]; 31: 75–97. Available from: https://periodicos.unb.br/index.php/sociedade/article/view/6080
23. Barbosa JL. Por uma quarentena de direitos para as favelas e as periferias! Espaço economia [Internet]. 2020 Apr 7 [cited 2020 Dec 18]. Available from: http://journals.openedition.org/espacoeconomia/10274
24. Libânio C de A, Libânio C de A. O fim das favelas? Planejamento, participação e remoção de famílias em Belo Horizonte. Cadernos Metrópole. 2016; 18: 765–784.
25. Teixeira SMF. Estado sem cidadãos: seguridade social na América Latina. Rio de Janeiro, RJ: Editora Fiocruz; 1994. 251 p.
26. Sposati A. Proteção social e seguridade social no Brasil: pautas para o trabalho do assistente social. Serviço Social & Sociedade. 2013; 116: 652–674.
27. Sposati A, Sposati A. Descaminhos da seguridade social e desproteção social no Brasil. Ciência & Saúde Coletiva. 2018; 23: 2315–2325.
28. Jurema W. Os resultados do racismo patriarcal sobre a saúde das mulheres negras são devastadores [Internet]. [cited 2020 Dec 18]. Available from:

http://jornalmulier.com.br/jurema-werneck-medica-e-coordenadora-da-organizacao-nao-governamental-criola/, http://jornalmulier.com.br/jurema-werneck-medica-e-coordenadora-da-organizacao-nao-governamental-criola/
29. Nunes NR. Mulher de favela: o poder feminino em territórios populares. Rio de Janeiro, RJ: Gramma; 2018. 267 p.
30. Raffestin C. Por Uma Geografia do poder. Brasilia: Atica; 1993.
31. Chauí M. Cultura política e política cultural. Estud av. 1995; 9: 71–84.
32. Goodman LA. Comment: on respondent-driven sampling and snowball sampling in hard-to-reach populations and snowball sampling not in hard-to-reach populations. Sociol Methodol. 2011; 41: 347–353.
33. Waters J. Snowball sampling: a cautionary tale involving a study of older drug users. Int J Soc Res Methodol. 2015; 18: 367–380.
34. Handcock MS, Gile KJ. Comment: on the concept of snowball sampling. Sociol Methodol. 2011; 41: 367–371.
35. Cohen N, Arieli T. Field research in conflict environments: methodological challenges and snowball sampling. J Peace Res. 2011; 48: 423–435.
36. Audemard J. Objectifying contextual effects: the use of snowball sampling in political sociology. Bull Methodol Sociol. 2020; 145: 30–60.
37. TenHouten WD. Site Sampling and snowball sampling — methodology for accessing hard-to-reach populations. Bull Methodol Sociol. 2017; 134: 58–61.
38. Rago M. Feminizar e preciso, ou por uma cultura filogina. La Manzana de la discordia. 2007; 2: 7–19.

Original Article

A community-health partnership response to mitigate the impact of the COVID-19 pandemic on Travellers and Roma in Ireland

Jacopo Villani[1], Petra Daly[2], Ronnie Fay[3], Lynsey Kavanagh[3], Sandra McDonagh[4] and Nurul Amin[3]

Abstract: Irish Travellers and Roma are two ethnic minorities experiencing high levels of health inequities. These communities are at greater risk of developing COVID-19 and of suffering more severe symptoms due to poor living environments and higher rates of comorbidities. This study explores the strategies adopted by community-health partnerships and NGOs to minimise the potential widening of Travellers' and Roma's health inequities during the initial response to the COVID-19 pandemic in Ireland. A descriptive qualitative approach was employed to provide a detailed account of three different community and partnership-led responses. Data were gathered from multiple sources and through first-hand participation in the COVID-19 responses. Data were analysed using thematic analysis. This study found that the main pandemic mitigation interventions implemented were public health measures, culturally sensitive communications, lobbying for policy change and economic and social support. These interventions, supported by the health promotion strategies of partnership, advocacy and empowerment, have proven to be extremely important to reduce potential inequities in exposure to the virus and in access to healthcare. The findings suggest that community-health partnerships between minority groups' organizations and healthcare professionals represent a viable approach to mitigate the disproportionate effects of a pandemic on Travellers and Roma.

Keywords: primary health care, Irish Travellers, Roma, collaboration/partnerships, pandemic preparedness planning and response, advocacy, health inequities, COVID-19

Introduction

In March 2020 the Irish Government introduced a series of public health protection measures to control the COVID-19 pandemic, caused by the severe acute respiratory syndrome coronavirus 2 (hereafter SARS-CoV-2). These included restrictions on non-essential travel, school and workplace closure, social distancing, proper hand washing and quarantining of patient contacts (1). People from low-income and ethnic minority backgrounds may have been disproportionately affected by these measures as they are often unable to work from home, rely on community and school-based services and face multiple barriers to adhere to public health advice (2).

This is indeed the case for Irish Travellers and Roma, two ethnic minority groups whose experience

1. Mental Health Services, Health Service Executive, Community Healthcare West, Galway, Ireland.
2. Mental Health Services, Health Service Executive, Community Healthcare Midlands Louth Meath, St Lomans Hospital, Mullingar, Ireland.
3. Pavee Point Traveller and Roma Centre, Mountjoy, Dublin, Ireland.
4. Offaly Traveller Movement, Tullamore, Ireland.

Correspondence to: Jacopo Villani, Mental Health Services, Health Service Executive, 2-3 Sherwood House, Sherwood Avenue, H91 TR22, Galway, Ireland. Email: jacopo.villani@hse.ie

(This manuscript was submitted on 10 July 2020. Following blind peer review, it was accepted for publication on 20 January 2021.)

Global Health Promotion 1757-9759; Vol 28(2): 46–55; 994075 Copyright © The Author(s) 2021, Reprints and permissions: http://www.sagepub.co.uk/journalsPermissions.nav DOI: 10.1177/1757975921994075 journals.sagepub.com/home/ghp

of social marginalisation has been largely documented (3–6). Travellers and Roma marginalisation is attributable to poor access to social and health services, lack of economic and political power and a low level of participation in Irish society (3–6). According to the 2016 national Census (7) and the 2018 *Roma in Ireland — A National Needs Assessment* (6), there are approximately 36,000 Irish Travellers and 5,000 Roma living in Ireland. Statistics show that a considerable proportion of these communities are homeless or live in overcrowded accommodations, and that they experience poorer educational and employment outcomes (4,6,7). It has also been estimated that over 1,000 Travellers are living on the side of the road in trailers (7), and that most Travellers and Roma lack water and sanitation, heating and other basic facilities (4,6). Hence, Travellers' and Roma's ability to comply with public health recommendations has been significantly limited by financial insecurity, low literacy rates and sub-standard living environments.

This is compounded by widespread discrimination (4) and the lack of culturally sensitive communication on COVID-19 (5) which may undermine effective community engagement and trust in mainstream health services. A systematic review documented that discrimination and cultural and language barriers are among the most common barriers to accessing healthcare for Travellers and Roma (8).

Studies conducted in Ireland (4) and continental Europe (9) show that Travellers and Roma experience extreme levels of health inequities. This includes a higher prevalence of heart disease, cancer and diabetes which, according to emerging epidemiological evidence on COVID-19 (10), increases susceptibility to the disease and disease severity.

There is evidence of the unequal levels of health outcomes among ethnic minorities during pandemics (11–13), which is corroborated by recent UK data demonstrating excessive COVID-19 death rates among minority groups (14). These findings suggest that Travellers and Roma as marginalised groups are more likely to experience higher levels of risk compared to the general Irish population.

Conceptual framework

Health inequities are avoidable inequalities in health status between different population groups (15). Whereas 'health inequality' simply indicates differences in health which are natural, 'health inequity' is charged with a value judgement, referring to differences which are avoidable and unfair. Therefore, tackling health inequities means addressing injustice (15), which is one of the ethical values underpinning health promotion practice.

This study is placed within a health inequity framework which describes the variety of theories on the social production of health and disease (16). While there are different aetiological pathways for the understanding of health inequities, such as cultural/behavioural, psychosocial, selection, life course and material explanations (16), one of the most influential models clarifying how health and disease are socially produced is offered by Diderichsen *et al*. (17).

According to Diderichsen *et al*. (17) people's social position will determine their 1) exposure to risks (*differential exposure*), it will define their 2) degree of vulnerability to disease if exposed (*differential vulnerability*), and 3) people from different socio-economic groups will suffer different consequences of disease as a result of inequalities in access to treatments (*differential consequences*). As a corollary, unequal levels of health and illness are a direct consequence of social position.

Following Diderichsen *et al*.'s model, which has been applied to pandemic influenza planning in the United States (11), these inequities can be narrowed by decreasing the exposure of disadvantaged people to health damaging factors, by reducing their susceptibility and intervening through the healthcare system to improve timeliness of access to treatments (17).

The literature on pandemic influenza preparedness and response for vulnerable populations suggests that the potential increase of health inequities during pandemics can be avoided by interventions that include culturally appropriate communications, coordination between public health and community safety-net systems, engaging minority organizations and development of partnerships between community-based organizations and healthcare providers (11–13).

Scholarly works have advanced the idea that health promotion principles and strategies can contribute to addressing the challenges of pandemics (18). This includes the strategies of partnership, advocacy and empowerment which were outlined as essential for the pursuit of health in the landmark 1986 Ottawa Charter for Health Promotion (19,20).

While advocacy in health promotion is the process of defending a cause, through empowering disenfranchised groups, or influencing policy makers to achieve public health goals (21), a partnership for health is an alliance of multiple actors aimed at promoting population health (22).

The involvement of communities, minorities and grassroots service users is considered essential in 'health promoting' partnerships, because community members can work alongside professionals to influence health among the wider population (22). This type of partnership can foster community engagement and empowerment which is a strategy aimed at enabling people to increase control over their health (19,20). An empowering approach requires the creation of supportive environments, life skills and opportunities, and access to information and appropriate communication (20).

Through the lens of this theoretical framework, this study explores the strategies implemented in Ireland to avoid a disproportionate health impact of COVID-19 on the Traveller and Roma communities.

The Traveller and Roma health infrastructures in Ireland

In Ireland there are 27 Primary Health Care for Traveller Projects (hereafter PHCTPs) and 3 Roma health projects, which are peer-led initiatives aimed at improving Travellers' and Roma's health outcomes through outreach health promotion and education (23,24). These projects employ approximately 300 Traveller community health workers and Roma mediators who use a social determinants of health approach to address health inequities. These government-funded community-based projects are connected to, and monitored by, seven Traveller Health Units (hereafter THUs), which are regional structures under the management of the main state healthcare provider in Ireland: the Health Service Executive (hereafter HSE) (25).

It is against this background that the COVID-19 mitigation plans for Travellers and Roma were implemented.

Study aims

This research study set out to contribute to the knowledge on pandemic responses for vulnerable populations with new evidence and recommendations from the initial response to the COVID-19 pandemic in Ireland.

The purpose of this study is to explore the contribution of health promotion strategies to minimising the potential exacerbation of Travellers' and Roma's health inequities. More specifically, the study examines the wide-ranging interventions implemented by non-governmental organisations (NGOs) and community-health partnerships to limit inequities in exposure to the coronavirus SARS-CoV-2 and in access to healthcare.

This study, therefore, seeks to document effective practices which can inform and improve future policies and programmes in the realm of pandemic preparedness and response for vulnerable ethnic minorities.

Methods

This study employed a descriptive qualitative approach which, following Sandelowski (26), is suitable for seeking the 'descriptive validity of events which most people, observing the same phenomena, would agree is accurate'. Through this approach, this study aims to provide a detailed account of three different community and partnership-led responses during Ireland's first three months of COVID-19 pandemic (March–May 2020).

These responses were selected through purposive sampling, as they are considered representative of the measures implemented in Ireland to mitigate the impact of the pandemic on the Traveller and Roma communities. The authors' active involvement in the implementation of these responses, and their extensive expertise in working with these populations from community development and healthcare perspectives, has driven the choice for this sampling approach. Although each response is unique and independent there is a small degree of overlap between them, as few interventions initiated at community level by NGOs were supported by partnership responses at a national level.

Researchers gathered evidence first-hand during the COVID-19 responses through participation in interagency meetings, development of advocacy strategies and management of the Traveller COVID-19 helpline. Data were collected from multiple sources such as: NGOs' briefings, Traveller COVID-19 helpline database, Traveller and Roma-specific COVID-19 multi-media sources, minutes of meetings and

Table 1. Strategies and interventions employed to minimise the widening of Traveller and Roma health inequities in Ireland.

Responses analysed	*Health promotion strategies employed*	*Mitigation interventions implemented*	*Possible sources of inequity addressed*
Community response in the Eastern region	Advocacy empowerment	Culturally sensitive and literacy friendly communication[a]	Access to healthcare and exposure to the virus
		Distribution of hygiene kits[b]	Exposure to the virus
		Distribution of food, telephones and assistance to access financial support[c]	
		Lobbying for policy changes on accommodations and evictions[d]	
National COVID-19 Traveller and Roma response team	Partnership empowerment advocacy	Lobbying to prioritize Travellers and Roma in COVID-19 testing[d]	Access to healthcare
		Dissemination of translated COVID-19 resources for Roma[a]	Access to healthcare and exposure to the virus
		Provision of isolation facilities for Roma[b]	Exposure to the virus
Traveller COVID-19 helpline	Partnership empowerment	Provision of information on COVID-19, testing and access to healthcare[a]	Access to healthcare and exposure to the virus
		Signposting of vulnerable cases to local Traveller Health Units, PHCTPs and community safety-net systems[c]	Exposure to the virus

[a]Culturally sensitive communication.
[b]Public health measures.
[c]Economic and social support.
[d]Lobbying for policy change.

observation notes. The data related to each response were collated into three separate folders. Ethical approval was sought and obtained from each group of healthcare providers and NGOs involved in the production of the data used for this study. Anonymity was adhered to throughout the research process and ensured by collecting anonymised information.

Following Braun and Clarke (27), data were analysed using thematic analysis. First, the entire data set was coded through codes derived from the data. In a second phase, some codes were disregarded and others were merged under broader categories (themes). The identification of these categories was mainly conducted through a deductive approach, informed by the literature on pandemic responses and through the lens of health promotion. The data presented in this study were the most prevalent across the data set and the most relevant for the study aims.

Results

The results of the analysis are presented in Table 1, which shows the different combinations of strategies and interventions adopted by NGOs and community-health partnerships. The mitigation interventions are coded to reflect the four main categories identified from the analysis.

Each response will be analysed individually in the following sections. This will show the distinctive features of each response in addressing the intersecting vulnerabilities of the selected populations.

The community response to the COVID-19 pandemic in the Eastern region

The first community responses to the crisis in the Eastern region were advocacy actions and lobbying initiated by the leading NGO Pavee Point Traveller and Roma Centre (hereafter Pavee Point) and supported by Traveller organizations and HSE partners. Since many Traveller families live in halting sites lacking water and sanitation and other basic facilities, it was paramount to rapidly improve these sites, to enable residents to comply with hygiene advice and protect themselves from COVID-19.

Moreover, due to specific Irish legislation which prohibits entering, occupying or bringing any object onto vacant lands (28), many Travellers living in trailers on the side of the road are in breach of such law, and are evicted by law enforcement. Evictions during the pandemic would have increased the vulnerability of a substantial number of Travellers.

In order to tackle these fundamental issues, Pavee Point implemented a set of coordinated activities, such as: writing a briefing paper with key recommendations, meeting with the Minister for Housing and exercising pressure through HSE partners. As a consequence, the Department of Housing issued a national circular to all local authorities taking into consideration Pavee Point's recommendations and prompting local authorities to improve facilities in halting sites and provide isolation units where necessary (29).

As a direct result of this work, many Traveller halting sites around Ireland have been equipped with extra toilets and waste collection, running water and extra mobile accommodation for isolation. Following a similar course of action, national emergency legislation included a ban on Traveller evictions (29).

At grassroots level, NGOs reported Travellers' difficulties in understanding key public health messages due to low health literacy and the lack of cultural sensitivity in mainstream communication around COVID-19. As a response NGOs designed culturally sensitive and literacy friendly communications. These can be defined as communications which incorporate 'the culture (norms, beliefs and values) of the target population' (30), in order to be more effective and accepted, and consider its literacy needs.

Communication campaigns included the production of video and audio messages, online resources and leaflets, designed *by* Travellers *for* Travellers, on COVID-19 prevention and how to access COVID-19 testing (29). Given the fact that 83% of Travellers receive their health information from the PHCTPs (4), COVID-19 resources were disseminated through Traveller Community Health Workers using social media and mobile phone technology. These workers played a key role in debunking disinformation around COVID-19 and confirming key public health messages.

In addition, many PHCTPs and Traveller groups worked with local agencies to support the distribution of hygiene kits, food, books and telephones to vulnerable Traveller families, and helped them to file applications to access financial support provided by the Red Cross and local charities.

The community-health partnership responses to COVID-19

The following sections contain an analysis of two partnership initiatives formed at the onset of the crisis.

The national COVID-19 Traveller and Roma response team

At a national level, a COVID-19 Traveller and Roma Response Team was formed in early March 2020 by the HSE National Social Inclusion Office, whose remit is supporting health access to a number of vulnerable groups (25). This national team included regional THUs and groups working with Roma, members of HSE Public Health, Social Inclusion, Mental Health and Health and Wellbeing. The aim of this group was to share information and data, identify emerging issues at local and regional levels and develop strategic responses.

One of the main achievements of this partnership was the inclusion of Travellers and Roma as vulnerable groups and consequently their prioritisation and fast-tracking for COVID-19 tests. This advocacy result was particularly relevant as these communities are more likely to experience sub-optimal engagement with healthcare services due to literacy, language and cultural barriers (4–6,8). This result was achieved as a result of the information provided by grassroots organizations that documented the challenges faced by the selected populations and built a timely and well-argued case. The long-standing working relationship between NGOs and HSE partners based on mutual trust was conducive to strengthening the alliance and achieving results.

A significant proportion of Roma in Ireland is particularly vulnerable to homelessness and poverty as it does not meet the criteria for the right to reside in the country, which is a prerequisite to accessing social housing and welfare payments (6). This long-standing challenge has been magnified by the COVID-19 pandemic which has exposed Roma to additional health risks. This has been confirmed by the Roma projects and the COVID-19 Roma helpline which reported worrying levels of homelessness and evictions and prompted coordinated actions from the

National Response Team.

After weeks of networking and negotiation with different stakeholders, the HSE secured a hotel in the Dublin area for the isolation of COVID-19 positive Roma people from all over the country. This service included transport to the facility, as well as access to medical assistance for the Roma people. In addition, COVID-19 resources and information on how to access public services were translated into different languages for Roma from continental Europe (25), and disseminated through the response team members.

The Traveller COVID-19 helpline

In recognition of the need for targeted measures to support Travellers during the crisis, a National COVID-19 Traveller helpline was established and managed by the Offaly Traveller Movement in partnership with the THU in Community Healthcare Midlands Louth Meath and HSE Mental Health Service Coordinators for Travellers (31).

The examination of the information collected from 205 calls, received from all over Ireland during 10 weeks of operation, shows that the majority of callers' concerns were about COVID-19 tests and worry about COVID-19 symptoms. The helpline provided timely information on COVID-19 infection prevention, on the need to quarantine symptomatic individuals and on the pathways to access COVID-19 tests. Through the helpline, Travellers were also advised on community services offering transport to testing facilities, General Practitioner (GP) and hospital appointments.

Concerns related to the social determinants of health represented the second highest reason for calling the service, and more specifically, they were related to overcrowding, food poverty, financial problems, lack of water and sanitation and homelessness. Several callers sought support for the purchase of food and medicines, and disclosed difficulties in managing their weekly budget during lockdown as a result of higher spending on groceries and the loss of income. These economic challenges magnified considerably the psychological impact of the COVID-19 crisis.

Many callers reported high levels of stress caused by fear of infection as a result of the inability to comply with public health advice due to overcrowding and lack of facilities. This included large families living in hotel rooms provided by local authorities as emergency accommodations and young homeless families living in trailers and sharing facilities with their elderly vulnerable parents. The exploration of the helpline database reveals that Travellers' socio-economic inequities represented a significant source of worry and an obstacle to COVID-19 prevention. This is particularly evident for Traveller women who have been excessively affected by the crisis. Several female callers residing in women's refuges, and single mothers living in trailers with several children with no running water, toilets and electricity, described with frustration and concern their daily challenges during lockdown.

The helpline was helpful in signposting callers to community services that could collect and deliver meals, essential household items and medication for people in isolation. The helpline was also instrumental in highlighting to the THUs, PHCTPs and local authorities some of the most vulnerable cases in need of support, informing callers on the emergency law protecting Travellers from evictions and helping them to fill out applications for financial support.

The impact of the pandemic on different gender and age groups

NGOs' reports revealed that Traveller women have been impacted by a rise in domestic violence during the pandemic. The lack of information about how services operated during the lockdown was a barrier to accessing domestic violence accommodations. In order to improve rates of admission in women's refuges, Pavee Point developed accessible information for Traveller women that was shared on social platforms.

NGOs reported that Traveller men experienced disproportionate levels of stress during the lockdown. It is plausible that this may have been the consequence of travel restrictions and not being able to provide for their families. In fact, Traveller men, as a result of a very traditional concept of masculinity, associate their identity with earning income and with transport, which is considered essential to generating income (32).

It has been reported that the lack of internet access and suitable hardware threatened Traveller and Roma school children with further educational disadvantage as schools moved to distance learning during lockdown. Pavee Point advocated with the Department of Education for IT support and access to mitigate the effects of school closure.

Study limitations

Two of the limitations of this study are the use of purposive sampling and the authors' involvement in the responses analysed, which may have led to the collection of biased data. In addition, the database utilized to log the calls of the Traveller helpline was not designed for research purposes, therefore these data are being used pragmatically and some of the concerns recorded may be subject to different interpretation.

Discussion

The COVID-19 pandemic demonstrated how the interplay between Traveller and Roma socio-economic vulnerabilities with the challenges posed by the government restrictions threatened to exacerbate existing health inequities by increasing the likelihood of SARS-CoV-2 exposure, susceptibility and delayed access to healthcare (17). The COVID-19 crisis has also exacerbated gender inequities as Traveller women have been disproportionately exposed to risks, especially those living in socioeconomically fragile circumstances.

This study examined the strategies adopted by three community and partnership-led responses to mitigate the impact of the pandemic on Travellers and Roma. The findings suggest that the employment of targeted mitigation interventions, supported by health promotion strategies, contributed to minimise the potential widening of health inequities during the initial response to the pandemic. The data analysed throughout this study shows that the most common approach adopted by NGOs and healthcare providers to achieve equity was to address social inequities experienced by the most disadvantaged families and individuals.

Prior to the pandemic, in Ireland there was an established collaboration between NGOs and healthcare providers through the Traveller Health Units (25). These had been very successful in developing targeted health initiatives for Travellers and Roma. In particular, the Primary Healthcare for Traveller Projects (PHCTPs) has been a successful model of community-oriented healthcare that, for over 20 years, helped to reach out to vulnerable families, compensating for the inability of the health services to deliver appropriate coverage to the whole population (4,23). Notwithstanding the existence of previous partnerships, the threat of a disproportionate health effect on thousands of Travellers and Roma required a closer collaboration with public health specialists and the employment of innovative pandemic mitigation interventions. These included targeted public health measures, economic and social support, culturally appropriate communications and lobbying for policy change (see Table 1). These interventions were supported by the health promotion strategies of partnership, advocacy and empowerment. The partnership approach emerged as being particularly effective in delivering comprehensive pandemic mitigation interventions and advocacy strategies played a pivotal role in achieving rapid policy change.

As shown throughout this article, these actions and strategies intervened to mitigate the processes that generate health inequities as illustrated by Diderichsen *et al.*'s (17) model. The actions implemented to provide economic and social support to affected families have been essential to reducing potential SARS-CoV-2 exposure by enabling adherence to quarantine measures. The employment of lobbying techniques was essential to reduce avoidable inequities in virus exposure through an improvement to living environments and a moratorium on evictions (29). Moreover, lobbying activities reduced possible inequities in access to medical care as a result of the prioritisation of Travellers and Roma for COVID-19 tests.

Culturally sensitive communications and targeted public health measures helped to decrease inequities in access to healthcare and exposure to the virus through provision of isolation facilities, hygiene kits and accessible information on COVID-19 which resonated with Traveller culture's belief system. This type of communication was particularly important as it has been reported that Travellers consider problems with literacy a major barrier to accessing services and they believe that culturally appropriate information is among the things that would most improve their health (4). Ensuring access to affordable hygiene products and implementing surge plans for isolation units are among the public health and social measures suggested by the World Health Organization in the context of COVID-19 (33).

These actions are in keeping with those recommended for the protection of ethnic minorities during pandemics (11–13). Hence, incorporating these strategies in future pandemic preparedness plans specifically developed for

Travellers and Roma would help reduce the unfair and unequal health impact of a pandemic on the most vulnerable.

Pandemic preparedness plans should systematically consider the wider socio-economic needs of Travellers and Roma and should include targeted measures for women, men and children. These should comprise the provision of suitable isolation facilities, improvement of halting site facilities, financial and food support, culturally sensitive communication, fast tracking women and children fleeing domestic violence in social housing allocation, and providing access to internet and hardware for children attending distance learning. Using equity as a guiding principle and a participatory approach to pandemic preparedness planning would ensure that the needs of these communities are accurately reflected (11).

As shown in this study, one of the essential strategies introduced was the establishment of new community-health partnerships at a national level, with a broader range of partners including specialists in public health medicine. These partnerships adopted a successful approach aimed at curbing the spread of the virus by coupling the medical response with a social response and through the synergy of multiple partners from different sectors. This socioecological approach aligns with Kickbusch and Sakellarides' (18) remarks on the role of health promotion in a pandemic threat and on the importance of focusing on the non-medical measures to control a pandemic.

The partnership-led model was essential for the establishment and management of the Traveller COVID-19 helpline (31). The helpline limited the potential deepening of social and health inequities through the provision of health information and a link to community safety nets to a highly mobile population with low health literacy and poor access to healthcare. Given the positive uptake of this service, establishing helplines for vulnerable populations with no access to the internet would be effective in helping them cope with adversities during a pandemic. Evidence from Greece suggests that a mental health telephone helpline has been crucial during the COVID-19 pandemic to refer emergency cases, network with other services and offer empathetic listening (34).

All the community-health partnerships analysed in this study included representatives of minority ethnic groups and combined NGOs' knowledge of grassroots needs with the expertise of partners from the healthcare sector. The variety of perspectives and skills combined with a shared commitment to tackle social and health inequities represent, in the view of the authors, a point of strength across these partnerships. These features are consistent with scholars' suggestions to establish partnerships between public health, NGOs, community based organisations and minority communities to reduce adverse health consequences on ethnic minorities during pandemics (12,13).

The data analysis shows that empowerment is the most prevalent strategy implemented; however, this was mainly limited to the provision of culturally tailored communications and improved living conditions. Although the long-term process of empowerment requires gaining control over the determinants of health (20), it is plausible to believe that the target communities may have moderately increased control over their life choices through greater knowledge of COVID-19 prevention and more supportive environments.

The examination of the community response, and the engagement of the PHCTPs in community health partnerships, demonstrates the value of the primary health care model in supporting disenfranchised communities during a pandemic. Renewed investments in primary health care projects would encourage the creation of a health system that respects cultural needs and protects the right to health of marginalised communities during pandemics.

Finally, socio-epidemiological studies have demonstrated that health inequities are stratified according to social position (17). While structural imbalances cannot be eliminated by pandemic responses and planning, this study has shown that the deepening of health inequities can be minimised during a pandemic by tackling the multiple routes of virus exposure and enhancing access to medical care. This can be achieved through targeted pandemic mitigation interventions delivered through community-health partnerships and the employment of advocacy strategies and empowerment approaches.

Acknowledgements

We would like to thank Professor Margaret Barry for her helpful comments on an earlier draft of this paper.

Authors' contribution

Jacopo Villani: conceptualization, methodology, investigation, formal analysis, writing – original draft, writing – review and editing, project administration. **Petra Daly:** investigation, formal analysis. **Ronnie Fay:** investigation, writing – review and editing. **Lynsey Kavanagh:** writing – review and editing. **Sandra McDonagh:** investigation. **Nurul Amin:** investigation.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Ethics

Ethical clearance was sought and obtained from all organizations involved in the production of the data used for this study.

ORCID iD

Jacopo Villani https://orcid.org/0000-0001-6157-8912

References

1. Department of the Taoiseach. Speech of an Taoiseach Leo Varadkar TD [Internet]. Dublin: Government Buildings; 2020 March 27 [cited 2021 February 9]. Available from: https://bit.ly/3e4Sqj8
2. Fortuna LR, Tolou-Shams M, Robles-Ramamurthy B, Porche MV. Inequity and the disproportionate impact of COVID-19 on communities of color in the United States: the need for a trauma-informed social justice response. Psychol Trauma. 2020; 12: 443–445.
3. Scullion L, Brown P. Understanding the social exclusion of Roma. In: Ahmed A, Rogers M (eds). Working with Marginalised Groups: From Policy to Practice. London: Palgrave Macmillan; 2016, pp.70–85.
4. All Ireland Traveller Health Study Team. All Ireland Traveller Health Study: Our Geels. Dublin: Department of Health and Children; 2010.
5. Armitage R, Nellums LB. COVID-19 and the Gypsy, Roma and Traveller population. Public Health. 2020; 185: 48.
6. Pavee Point Traveller Roma Centre & Department of Justice and Equality. Roma in Ireland—A National Needs Assessment. Dublin: Pavee Point; 2018.
7. Central Statistics Office. Census Population 2016, Irish Travellers-Demographics [Internet]. Dublin: Central Statistics Office; 2016 [cited 2021 February 9]. Available from: https://bit.ly/2MW49nK
8. McFadden A, Siebelt L, Gavine A, Atkin K, Bell K, Innes N, et al. Gypsy, Roma and Traveller access to and engagement with health services: a systematic review. Eur J Public Health. 2018; 28: 74–81.
9. La Parra Casado D, Gil González D, de la Torre Esteve M. The social class gradient in health in Spain and the health status of the Spanish Roma. Ethn Health. 2016; 21: 468–479.
10. Docherty AB, Harrison EM, Green CA, Hardwick HE, Pius R, Norman L, et al. Features of 20,133 UK patients in hospital with COVID-19 using the ISARIC WHO Clinical Characterisation Protocol: prospective observational cohort study. BMJ. 2020; 369: m1985. DOI: 10.1136/bmj.m1985.
11. Blumenshine P, Reingold A, Egerter S, Mockenhaupt R, Braveman P, Marks J. Pandemic influenza planning in the United States from a health disparities perspective. Emerg Infect Dis. 2008; 14: 709–715.
12. Quinn SC, Kumar S, Freimuth VS, Musa D, Casteneda-Angarita N, Kidwell K. Racial disparities in exposure, susceptibility, and access to health care in the US H1N1 influenza pandemic. Am J Public Health. 2011; 101: 285–293.
13. Hutchins SS, Fiscella K, Levine RS, Ompad DC, McDonald M. Protection of racial/ethnic minority populations during an influenza pandemic. Am J Public Health. 2009; 99(Suppl 2): S261–S270.
14. Public Health England. Disparities in the Risk and Outcomes of COVID-19 [Internet]. London: Public Health England; 2020 [cited 2021 February 9]. Available from: https://bit.ly/2yYSQrj
15. Graham H. Social determinants and their unequal distribution: clarifying policy understandings. Milbank Q. 2004; 82: 101–124.
16. Bartley M. Health Inequality: An Introduction to Concepts, Theories and Methods. 2nd ed. Cambridge, MA: Polity Press; 2017.
17. Solar O, Irwin A. A Conceptual Framework for Action on the Social Determinants of Health [Internet]. Geneva: WHO Document Production Services; 2010 [cited 2021 February 9]. Available from: https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf
18. Kickbusch I, Sakellarides C. Flu city—smart city: applying health promotion principles to a pandemic threat. Health Promot Int. 2006; 21: 85–87.
19. World Health Organization. Ottawa charter for health promotion. Can J Public Health. 1986; 77: 425–430.
20. Saan H, Wise M. Enable, mediate, advocate. Health Promot Int. 2011; 26(Suppl 2): ii187–ii193.
21. Wise M. The role of advocacy in promoting health. Promot Educ. 2001; 8: 69–74.
22. Jones J, Barry MM. Factors influencing trust and mistrust in health promotion partnerships. Glob Health Promot. 2018; 25: 16–24.
23. McCabe C, Keyes F. A Review of Travellers' Health Using Primary Care as a Model of Good Practice [Internet]. Dublin: Pavee Point Traveller and Roma Centre; 2005 [cited 2021 February 9]. Available from: https://bit.ly/2ALumml
24. Pavee Point Traveller and Roma Centre. Pavee Point Roma Programme [Internet]. Dublin: Pavee

Point Traveller and Roma Centre; 2019 [cited 2021 February 9]. Available from: https://bit.ly/3eeKQlh
25. HSE National Inclusion Office. Irish Travellers [Internet]. Dublin: HSE National Inclusion Office; 2020 [cited 2021 February 9]. Available from: https://www.hse.ie/eng/about/who/primarycare/socialinclusion/travellers-and-roma/irish-travellers/irish-travellers-information-and-strategy.html
26. Sandelowski M. Whatever happened to qualitative description? Res Nurs Health. 23: 334–340.
27. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006; 3: 77–101.
28. Government of Ireland. Housing (Miscellaneous Provisions) Act [Internet]. 2002. [cited 2021 February 9]. Available from: https://bit.ly/31SRz0k
29. Pavee Point Traveller and Roma Centre. COVID-19 Information and Resources [Internet]. Dublin: Pavee Point Traveller and Roma Centre; 2020 [cited 2021 February 9]. Available from: https://www.paveepoint.ie/stay-safe-from-coronavirus-covid-19/
30. Hodge DR, Jackson KF, Vaughn MG. Culturally sensitive interventions and health and behavioral health youth outcomes: a meta-analytic review. Soc Work Health Care. 2010; 49: 401–423.
31. HSE National Inclusion Office. Traveller COVID-19 Helpline [Internet]. Dublin: HSE National Inclusion Office; 2020 [cited 2021 February 9]. Available from: https://bit.ly/2YpF8Yg
32. Hodgins M, Fox F. 'Causes of causes': ethnicity and social position as determinants of health inequality in Irish Traveller men. Health Promot Int. 2014; 29: 223–234.
33. World Health Organization. Overview of Public Health and Social Measures in the Context of COVID-19-Interim Guidance [Internet]. Geneva: World Health Organization; 18 May 2020 [cited 2021 February 9]. Available from: https://www.who.int/publications-detail-redirect/overview-of-public-health-and-social-measures-in-the-context-of-covid-19
34. Peppou LE, Economou M, Skali T, Papageorgiou C. From economic crisis to the COVID-19 pandemic crisis: evidence from a mental health helpline in Greece. Eur Arch Psychiatry Clin Neurosci. Epub ahead of print July 2020. DOI: 10.1007/s00406-020-01165-4.

Original Article

Affective communication: a mixed method investigation into COVID-19 outbreak communication using the Taiwanese government Facebook page

Chia Yu Lien[1] and Yun-Hsuan Wu[2]

Abstract: The COVID-19 outbreak has created an unprecedented challenge for governments to convey information to the public, and social media has become a critical method of COVID-19 communication in Taiwan.
Objectives: This study examines a total of 1128 Facebook posts published by Taiwan's principal health authority from December 1, 2019 to May 31, 2020.
Methods: Using both qualitative and quantitative approaches, this study investigates strategies used by the Taiwan government to communicate the COVID-19 outbreak and public responses toward these strategies.
Result: Novel uses of Facebook posts on outbreak communication were identified, including solidarity, reviews of actions, press conferences, and the use of animal and cartoon images. Quantitative results showed that the public responded significantly more frequently to messages generating positive affects, such as posts that reviewed government actions and public efforts; posts that expressed thanks, approval, or comradeship; and posts that paired text with photographs of frontline workers or cute animals.
Conclusion: These results suggest that, amid a disease outbreak, the public not only look for updated situations and guidelines but also for affective affirmation from government agencies.

Keywords: COVID-19, Taiwan, outbreak communication, Facebook

Introduction

The COVID-19 crisis has created an unprecedented challenge for governments to convey information to the public. Social media (e.g. Facebook and Twitter) has played an ever-increasing role in health communication (1). Building on Web 2.0 technologies, social media provides government platforms to disseminate timely information (2,3). In the past two decades, the Taiwan government has increasingly used social media for policy communication (4). Understanding social media used by the Taiwan government provides a good opportunity to examine the relationship between COVID-19 outbreak communication and public responses.

Studies have begun to examine the role of social media in infectious disease communication over the past decade. Using the thematic analysis method, these studies identified themes in manifest content published by governmental agencies to communicate a disease outbreak (5). For example, Ding and Zhang (6) identified six themes from the investigation of 163 posts published on Facebook and Twitter by the US Centers for Disease Control and Prevention (CDC) and Department of Health and Human Services (DHHS) in response to the 2009 H1N1 outbreak: case updates, policies and guidelines, prevention topics, official actions and efforts, general information, and scientific research. Kim and Liu (7) compared messages posted by governments and

1. Washington University in Saint Louis, Saint Louis, Missouri, United States.
2. China Medical University, Taichung, Taiwan.

Correspondence to: Chia Yu Lien, Washington University in Saint Louis, McMillan Hall, 1 Brookings Dr, Saint Louis, MO 63130-4899, Missouri, United States. Email: chiayu.lien@wustl.edu

(This manuscript was submitted on 3 August 2020. Following blind peer review, it was accepted for publication on 26 February 2021.)

Global Health Promotion 1757-9759; Vol 28(2): 56–66; 1003539 DOI: 10.1177/17579759211003539 journals.sagepub.com/home/ghp

private sectors in response to the 2009 flu outbreak and reported that governmental agencies are more likely to update situations and to provide instructive information. Likewise, Wong *et al*. (8) analyzed 1648 tweets made by US local health departments in response to the 2014 Ebola epidemic and proposed four themes that are more likely to be published: information giving, preparation, news updates, and event promotion.

These studies provide valuable insight into the message strategies used by governmental agencies during a disease outbreak, yet how the public would respond to these strategies has not been fully addressed. Social media could serve as platforms for information dissemination only when users respond to the messages. On Facebook, for example, messages that users like, comment on, and share will be broadcast to their network of friends (9,10). Previous research on Facebook has shown that different message strategies generate different responses. Kim and Yang (11), for example, examined 600 Facebook posts published by 20 companies and found that users often liked posts paired with multimedia elements, while they shared posts both with and without these elements. They also found that *like* is affective, while *share* is either affective or cognitive, or a combination of both. Finally, they noted that *like* indicated the lowest level of commitment, while *share* indicated the highest. A later study (12) has supported their conclusion that *like* and *share* represent different affects and commitments.

Limited existing research has shown that the public might respond differently to various types of messages used by governmental agencies during an infectious disease outbreak. Studying the Singapore 2016 Zika outbreak, Vijaykumar *et al*. (13) found that the public most often liked government Facebook messages on investigation, while sharing messages on news updates. Lwin *et al*. (14) found that the public most often liked government Facebook messages that emphasized self-efficacy, while they shared messages about risk, uncertainty reduction, and reassurance. Additionally, Lwin *et al*. reported that the public was more likely to react to posts made before the outbreak then, after that, the frequency of both likes and shares decreased. The results indicated that the public ceased to disseminate even important information that was familiar to them.

So far, research on infectious disease communication has tended to examine strategies in terms of message content. However, studies on government communication showed that both message content and multimedia formats (photos, videos, etc.) impacted public engagement and information dissemination. Bonsón *et al*. (15) investigated the use of Facebook by governmental agencies in 15 different countries and suggested that text messages paired with photographs effectively increased public engagements. Similar findings are demonstrated by Lev-On and Steinfeld (16), who studied Facebook use by the Israeli governments. To our knowledge, no studies have investigated the effectiveness of multimedia used by governmental agencies to communicate an infectious disease outbreak. This phenomenon is worth investigating since it provides insight into strategies that sustain public engagement with important infectious disease information.

The current study investigates the strategies (contents and multimedia formats) used by the Taiwan government to communicate COVID-19 outbreak information, and public responses toward these strategies. Taiwanese officials confirmed the first COVID-19 cases on January 21, 2020. Since December 31, 2019, the Taiwan government has implemented more than 100 policies and actions to contain the outbreak (17). Social media, particularly Facebook, has become a critical locus of COVID-19 communication (18). However, strategies used by governmental agencies to communicate COVID-19 information on this platform have not been studied. To address this issue, the study asks three questions: (i) what were the characteristics of, and the public responses toward, governmental Facebook posts about COVID-19 in Taiwan; (ii) what content and multimedia strategies did the Taiwan government use to communicate information concerning the COVID-19 outbreak; and (iii) what were the public responses to these different strategies? The findings of this study will increase current knowledge about the effectiveness of infectious disease communication.

Method

Data collection

To better understand the government's COVID-19 communication, this study examined all Facebook posts made by the Taiwan Ministry of

Health and Welfare (MOHW) from December 1, 2019 to May 31, 2020. The posts were collected for this period as it marked the first post published by the MOHW in December 2019 up to the current date. The MOHW Facebook page was selected for two reasons: First, the MOHW is the principal health authority of Taiwan and is responsible for COVID-19 prevention and information communication. Second, the MOHW is the most-followed governmental health agency, followed by more than 600,000 people as of May 31, 2020. An Excel spreadsheet was created with all posts downloaded from the MOHW Facebook page, which included text content, multimedia formats (images, videos, etc.), the published date of each post, and the number of *likes* and the number of *shares* associated with each post.

Post analysis

All MOHW Facebook posts were first coded based on whether COVID-19 messages were present. COVID-19-related posts were further analyzed using a combination of inductive and deductive coding as proposed by Bernard *et al*. (19). According to Bernard *et al*, this coding started with themes derived from previous studies and added more themes and subthemes as the process continued. This method was preferred because it allowed us to compare our findings with previous studies on infectious disease communication. Specifically, to analyze post content, we drew on themes of preparation, news updates, event promotion, and information giving from Wong *et al*.'s article (8). To analyze post multimedia formats, we drew on the formats of videos, photographs, links, and texts from Bonsón *et al*.'s article (15). In Bonsón *et al*.'s article, texts paired with photos, links or videos were counted as for the latter. Only posts without all these multimedia forms were counted as texts.

Two researchers then used the grounded theory proposed by Bernard (19) to read each post line by line and note the keywords. The researchers pulled posts with similar keywords together and discussed how each group of posts might be related to the themes and formats derived from previous studies. From this process, we renamed 'event promotion', which is defined by Wong *et al*. (8) as a 'physical or virtual platform to deliver information' to 'tech promotion' and grouped it under 'preparation', which included information about actions implemented by governmental agencies to contain the disease. We added new themes of recommendation, solidarity, press conferences, and reviews of actions, that had not been mentioned in Wong's article. In multimedia analysis, we deleted the category of 'link' since it was not used by the MOHW. We added two new formats, animal and comic, that had not been mentioned in Bonsón *et al*.'s article (15) but repeatedly appeared in our data. A codebook was then developed using NVivo 10 QSR International software.

Public response analysis

We collected information about the number of *likes* and *shares* based on identified contents and multimedia formats and reported them by mean and standard deviation. In order to further explore the public response regarding post content and multimedia, we focused on COVID-19 related posts and used one-way ANOVA to determine whether the average number of *likes* and *shares* across various types of content, as well as multimedia, were different. Additionally, we implemented Bonferroni post hoc analyses to determine which of the content and multimedia type differed significantly on *likes* and *shares*. All analyses were carried out with the STATA SE statistical package, version 14.

Results

Table 1 describes the monthly conditions of the MOHW Facebook posts and the public responses. The first COVID-19 post was published on December 31, 2019. From December 1, 2019 to May 31, 2020, a total of 1128 posts were collected for analysis, including those created by the MOHW and those created by other government agencies that were then shared by the MOHW. Out of these posts, 925 (82%) were COVID-19-related. From December to February, there was a sharp decline in the number of non-COVID-19-related posts, and a sharp increase in COVID-19-related posts. After this, the number of COVID-19-related posts plateaued at 7–8 posts published by the MOHW each day.

The public response showed that COVID-19 posts had outpaced non-COVID-19 posts in the number of *likes* and *shares* received, with the exception of the number of *shares* in April 2020.

Table 1. Descriptions of MOHW Facebook posts and the public responses.

Month	*Posts not about COVID-19 N (%)*	*Posts about COVID-19 N (%)*	*Total posts N*	*Average likes of COVID-19 posts*	*Average likes of non-COVID-19 posts*	*Average shares of COVID-19 posts*	*Average shares of non-COVID-19 posts*
December, 2019	84 (98.82)	1 (1.18)	85	1800	732.64	1200	338.38
January, 2020	62 (46.27)	72 (53.73)	134	1977.03	1209.85	787.82	533.13
February, 2020	6 (2.64)	211 (97.36)	227	8606.99	4583.33	600.72	533.33
March, 2020	19 (7.98)	219 (92.02)	238	7615.52	5231.21	622.05	436.16
April, 2020	22 (9.44)	211 (90.56)	233	13081.04	11386.36	729.55	899.59
May, 2020	11 (4.95)	211 (95.05)	222	12540.47	5671.00	464.19	226.00

The number of *likes* COVID-19 posts received had increased from January, with nearly four times as many *likes* in February and seven times as many in April. Meanwhile, the number of *shares* COVID-19 posts received peaked in December, then declined in the following months.

Analysis of government COVID-19 posts

Table 2 shows the results of a thematic analysis on post contents. Of 925 COVID-19 posts, 27.24% were news updates, 24.21% were recommendations, 23.46% were on preparation, 10.81% were on solidarity, 8.11% were on information-giving, 4.43% were on press conferences, and 1.73% were on reviews of governmental actions. The intercoder reliability was calculated using Cohen's Kappa coefficient. The coefficients were excellent (0.75–1.00) for all thematic categories, with the exception of information-giving (0.40–0.75), which overlapped with news updates, behavioral recommendations, and preparation.

Posts coded as news updates provided information on international and domestic COVID-19 infection situations, including new confirmed cases, current case reports, and changes in status of isolation and quarantine. These posts also updated the risk of exposure for a specific geographic area. Posts coded as recommendations encouraged certain behaviors, such as handwashing and mask-wearing, and discouraged other behaviors, such as dumping masks and violating quarantine.

Posts on preparation informed policies implemented by governments, including cross-border preparation, such as travel alerts, flight transfer policy, and domestic preparation, such as policies related to quarantine, social gatherings, and testing. They also informed policies lifted in April and May after a period of absence of new cases. Moreover, posts under these themes provided information on resource allocation, such as mask availability and accessibility, and technical support on information and resource access.

Posts coded as solidarity encouraged the public to express their appreciation for frontline workers and show comradeship with their fellow citizens. These posts prompted members of the public to think of themselves not as separate individuals but as part of a wider community, and, in doing so, remember the vulnerability of others. Posts coded as information-giving provided COVID-19-related knowledge on

Table 2. Content analysis on government COVID-19 posts

Theme categories	*Description*	*Examples*	*n*	*%*
News update	**New information on COVID-19 disease outbreak**		**252**	**27.24**
Case reports	Description of current domestic and international COVID-19 cases	The Central Epidemic Command Center (CECC) announced that to date (5/29), there have been a total of 442 confirmed COVID-19 cases. Among these cases, 351 were imported and 55 were local	120	12.97
New cases	Reports on new confirmed domestic cases	The newest confirmed case is a 30-year-old woman who worked in the United Kingdom. She reported symptoms upon arrival. She was tested and hospitalized. We will investigate the contacts on the plane	82	8.86
Change in status	Shift in COVID-19 cases regarding isolation and hospitalization	There is a total of 379 confirmed COVID-19 cases: 67 were released from isolation, and the rest remain in isolation in hospital	50	5.41
Information giving	**General information on COVID-19**		**75**	**8.11**
Provides knowledge	Information on disease mechanism, diagnosis, and treatment	National Taiwan University public health professor Dr. Lin and his team found out that transmissibility of COVID-19 was higher among those whose exposure to index cases started within five days of symptom onset	44	4.76
Dispelling myths	Statement to clarify misinformation	'Theaflavin,' which is found in black tea or pu'er tea, cannot help to fight coronavirus. Do not believe the rumors and avoid passing them on to friends or family	31	3.35
Preparation	**New information on policies implemented against COVID-19**		**217**	**23.46**
Cross-border preparation	Information on border control policies and actions	Taiwan bans airline passenger transit through the country starting on March 24 until April 7 to prevent the spread of COVID-19 via air transport	43	4.65
Domestic preparation	Information on domestic policies and actions	All inbound travelers should fill in the Quarantine System form upon entry. Those living with older adults, children, people with chronic illnesses, or those without a separate room (including a separate bathroom) are required to stay at a quarantine hotel	64	6.92
Ban lifting	Information on ban lifting	Since the risk of community transmission is low, CECC decided to reduce restrictions on psychiatric hospital visits	7	0.76
Resource allocation	Information on financial or material resources	Provisions have been adjusted for the name-based mask distribution system starting on April 9. Masks can be bought every 14 days — nine adult masks or ten child masks	89	9.62
Tech promotion	Information on digital resources	We collaborated with HTC DeepQ and Line to develop the Line Bot, which enables people in quarantine to ask questions and report their health status to civil servants	14	1.51
Recommendation	**Behavioral guidance and warnings to prevent COVID-19**		**224**	**24.21**
Recommended behavioral changes	Actions one can take to prevent the spread of COVID-19	Keep social distancing with others. Maintain a 1.5-meter distance in indoor environments. Maintain a 1-meter distance in outdoor environments. Wear face masks on public transportation	191	20.65
Warning against misconduct	Statement to warn and fine people for misconduct	Violation of regulations on quarantine / isolation are subjected to a penalty fine of NT 1,000,000 maximum	33	3.57
Other themes				
Solidarity	Expressions of thanks, approval, and comradeship	We thank medical workers. Taiwan nurses, we stand with you. More than 170,000 nurses currently work in hospitals, clinics, schools, airports, and other facilities. Please send these nurses a picture or a message	100	10.81
Review of actions	Review of actions taken by government	The virus treats people equally, but in Taiwan, we handled it differently. This video is dedicated to the Taiwanese. We wish you all the best	16	1.73
Press conference	Video of press conference	April 30 COVID-19 press conference will start at 14:00	41	4.43

Table 3. Multimedia analysis on government COVID-19 posts.

Category	*Description*	*Examples*	*n*	*%*
Photograph	Posts that include photos.	 URL: https://www.facebook.com/470265436473213/posts/1551563158343430/	96	10.38
Video	Posts that include videos.	 URL: https://www.facebook.com/470265436473213/posts/1569196643246748/	64	6.92
Comic	Posts that include comics, cartoons, or emojis.	 URL: https://www.facebook.com/470265436473213/posts/1530064037160009/	93	10.05
Animals	Posts that include animals.	 URL: https://www.facebook.com/mohw.gov.tw/photos/a.484593545040402/1530089737157439/	264	28.54
Pure text	Posts with a plain background.	 URL: https://www.facebook.com/470265436473213/posts/1547279608771785/	408	44.11

disease transmission, prevention, and treatment. A small number of posts in this category were made to dispel myths and fake news.

Finally, 41 posts were press conferences, which have been held daily since February to update the public on COVID-19 situations, announce governmental preparations, recommend behavioral changes, facilitate solidarity, and to answer questions raised by journalists. Sixteen posts were made to review the actions taken by governmental agencies and the performance of Taiwan regarding the outbreak.

Table 3 shows results for the thematic analysis on post multimedia types. Of all COVID-19 posts, 44.11% were in pure text form, 28.54% in text paired with images of animals (263 with a shiba inu dog), 10.38% with photographs, 10.05% with comics, cartoons, or emojis, and 6.92% with videos. The coefficients were excellent (0.75–1.00) for all multimedia categories.

Public responses to the government posts

On average, each COVID-19 post received 9766.66 *likes* and 628.69 *shares*. Table 4 provides results on *likes* and *shares* received by each content type and multimedia format. Different content types received significantly different numbers of *likes* ($p < 0.05$) and *shares* ($p < 0.05$). Post hoc analyses further showed that, compared to other types, posts that reviewed actions taken by the government received the highest number of *likes* and *shares* ($p < 0.005$). Posts on solidarity received a significant number of *likes* compared to news updates ($p = 0.007$), recommendations ($p < 0.001$), preparation ($p < 0.001$), information-giving ($p < 0.001$), and press conferences ($p < 0.001$). Content providing information received a significant number of *shares* compared to posts on press conferences ($p = 0.049$).

Different multimedia formats received significantly different numbers of *likes* ($p < 0.05$), but not *shares* ($p > 0.05$). Posts including photos received the highest number of *likes* and *shares*, followed by posts including animals. Post hoc analyses showed that posts including photos received a significantly higher number of *likes* compared to all other formats ($p < 0.001$). Posts including animals received a greater number of *likes* compared to posts of pure text ($p = 0.007$).

Discussion

This study examined the characteristics and effectiveness of social media use by the Taiwan government agency to communicate various COVID-19 issues. The findings show that the Taiwan government agency has actively used Facebook to communicate the COVID-19 outbreak. Parallel to previous studies (14), the findings show that the public increased their *shares* of infectious disease information in the pre-outbreak phase, then decreased them after they gained familiarity with the disease information. However, in contrast to previous studies (14), we found that people in Taiwan increased their *likes* of governmental posts after the pre-outbreak phase, demonstrating that the government had generated sustained public attention toward the COVID-19 situation.

To investigate strategies applied by the government agency to sustain public responses, this study analyzed thematic categories of content and multimedia of COVID-19 posts and the public responses to each category. Most posts fell into the thematic categories of news updates, behavioral recommendations, and government preparations, which provided information on the incidence, spread, and containment of the outbreak. These findings align with the analysis of previous research on government infectious disease communication that has identified the use of social media by governmental agencies to provide information and advice (20,21). Our study also identified thematic categories that are rarely mentioned, including posts that encouraged expressions of thanks, approval and comradeship, and posts that reviewed efforts made by government agencies and the public. Rather than providing new outbreak information, these categories offer emotional support and facilitate solidarity between citizens and the country.

It was found that people were more inclined to *like* posts on review of actions, solidarity, and news updates, and *share* posts on review of actions, information giving, and preparation. The findings regarding *likes* provide new insight into the needs of the public during a disease outbreak, indicating that the public sought affective affirmation from the government during the crisis, and they were encouraged by efforts made by the government and

Table 4. Public responses to the government posts.

Responses	*Like*	*Share*
	Mean (SD)	*Mean (SD)*
Content		
News update	11136.77 (15136.64)	541.45 (769.63)
Information-giving	5497.95 (7134.76)	853.03 (1511.18)
Preparation	7661.15 (10030.29)	754.35 (1358.65)
Recommendation	7727.62 (9068.30)	576.55 (1141.21)
Solidarity	17421.00 (26887.39)	410.11 (421.60)
Press conference	4037.00 (2365.83)	67.88 (44.71)
Review of actions	32356.25 (40727.08)	2814.69 (6244.12)
p-Value	<0.01	<0.01
Multimedia		
Animal	11394.05 (12500.22)	631.27 (1105.76)
Comic	9190.66 (9609.94)	571.20 (919.97)
Photograph	18735.29 (31949.10)	782.76 (1252.77)
Pure text	7371.49 (10993.70)	616.42 (1141.36)
Video	5754.92 (12335.70)	557.95 (3165.99)
p-Value	<0.01	0.81

themselves to contain the disease. The findings on *shares* confirm the importance of affective affirmation. Meanwhile, the findings regarding *shares* also confirm that the public deemed information that promoted their knowledge and preparation around COVID-19 to be important (22). The discrepancy between *like* and *share* parallels Kim's finding (7) that *likes* indicate an affective response while *shares* indicate either an affective or a cognitive response.

Five thematic categories were identified from the multimedia of the posts. Half of the posts were purely text-based, and some posts contained text paired with photographs of frontline workers or videos. All these formats are common in governmental use of social media (15,16). However, we also identified that the Taiwan MOHW paired more than one-third of COVID-19 information with animal or comic images, unseen in previous research on government use of social media. We called this strategy 'playing cute.' In this context, 'cuteness' is defined as having the appearance of an infant or animal (i.e., a small body, round eyes, and a chubby face) (23,24). Images of cuteness are commonly used in both the political and apolitical spheres in Taiwan (24). Cultural studies research has shown that cute images or objects create a more personal feeling for the reader. In Taiwan, these images and objects have been demonstrated to be an effective tool in advertisements (24).

Our results found that people mostly *liked* COVID-19 text paired with photographs, animals, and comics, while they *shared* posts with text paired with photographs and animals, along with text-based posts. They were least inclined to *like* or *share* videos published by governmental agencies. On social media, multimedia formats have been demonstrated to affect public engagement significantly (25,26). Photographs of frontline workers, such as governmental officials, civil servants and medical staff are mostly engaging, which is parallel with studies showing that the public often responds to photographs of events and news relevant to them (15,26). Meanwhile, our findings show the effectiveness of 'playing cute' in infectious disease communication in Taiwan: COVID-19 posts containing text paired with images of cute dogs were more likely to be *liked* and *shared*. The popularity of text paired with workers' photos and cute animals supports our finding that posts generating positive affects are more likely to be disseminated, indicating that people look for calming messages from the government during a disease outbreak.

Affect has been identified as a driving force for online information dissemination (27,28). Limited existing research shows that some government agencies have incorporated reassuring messages as part of infectious disease communication. Studying the responses toward the 2009 H1N1 virus, Liu and Kim (29) observed that compared with corporate organizations, government agencies (US CDC, US DHHS, and the WHO) were less likely to incorporate affective messages, yet when they did, they often sent messages of sympathy and awareness, while corporate organizations sent messages of fear. Likewise, Lwin *et al*. (14) reported that the Singapore government incorporated calming and thanking messages to remove uncertainty and fear surrounding the threat of Zika, which attracted a great number of *likes* and *shares* in the pre-outbreak phase. Our results add that affective affirmation plays a key role in sustaining public attention toward infectious disease messages in the post-outbreak phase: though the public decreasingly shared COVID-19 posts after they gained familiarity with the information, they increasingly liked those posts conveying positive affects. We also observed that in addition to reassuring contents (reviewing actions taken by the government and the public, and expressing solidarity), reassuring or soothing images (photographs of frontline workers and cute animals) can facilitate infectious disease communication.

Based on our findings, we suggest that government agencies pay attention to the role of affect in policy communication in different phases of a pandemic. We also suggest that government agencies incorporate multimedia formats to facilitate information dissemination. Finally, we are aware that people of different cultures may perceive and react to similar messages differently. The effectiveness of using 'playing cute' by the MOHW, for example, reflects not how a government agency creates a new strategy for communication, but utilizes an already existing, culturally effective one. Therefore, we suggest that government agencies investigate and integrate local culture to strengthen the coordination of the public. This study has several limitations. First, while this study focused on infectious disease communication in Taiwan, future research should consider studying the same topic in different countries to compare the effectiveness of affective affirmation in information dissemination. Second, while this study used *likes* and *shares* to estimate the spread of COVID-19 information, further study on social networks should be carried out to determine the actual distribution of messages. Third, we did not analyze the content of reactions using comments. More in-depth content analysis of comments is needed to reveal the interactions and discussions between the public and the government.

Conclusion

COVID-19 had infected over one million people globally by the end of May 2020. In Taiwan, as of May 31st, only 442 people in a population of 23 million had been identified as being infected, and only 7 of these people died (30). Taiwan's performance on COVID-19 containment was a result of the government's multiple policies and actions, such as border control measures, travel restrictions, and various resource allocations. However, without an effective tool for communication, these actions might have caused confusion and frustration. This research provides insight into the strategies applied by the Taiwan principal health agency to communicate about the disease outbreak. It is among the few studies to analyze the impact of the contents of Facebook posts and the use of multimedia formats in posts on the effectiveness of information dissemination. On social media, a piece of information always needs to compete with other messages for engagement. Our results provide insight into strategies that can be used by health departments to inform the public about an emerging infectious disease.

Acknowledgements

All figures were downloaded from Taiwan Ministry of Health and Welfare (MOHW) Facebook page. The writers thank MOHW for permission to use the figures. Currently Chia Yu Lien is sponsored by Washington University in St. Louis. We are grateful to the Washington University anthropology faculties (Rebecca Lester and Bradley Stoner) for reading our research and providing valuable insights and suggestions.

Author contributions

This study was initiated by Chia Yu Lien. Lien was responsible for designing the study, analyzing the qualitative data, and drafting the article. Yun-Hsuan Wu was responsible for analyzing the quantitative data. Both Lien and Wu were responsible for developing the storyline.

Declaration of conflicting interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Chia Yu Lien https://orcid.org/0000-0003-2232-4295

References

1. World Health Organization. Novel Coronavirus (2019-nCoV): Situation Report, 13. 2020. [cited 2020 June 28]. Available from: https://apps.who.int/iris/bitstream/handle/10665/330778/nCoVsitrep02Feb2020-eng.pdf
2. Norman CD. Social media and health promotion. Glob Health Promot. 2012; 19: 3–6.
3. Moorhead SA, Hazlett DE, Harrison L, Carroll JK, Irwin A, Hoving C. A new dimension of health care: systematic review of the uses, benefits, and limitations of social media for health communication. J Med Internet Res.2013; 15: e85.
4. Hung YH, Chen W-K, Chou S-CT. Exploring the management of government social media-studies from the Facebook fan pages in Taiwan. 2018 IEEE/ACM International Conference on Advances in Social Networks Analysis and Mining (ASONAM); 2018, Barcelona. New York: Institute of Electrical and Electronics Engineers. 2018: 1015–1020.
5. Tang L, Bie B, Park S-E, Zhi D. Social media and outbreaks of emerging infectious diseases: a systematic review of literature. Am J Infect Control. 2018; 46: 962–972.
6. Ding H, Zhang J. Social media and participatory risk communication during the H1N1 flu epidemic: a comparative study of the United States and China. China Media Res. 2010; 6: 80–91.
7. Kim S, Liu BF. Are all crises opportunities? A comparison of how corporate and government organizations responded to the 2009 flu pandemic. J Pub Relat Res. 2012; 24: 69–85.
8. Wong R, Harris JK, Staub M, Bernhardt JM. Local health departments tweeting about Ebola: characteristics and messaging. J Public Health Manag Pract. 2017; 23: e16–e24.
9. Sun E, Rosenn I, Marlow C, Lento TM. Gesundheit! Modeling contagion through Facebook news feed. Third International AAAI Conference on Weblogs and Social Media; 2009; San Jose. Palo Alto: Association for the Advancement of Artificial Intelligence. 2009.
10. Gerlitz C, Helmond A. The like economy: social buttons and the data-intensive web. New Media Soc. 2013; 15: 1348–1365.
11. Kim C, Yang S-U. Like, comment, and share on Facebook: how each behavior differs from the other. Public Relat Rev. 2017;43(2):441–449.
12. Srivastava J, Saks J, Weed AJ, Atkins A. Engaging audiences on social media: identifying relationships between message factors and user engagement on the American Cancer Society's Facebook page. Telemat Inform. 2018; 35: 1832–1844.
13. Vijaykumar S, Meurzec RW, Jayasundar K, Pagliari C, Fernandopulle Y. What's buzzing on your feed? Health authorities' use of Facebook to combat Zika in Singapore. J Am Med Inform Assoc. 2017; 24: 1155–1159.
14. Lwin MO, Lu J, Sheldenkar A, Schulz PJ. Strategic uses of Facebook in Zika outbreak communication: implications for the crisis and emergency risk communication model. *Int J Environ Res Public Health*. 2018; 15: 1974.
15. Bonsón E, Royo S, Ratkai M. Citizens' engagement on local governments' Facebook sites. An empirical analysis: the impact of different media and content types in Western Europe. Gov Inf Q. 2015; 32: 52–62.
16. Lev-On A, Steinfeld N. Local engagement online: municipal Facebook pages as hubs of interaction. Gov Inf Q. 2015; 32: 299–307.
17. Wang CJ, Ng CY, Brook RH. Response to COVID-19 in Taiwan: big data analytics, new technology, and proactive testing. JAMA. 2020; 323: 1341–1342.
18. Ko N-Y, Lu W-H, Chen Y-L, Li D-J, Wang P-W, Hsu S-T, et al. COVID-19-related information sources and psychological well-being: an online survey study in Taiwan. Brain Behav Immun. 2020; 87: 153–154.
19. Bernard HR, Wutich A, Ryan GW. Analyzing Qualitative Data: Systematic Approaches. Thousand Oaks, CA: Sage Publications; 2016.
20. Biswas M. Health organizations' use of social media tools during a pandemic situation: an H1N1 flu context. J New Commun Res. 2013; 5: 46–81.
21. Raamkumar AS, Tan SG, Wee HL. Measuring the outreach efforts of public health authorities and the public response on Facebook during the COVID-19 pandemic in early 2020: cross-country comparison. J Med Internet Res. 2020; 22: e19334.
22. Lazard AJ, Scheinfeld E, Bernhardt JM, Wilcox GB, Suran M. Detecting themes of public concern: a text mining analysis of the Centers for Disease Control and Prevention's Ebola live Twitter chat. Am J Infect Control. 2015; 43: 1109–1111.
23. Yueh H-IS. Identity Politics and Popular Culture in Taiwan: A Sajiao Generation. Lanham, Boulder, New York, and London: Lexington Books; 2016.
24. Chuang YC. Kawaii in Taiwan politics. Int J Asia Pacific Stud. 2011; 7: 1–17.
25. Lappas G, Triantafillidou A, Deligiaouri A, Kleftodimos A. Facebook content strategies and citizens' online engagement: the case of Greek

local governments. Rev Soc Netw Strat. 2018; 12: 1–20.
26. Guidry JPD, Jin Y, Orr CA, Messner M, Meganck S. Ebola on Instagram and Twitter: how health organizations address the health crisis in their social media engagement. Public Relat Rev. 2017; 43: 477–486.
27. Berger J, Katherine LM. What makes online content viral? J Mark Res. 2012; 49: 192–205.
28. Guadagno RE, Daniel MR, Shannon M, Bradley MO. What makes a video go viral? An analysis of emotional contagion and Internet memes. Comput Hum Behav. 2013; 29: 2312–2319.
29. Liu BF, Sora K. How organizations framed the 2009 H1N1 pandemic via social and traditional media: implications for US health communicators. Public Relat Rev. 2011; 37: 233-244.
30. Ministry of Health and Welfare. 2020 年 5 月 31 日 14:00 國內即時疫情 2020. [cited 2020 June 28]. Available from:https://www.facebook.com/mohw.gov.tw/photos/a.484593545040402/1579431775556568/?type=3&theater

Health inequities and technological solutions during the first waves of the COVID-19 pandemic in high-income countries

Muriel Mac-Seing and Robson Rocha de Oliveira

Abstract: The COVID-19 pandemic has resulted in massive disruptions to public health, healthcare, as well as political and economic systems across national borders, thus requiring an urgent need to adapt. Worldwide, governments have made a range of political decisions to enforce preventive and control measures. As junior researchers analysing the pandemic through a health equity lens, we wish to share our reflections on this evolving crisis, specifically: (a) the tenuous intersections between the responses to the pandemic and public health priorities; (b) the exacerbation of health inequities experienced by vulnerable populations following decisions made at national and global levels; and (c) the impacts of the technological solutions put forward to address the crisis. Examples drawn from high-income countries are provided to support our three points.

Keywords: equity, social justice, responsible innovation, public health, global health, globalization, COVID-19, pandemic response

Since January 2020, all nations have been disarmed by the outbreak of a new coronavirus disease (COVID-19) (1). On March 11, given its spread worldwide, the World Health Organization declared the outbreak a pandemic (2). This has resulted in massive disruptions to public health, healthcare, as well as political and economic systems across national borders, thus requiring an urgent need to adapt. As of October 20, there were 40,251,950 confirmed cases worldwide and 1,116,131 deaths (3). In Canada, there were 198,148 confirmed cases and 9760 deaths (3), while in the province of Québec, where both authors reside, there were 92,216 confirmed cases and 6055 deaths registered (4). As junior global and public health researchers entering the profession, we have been immediately challenged by how certain population groups have been disproportionately affected, specifically in high-income countries ranking in the first tier of the 2019 Global Health Security Index (5). This unprecedented health crisis has highlighted three key public health issues: (a) the tenuous intersections between the responses to the pandemic and public health priorities; (b) the exacerbation of health inequities experienced by vulnerable populations; and (c) the impacts of the technological solutions put forth to address the crisis. We will discuss these issues through a health equity lens, using examples drawn from high-income settings. Health equity refers to the concept that 'everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential' (6). Although health equity is not new to global and public health practitioners and researchers, we argue that health equity takes on a renewed importance which can no longer be taken for granted.

First, this global health crisis has brought to the surface the unpreparedness of governments and public health authorities to swiftly respond to this pandemic, despite the lessons learned from past epidemics such as Ebola, Influenza and SARS (7).

Department of Social and Preventive and Medicine, School of Public Health, Université de Montréal; Centre de recherche en santé publique, Université de Montréal et CIUSSS du Centre-Sud-de-l'Île-de-Montréal; Montreal, Canada

Correspondence to: Muriel Mac-Seing, Université de Montréal, 7101, Avenue du Parc, 3e étage, Montreal, QC H3N 1X9, Canada. Email: muriel.k.f.mac-seing@umontreal.ca

(This manuscript was submitted on 22 June 2020. Following blind peer review, it was accepted for publication on 2 December 2020.)

Global Health Promotion 1757-9759; Vol 28(2): 67–71; 984185 DOI: 10.1177/1757975920984185 journals.sagepub.com/home/ghp

After years of reduced investment in public health in Québec, as in other Canadian provinces (8) and in the Organisation for Economic Co-Operation and Development (OECD) countries (9), this pandemic has brutally revealed the critical roles of health promotion, disease prevention, epidemiological surveillance and regular communication on health issues to the public. In Italy (10) and New York City (11), during the peak of their epidemic, the number of critically ill COVID-19 patients surpassed the usual capacity of the public health and healthcare systems to adapt. This could partly be explained by delayed political decisions to act and the ongoing de-prioritisation of basic disease prevention and health promotion, the lack of focus on health equity, combined with a lack of equipment to treat people. Recently, the *New England Journal of Medicine* took a position for the first time in its history by denouncing the 'leadership vacuum' in the USA, where political decisions regarding quarantine and basic health promotion and disease prevention measures, such as wearing a mask and physical distancing, were both inconsistent and politicised (12). Consequently, more than 200,000 people have died, with people of colour being disproportionally affected, while healthcare workers were stretched to their limits (12). In Canada (13), in order to have enough beds for a potential increased number of COVID-19 patients, such as that witnessed in Italy or New York City, resources were directed to repurpose and free up hospital beds, often occupied by elderly people waiting for a place in the community. It is hypothesised that due to a combination of chronic under-investment in public health priorities and a lack of community homecare for vulnerable elderly people (14), this group was most affected by the pandemic in Canada (15). In April 2020, although elderly people living in long-term facilities constituted less than 2% of confirmed COVID-19 cases, they accounted for approximately 46% of COVID-related deaths in the country (15).

Second, with the declaration of the COVID-19 pandemic, vulnerable populations, who were already facing heightened risks of further vulnerability, were reported to be the most affected by health inequities as a result of the pandemic and its responses (16). To address the emerging challenges caused by the pandemic, governments worldwide have made both political and legal decisions to enforce preventative and control measures. These measures have ranged from school closures, to the shutting down of cultural events, the banning of visits to elderly people in long-term care facilities, home confinement, a compulsory quarantine for returning travellers and prohibition on gatherings of people (indoors and outdoors) (17). Although these measures were necessary to control the spread of the pandemic, they have impacted various vulnerable social groups differently. Without pretending to be an exhaustive list, some specific populations infected and/or affected by the pandemic include elderly people (15), women (18), essential workers including those working in healthcare (19), people of colour (19), people with disabilities (20), survivors of violence (21) and homeless people (22). When compared to more privileged groups, what these populations have in common is their intersectional socioeconomic disadvantages and their experience of structural inequality (23). If global and national health governance decisions are left unchecked, they can exacerbate existing systemic inequities, disproportionately benefiting the powerful and economically better-off (24). As Bowleg, a scholar in Intersectionality and social sciences, argues, 'we're not all in this together (23)', which stresses the unequalising experience the confinement and public health measures put in place have had on different groups. Home confinement, requested to reduce COVID-19 transmission, was detrimental to survivors of violence who were potentially further abused and trapped indoors, with limited or no contact with the outside world (21). People living on the street could not implement basic health promotion behaviours such as hand-washing (22). Moreover, the gendered impacts of the pandemic have not considered the additional burden the pandemic has had on women who are still considered the implicit caregivers of sick relatives and home-bound children due to school closures (18). Women, who compose most of the unpaid care work and frontline healthcare workers, are exposed to an increased risk of contracting COVID-19 (18). People of colour in the USA, who constitute the majority of essential workers, are reported to be among those most affected by COVID-19 (19). The lessons learned from past influenza pandemics have emphasised the need to recognise the differential challenges affecting vulnerable populations and

groups at risk in a time of crisis, and how health equity must be addressed from the outset of the pandemic preparedness-response continuum (25).

Third, not only have health inequities been experienced at the population health level, but they could also have consequences when seeking solutions to address the pandemic. This public health crisis has also highlighted the extent to which technological solutions raise certain ethical, economic, social and environmental issues which can potentially increase health inequities and threaten the sustainability of healthcare systems. Furthermore, we should consider whether these technological solutions violate fundamental rights to privacy and autonomy and whether they have negative impacts on the environment. For example, contact tracing applications based on artificial intelligence have been developed in several countries as an enthusiastic response to promote the self-isolation of anyone potentially exposed to COVID-19 (26). However, their use has raised concerns about data security and privacy as well as the possibility that vulnerable communities, which have a higher morbidity and mortality rate, may not have the means to access them (27). Vulnerable populations without access to digital technology and/or who have limited digital skills should be considered early in the innovation loop to avoid aggravating the existing 'digital divide' (28). In Ontario (Canada), a company launched a crowdsourcing request to local manufacturers equipped with 3D printers to enhance the capacity to locally produce face shields for hospitals and long-term care facilities (29). These examples remind us that the development of frugal solutions that address system-level challenges should be the usual way of innovating, and not just during a crisis. The urgency of seeking solutions to tackle this crisis should not hide the importance of developing responsible innovations that are relevant and efficient, and that promote equity and social justice (30). Responsible innovation further stresses the collaborative process among developers, suppliers, distributors and users throughout the entire life cycle of a 'sociotechnical solution' (31).

As junior researchers, we believe we have a historical opportunity and a duty to proactively work toward health equity, without fail. This current pandemic has taught us that vulnerable groups cannot be left behind. Despite the misinformation diffused through some traditional media as well as through social media, along with the importance of understanding and adopting healthy behaviours amid this pandemic, health promotion can be an important driver to tackle social and health inequities that have been exacerbated during this pandemic. (32). What are needed are more friendly prevention behaviour change measures, promotion of the role of health literacy and the empowerment of local communities during and after this crisis (32). Moreover, active epidemiological surveillance and control, efficient and effective translation of knowledge, responsible innovation, and reinvestment in public health and healthcare systems should not be exceptional measures to be taken only during pandemics. Rather, they should be commonplace and integrated into global, national and local networks of action and practical solution development, all while leaving no one behind. Decision-makers must apply both the ongoing and past lessons that we have learned and urgently reinvest in public health, including health promotion, while considering health equity in all decision-making processes. Innovation developers have a duty to provide technological solutions which do not exacerbate health inequities, but rather attenuate them. As researchers, we have the responsibility to ask research questions and implement methodologies which continuously address health equity at a structural level. In the wake of the COVID-19 second waves worldwide, addressing health equity is crucial to foster responsible decision-making through innovative solutions. Failing to do so means that vulnerable and marginalised populations will continue to be excluded and die. For us, consideration of health equity and social justice when revisiting our public health and healthcare systems is not a luxury; it is a prerequisite for a delicate equilibrium between our survival and that of our planet.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iDs

Muriel Mac-Seing https://orcid.org/0000-0001-5966-6702

Robson Rocha de Oliveira https://orcid.org/0000-0003-4135-676X

References

1. Heymann DL, Shindo N. COVID-19: what is next for public health? Lancet. 2020; 395: 542–545.
2. World Health Organization (WHO). WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 Mar 2020 [Internet]. WHO; 2020 [cited 4 Oct 2020]. Available from: https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19—11-march-2020
3. World Health Organization (WHO). WHO Coronavirus Disease (COVID-19). Dashboard [Internet]. WHO; 2020 [cited 20 Oct 2020]. Available from: https://covid19.who.int/
4. Gouvernement du Québec. Situation du coronavirus (COVID-19) au Québec [Internet]. Gouvernement du Québec; 2020 [cited 20 Oct 2020]. Available from: https://www.quebec.ca/sante/problemes-de-sante/a-z/coronavirus-2019/situation-coronavirus-quebec/#c47900
5. Abbey EJ, Khalifa BAA, Oduwole MO, Ayeh SK, Nudotor RD, Salia EL, et al. The Global Health Security Index is not predictive of coronavirus pandemic responses among Organization for Economic Cooperation and Development countries. PLoS ONE. 2020; 15: e0239398.
6. World Health Organization (WHO). Health equity [Internet]. WHO; 2020 [cited 13 Sep 2020]. Available from: https://www.who.int/topics/health_equity/en/
7. World Bank. Pandemic preparedness and COVID-19 (coronavirus) [Internet]. WB; 2020 [cited 11 Oct 2020]. Available from: https://www.worldbank.org/en/topic/pandemics
8. Fiset-Laniel J, Guyon Ai, Perreault R, Streumpf E. Public health investments: neglect or wilful omission? Historical trends in Quebec and implications for Canada. Can J Public Health. 2020; 111: 383–388.
9. Gmeinder M, Morgan D, Mueller M. How much do OECD countries spend on prevention? [Internet]. OECD; 2017 [cited 10 Oct 2020]. Available from: https://www.oecd-ilibrary.org/social-issues-migration-health/how-much-do-oecd-countries-spend-on-prevention_f19e803c-en
10. Remuzzi A, Remuzzi G. COVID-19 and Italy: what next? Lancet. 2020; 395: 1225–1228.
11. Keely C, Jimenez J, Jackson H, Boudourakis L, Salway RJ, Cineas N, et al. Staffing up for the surge: expanding the New York city public hospital workforce during the COVID-19 pandemic. Health Aff. 2020; 39: 1426–14230.
12. The Editors. Dying in a leadership vacuum. N Engl J Med. 2020; 383: 1479–1480.
13. Desson Z, Weller E, McMeekin P, Ammi M. An analysis of the policy responses to the COVID-19 pandemic in France, Belgium, and Canada. Health Policy Technol. 2020; 457.
14. Hébert R. Les soins à domicile : financer davantage mais surtout autrement [Internet]. Policy Options Politiques; 2020 [cited 10 Oct 2020]. Available from: https://policyoptions.irpp.org/fr/magazines/may-2020/les-soins-a-domicile-financer-davantage-mais-surtout-autrement/
15. Hsu AT, Lane N, Sinha SK, Dunning J, Dhuper M, Kahiel Z, et al. Impact of COVID-19 on residents of Canada's long-term care homes–ongoing challenges and policy response [Internet]. LTC Responses to COVID-19, International Long-Term Care Policy Network; 2020 [cited 30 May 2020]. Available from: https://ltccovid.org/2020/04/15/impact-of-covid-19-on-residents-of-canadas-long-term-care-homes-ongoing-challenges-and-policy-response/
16. Scott C, Zwicker J, Kneebone R. Social policy trends: vulnerable populations and the COVID-19 pandemic. School Public Policy Public. 2020; 12.
17. Tanne JH, Hayasaki E, Zastrow M, Pulla P, Smith P, Rada AG. Covid-19: how doctors and healthcare systems are tackling coronavirus worldwide. BMJ. 2020; 368: 1–5.
18. Wenham C, Smith J, Morgan R. COVID-19: the gendered impacts of the outbreak. Lancet. 2020; 395: 846–848.
19. The Lancet. The plight of essential workers during the COVID-19 pandemic. Lancet. 2020; 395:1587.
20. Boyle CA, Fox MH, Havercamp SM, Zubler J. The public health response to the COVID-19 pandemic for people with disabilities. Disabil Health J. 2020; 13: 100943.
21. Nigam S. COVID-19, lockdown and violence against women in homes. SSRN. 2020; 1–10.
22. Tsai J, Wilson M. COVID-19: a potential public health problem for homeless populations. Lancet Public Health. 2020; 5: e186-e7.
23. Bowleg L. We're not all in this together: On COVID-19, intersectionality, and structural inequality. Am J Public Health. 2020; 110: 917.
24. Ottersen OP, Dasgupta J, Blouin C, Buss P, Chongsuvivatwong V, Frenk J, et al. The political origins of health inequity: prospects for change. Lancet. 2014; 383: 630–667.
25. Bouye K, Truman BI, Hutchins S, Richard R, Brown C, Guillory JA, et al. Pandemic influenza preparedness and response among public-housing residents, single-parent families, and low-income populations. Am J Public Health. 2009; 99(S2): S287-S293.
26. Zastrow M. Coronavirus contact-tracing apps: can they slow the spread of COVID-19? Nature. Epub ahead of print May 2020. https://doi.org/10.1038/d41586-020-01514-2.
27. Woodhams S. COVID-19 digital rights tracker [Internet]. TOP10VPN. 20 Mar 2020. [cited 2020 Jun 4]. Available from: https://www.top10vpn.com/news/surveillance/covid-19-digital-rights-tracker/

28. Watts G. COVID-19 and the digital divide in the UK. Lancet Digit Health. 2020; 2: e395-e396.
29. Hanson K. Canadian makers 3D-print PPE in response to COVID-19 [Internet]. The Additive Report; 2020 [cited 30 May 2020]. Available from: https://www.thefabricator.com/additivereport/article/additive/canadian-makers-3d-print-ppe-in-response-to-covid-19/
30. Lehoux P, Alami H, Morch C, Rivard L, Rocha R, Silva H. Can we innovate responsibly during a pandemic? [Internet]. Université de Laval; 2020 [cited 17 June 2020]. Available from: https://observatoire-ia.ulaval.ca/en/can-we-innovate-responsibly-during-a-pandemic/
31. Pacifico Silva H, Lehoux P, Miller FA, Denis J-L. Introducing responsible innovation in health: a policy-oriented framework. Health Res Policy Syst. 2018; 16: 90.
32. Van den Broucke S. Why health promotion matters to the COVID-19 pandemic, and vice versa. Health Promo Int. 2020; 35: 181–186.

Can transdisciplinary approaches contribute to the COVID-19 fight?

Dilek Aslan

Abstract: Novel Coronavirus Disease (COVID-19) raised many questions needing answers in order to overcome the disease burden globally. Uncertainty about COVID-19 contributes to the complexity of the burden on the health, social, economic, and cultural influences of COVID-19. In this context, all related disciplines are working together to mitigate the negative influences of the disease. In particular, health promotion, a discipline of public health, matters to the pandemic as it may address the threats at different levels. Health promotion strategies mostly use solution-oriented efforts with inter- and multidisciplinary approaches. Nevertheless, as the COVID-19 burden has many time-critical determinants, these approaches cannot be sufficient to overcome the problem. A transdisciplinary approach in its broader sense using almost all inputs to synthesize and produce an integrative solution may be extremely helpful. In this paper, the importance of transdisciplinary approaches in health promotion to combat COVID-19 has been discussed.

Keywords: COVID-19, pandemic, transdisciplinary approach

The Novel Coronavirus Disease (COVID-19) pandemic has been the most important global public health issue since March 2020. It is an infectious disease caused by a newly discovered coronavirus (1), named Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (2).

Although COVID-19 vaccines have been introduced for the benefit of humanity (3), today's scientific information still addresses four main preventive strategies of COVID-19: staying at home, using face masks, physical distancing, and hand hygiene (4), which were also vital for previous pandemics in different eras (5), and all of which need individual behavioral change.

Many health disciplines are working together focusing on different aspects of the disease to mitigate the negative influences of the disease burden. Public health and its major disciplines including epidemiology, control of communicable disease, and health promotion (HP) are trying to contribute to the solution. By its nature, HP directly addresses the pandemic fight through behavioral change strategy (6). Human behaviors are complex and influenced by social determinants of health, which the World Health Organization (WHO) defines as '*the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life* (7)'. Social, economic, and cultural characteristics of the individual shape human behavior and play crucial roles in changes in individual and community behavior patterns. In brief, when one attempts to change behavior, success cannot be achieved without focusing on the relationship between the behavior and the social determinants of health.

The COVID-19 fight needs a similar perspective with the contribution of many disciplines. The relationship and the interaction between disciplines may appear in single, multi-, inter-, and transdisciplinary approaches. Among all these potential approaches, the transdisciplinary approach may be helpful in interactively exploring and integrating all dynamics for better health (8).

In this paper, the question '*Can transdisciplinary approaches contribute to the COVID-19 fight?*' is

Hacettepe University Faculty of Medicine, Ankara, Turkey.

Correspondence to: Dilek Aslan, Hacettepe University Faculty of Medicine, 06100 Sihhiye-Ankara, Turkey.
Email: diaslan@hacettepe.edu.tr

(This manuscript was submitted on 31 July 2020. Following blind peer review, it was accepted for publication on 22 February 2021.)

Global Health Promotion 1757-9759; Vol 28(2): 72–77; 1002376 DOI: 10.1177/17579759211002376 journals.sagepub.com/home/ghp

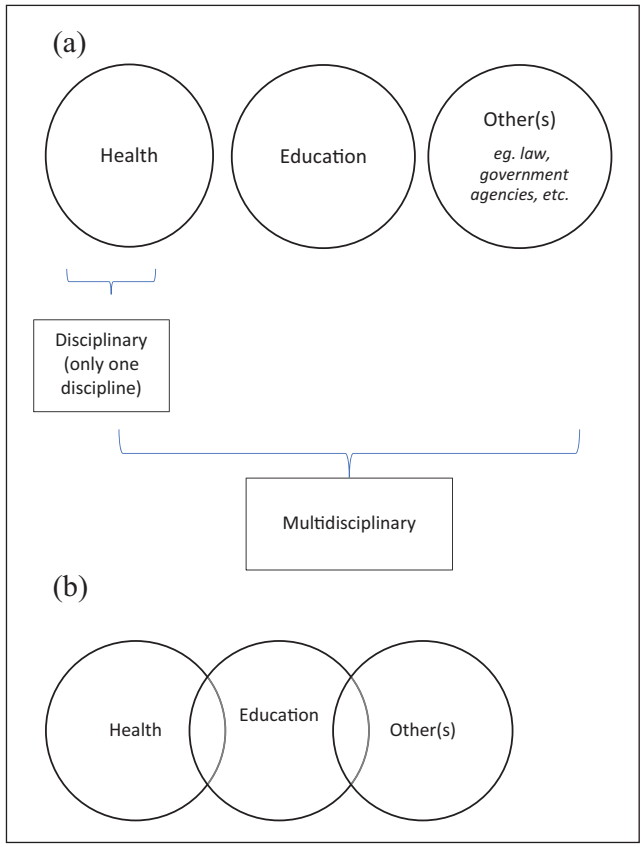

Figure 1. Disciplinary approaches in HP: (a) (single) disciplinary and multidisciplinary approaches; and (b) interdisciplinary approach.

addressed. Specifically focusing on HP, we discuss how current evidence-based preventive measures toward the disease are based on individual behaviors.

Before going into the details, we need to understand the existing disciplinary-based perspectives, such as disciplinary, inter-, and multidisciplinary approaches, which we may use in HP strategies (Figure 1).

Experts use traditional methods for solutions in the multidisciplinary approach. There is cooperation among partners; however, no integration occurs in this perspective. In interdisciplinary work, there is collaboration and integration between the disciplines; thus, each discipline is still preserving its main traditional approach, and each contributes to the efficacy of the multiplicity of transdisciplinary approaches being used. Solutions arise from disciplinary perspectives.

For a better understanding, we can look at HP practices in tobacco control. Health promotion frequently includes multi- and interdisciplinary approaches. Almost all sectors focus on reducing tobacco consumption in the community. Doctors' recommendations on quitting smoking, methods of raising community awareness about the manipulations of the tobacco industry, and implementation of legislative regulations are signs that they work together in their own backgrounds and competencies. However, integrative and collaborative 'proactive' approaches and concrete practices may facilitate success in tobacco control. In other words, the transdisciplinary approach in tobacco control is that all sectors should unite, exchange, and finally go beyond their 'individual' capacity for a tobacco-free world (9). The WHO Framework Convention on

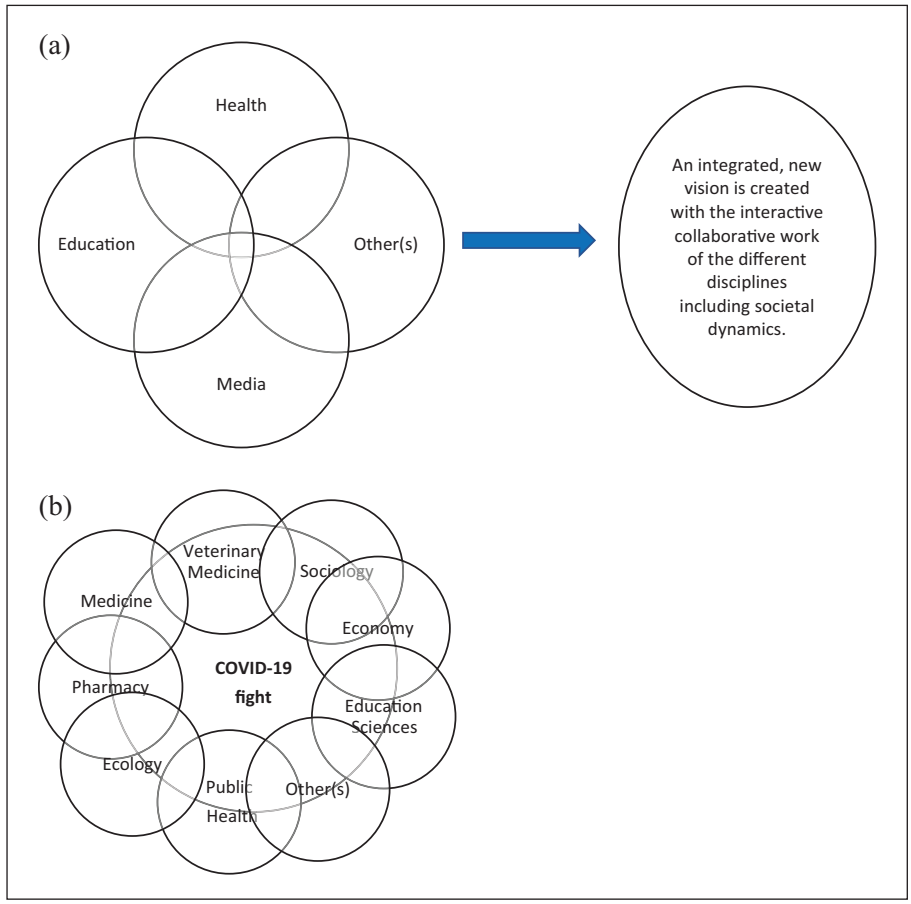

Figure 2. Transdisciplinary approach: (a) general approach in HP; and (b) specific approach to the COVID-19 fight.

Tobacco Control (10) and M-POWER (11) strategies are good examples to be used in building the transdisciplinary approach in tobacco control.

As COVID-19 has complex features, with a strong connection to the determinants of health, a new vision such as the 'transdisciplinary approach' may be helpful. The transdisciplinary approach engages different disciplines in implementing potential solutions to societal issues and the engagement creates a holistic approach (12). The approach facilitates transforming knowledge and societal transformation (13).

In this approach, there is more than one discipline, and societal perspectives are expected to be integrated in the 'new' vision. The 'new' product with its new vision should also contribute to societal improvement. In a transdisciplinary approach, science, society, and other related components contribute to the solution. All population dynamics play a role in organizing the response to the 'need' (Figure 2(a)) (12).

The global society is not 100% successful in the implementation of the four strategies (face mask use, staying at home, hand hygiene, social distancing), causing hundreds of thousands of cases and deaths globally. Moreover, societal, economic, and other problems also accumulate when prolongation of the disease burden occurs. Table 1 emphasizes that traditional disciplinary approaches have been insufficient in responding to the COVID-19 fight. Determinants of health may contribute to the disease burden as they may

Table 1. Understanding the capacity of the behavioral preventive strategies (e.g. face mask use, staying at home, hand hygiene, social distancing) in the COVID-19 fight with the traditional disciplinary approach.

	Behavioral preventive strategies of COVID-19			
	Face mask use	*Staying at home*	*Hand hygiene and other hygienic conditions*	*Social/physical distancing*
Is there global success in prevention of the disease?	Not yet	Not yet	Not yet	Not yet
What is the scientific evidence (indicator) supporting the increase in the disease burden?	Confirmed cases and deaths globally (9)			
Is there a relation between the preventive strategies and the determinants of health?	Yes	Yes	Yes	Yes
Are there barriers to not achieving the goals?	Yes	Yes	Yes	Yes
Examples of barriers	No access to face mask	Go to work	No access to soap and other hygienic tools	Lack of information
	Infodemic	Infodemic	No access to water	No access to correct information
	Lack of information	Lack of information	Infodemic	Live in crowded families
			Lack of information	Live in housing in which social distancing cannot be achieved
				Disability situations
Underlying factors of barriers	Personal factors			
	Social, economic, and environmental factors			
	Poverty, globalization, migration, health illiteracy, others			
Do the underlying factors have an interconnection?	Yes	Yes	Yes	Yes
Are other problems raised?	Yes	Yes	Yes	Yes
Examples of the other problems raised due to COVID-19 pandemic	Spread of the disease			
	Increase in mortality due to other diseases			
	Violence against vulnerable groups			
	Deepening of inequalities, poverty			
	Interruption of routine health services			
	Stigma, labeling issues of the disease			
	Interruption of the mental and social wellbeing component of health in the community			
	Other(s)			
Is there inter- and multidisciplinary work in the COVID-19 fight?	Yes	Yes	Yes	Yes
Has current inter- and multidisciplinary work in the COVID-19 fight been successful?	No[a]	No[a]	No[a]	No[a]

[a]Success has not been achieved yet, as COVID-19 is still a global threat.

restrain individuals from engaging in preventive behaviors. For example, if one lives in poor conditions, the individual must work to earn money to support the family, thus precluding staying at home, having access to face masks or soap, or providing social/physical distancing in a crowded home. Sharma *et al*. (14) emphasized the compounding influence of the pandemic linked with the basic social needs of the people and called for action to respond to the needs of especially vulnerable populations.

At this point, we can conclude that science is trying to find solutions to tackle the problem and 'new' visionary approaches. In particular, a 'transdisciplinary approach', which also means 'asking different questions, seeing further, and perceiving the current situation with new insights (15)', and producing an integrative solution may be extremely helpful in dealing with COVID-19. Figure 2(b) will help us understand how the transdisciplinary approach tackles COVID-19.

As health is an outcome and is influenced by various determinants, maintaining success in the COVID-19 fight needs many disciplines' collaborative perspectives and contributions including medical, social, behavioral, and biological sciences approaches (12). A joint new conceptual, theoretical, and methodological approach, beyond discipline-specific approaches for the common problem (16) of addressing COVID-19, should be created and designated as a 'transdisciplinary approach'. In this approach, the intersecting surfaces of the individual disciplines are expected to be wide. Figure 2(b) shows the possible components which are needed in the COVID-19 fight in a transdisciplinary approach. The point is that the approaches of 'unique' disciplines are amalgamated into a 'synthesized' and integrated perspective and approach. This approach is similar to the 'One Health' approach, 'which implements programs, policies, legislation, and research for better public health outcomes', as defined by the WHO (17). Kelly *et al*. (18) emphasize that the One Health approach recognizes the need to expand disciplinary expertise in public health.

In conclusion, the existence of conventional approaches has not been sufficient in producing and implementing multidimensional solutions which are 'more' needed these days, and the answer to the question '*Can transdisciplinary approaches contribute to the COVID-19 fight?*' will be YES. This approach with its broad vision will cover all aspects to produce 'new' inputs, facilitate the COVID-19 fight, and help humanity to be prepared for future global threats.

Declaration of conflicting interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Dilek Aslan https://orcid.org/0000-0002-4053-2517

References

1. WHO Coronavirus Disease (COVID-19). What is COVID-19? [Internet]. 2020 [cited 2020 Nov 30]. Available from: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-coronaviruses
2. WHO. Naming the coronavirus disease (COVID-19) and the virus that causes it [Internet]. 2020 [cited 2020 Jul 12]. Available from: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it
3. WHO. COVID-19 vaccines [Internet]. 2020 [cited 2020 Feb 20]. Available from: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-vaccines
4. WHO Coronavirus Disease (COVID-19). What can I do to protect myself and prevent the spread of disease? [Internet]. 2020 [cited 2020 Jul 12]. Available from: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-coronaviruses#
5. Cowling BJ, Zhou Y, Ip DK, Leung GM, Aiello AE. Face masks to prevent transmission of influenza virus: a systematic review. Epidemiol Infect. 2010; 138: 449–456.
6. Van den Broucke S. Why health promotion matters to the COVID-19 pandemic, and vice versa. Health Promot Int. 2020; 35: 181–186.
7. Social Determinants of Health [Internet]. [cited 2020 Sep 20]. Available from: https://www.who.int/health-topics/social-determinants-of-health/
8. Ciesielski TH, Aldrich MC, Marsit CJ, Hiatt RA, Williams SM. Transdisciplinary approaches enhance the production of translational knowledge. Transl Res. 2017; 182: 123–134.

9. Abraham DB. Transdisciplinary research paradigms for tobacco prevention. Nicotine Tob Res. 1999; 1: S15–S23.
10. WHO Framework Convention on Tobacco Control [Internet]. 2003 [cited 2020 Nov 20]. Available from: https://www.who.int/fctc/text_download/en/
11. WHO M-POWER brochures and other resources [Internet]. 2019 [cited 2020 Nov 30]. Available from: https://www.who.int/tobacco/mpower/en/
12. Faverjon C, Bernstein A, Grütter R, Nathues C, Nathues H, Sarasua C, et al. A transdisciplinary approach supporting the implementation of a Big Data project in livestock production: an example from the Swiss pig production industry. Front Vet Sci. 2019; 6: 215.
13. Hitziger M, Esposito R, Canali M, Aragrande M, Häsler B, Rüegg SR. Knowledge integration in One Health policy formulation, implementation and evaluation. Bull World Health Organ. 2018; 96: 211–218.
14. Sharma SV, Chuang R, Rushing M, Naylor B, Ranjit N, Pomeroy M, et al. Social determinants of health-related needs during COVID-19 among low-income households with children. Prev Chronic Dis. 2020; 17: 200322.
15. Parkes MW, Bienen L, Breilh J, Hsu LN, McDonald M, Patz JA, et al. All hands on deck: transdisciplinary approaches to emerging infectious disease. Ecohealth. 2005; 2: 258–272.
16. Definitions, Harvard Transdisciplinary Research in Energetics and Cancer Center [Internet]. 2020 [cited 2020 Jul 12]. Available from: https://www.hsph.harvard.edu/trec/about-us/definitions/
17. One Health [Internet]. 2017 [cited 2020 Sep 20]. Available from: https://www.who.int/news-room/q-a-detail/one-health
18. Kelly TR, Karesh WB, Johnson CK, Gilardi KV, Anthony SJ, Goldstein T, et al., PREDICT Consortium. One Health proof of concept: bringing a transdisciplinary approach to surveillance for zoonotic viruses at the human-wild animal interface. Prev Vet Med. 2017; 137(Pt B): 112–118.

Art during tough times: reflections from an art-based health promotion initiative during the COVID-19 pandemic

Ilhan Abdullahi, Navneet Kaur Chana, Marco Zenone and Paola Ardiles

Abstract: With the current COVID-19 pandemic impacting communities across the globe, diverse health promotion strategies are required to address the wide-ranging challenges we face. Art is a highly engaging tool that promotes positive well-being and increases community engagement and participation. The 'Create Hope Mural' campaign emerged as an arts-based health promotion response to inspire dialogue on why hope is so important for Canadians during these challenging times. This initiative is a partnership between a health promotion network based in Vancouver and an 'open air' art museum based in Toronto. Families were invited to submit artwork online that represents the concept of hope. This paper discusses the reflections of organizers of this arts-based health promotion initiative during the early months of the pandemic in Canada. Our findings reveal the importance of decolonizing practices, centring the voices of those impacted by crisis, while being attentive to the social and political context. These learnings can be adopted by prospective health promoters attempting to use arts-based methods to address social and health inequities.

Keywords: COVID-19, art, decolonization, health promotion

In March 2020, the World Health Organization declared the outbreak of the novel coronavirus disease (COVID-19) to be a public health emergency of international concern (1). This pandemic has devastated the world and continues to disproportionately impact underserved communities. This paper discusses the reflections of organizers of an arts-based health promotion initiative during the early months of the pandemic in Canada.

Arts-based initiatives as a health promotion strategy

Evidence suggests that arts-based initiatives are an effective health promotion strategy and can be highly impactful in fostering community resilience and increasing the ability of communities to positively respond to traumatic events (2). In relation to this current pandemic, art can be a highly engaging tool that promotes positive well-being and increases community engagement and participation. As Springett and Masuda (3) noted, 'participation is not just a process; it is a mindset, a philosophy of being and acting in the world ecologically, organically, and holistically, and in health promotion, with the ultimate aim of improving the conditions for optimal health and social justice.' Arts-based approaches in health promotion can be best understood through the socio-ecological model that recognizes the collective social and environmental factors that create a distinct experience during uncertain times (4). This framework asserts that an individual's health is in a complex, bidirectional relationship with their social environment, and thus, is directly

Simon Fraser University, Burnaby, British Columbia, Canada.

Correspondance to: Ilhan Abdullahi, Simon Fraser University, 8888 University Drive, Burnaby, British Columbia V5A 1S6, Canada. Email: ilhan_abdullahi@sfu.ca

(This manuscript was submitted on 14 July 2020. Following blind peer review, it was accepted for publication on 5 February 2021.)

Global Health Promotion 1757-9759; Vol 28(2): 78–82; 998638 DOI: 10.1177/1757975921998638 journals.sagepub.com/home/ghp

influenced by it (5). Socio-ecological systems require approaches that are conscious of the social conditions one lives in and how these factors facilitate or challenge their health and well-being (4).

Engagement or participatory practice in health promotion is one that encourages a cyclical process of reflection and action that is designed to uncover and address the conditions undermining health and perpetuating health inequities (3). Critical voices within academia and health promotion research have called for the decolonization of health promotion strategies, which traditionally draw upon the theories of empowerment and self-efficacy (6,7). Concepts like empowerment and self-efficacy may put the onus of ill health outcomes on individuals, rather than a product of their environment and do not critically examine the history of colonialism that can inform health strategies (8). Participatory approaches focus on relational power in the process toward social change (3). Within academic literature in Canada, decolonization was a term first coined by Indigenous scholars and researchers and has increasingly become important in health and community engagement literature (8,9). Through a decolonization lens, the complex realities of individuals experiencing poorer health and mental health can be centred in health promotion initiatives through community participation.

Responses to the emerging health needs of individuals, as a result of the COVID-19 pandemic, requires the use of engaging and participatory tools that centre the experiences of communities. Therefore, this paper looks to provide insights on the learning from an interdisciplinary team of diverse members of the Create Hope campaign, an art-based health promotion initiative that emerged in Canada during the COVID-19 pandemic.

Create Hope campaign

The Create Hope campaign emerged as a volunteer, grassroots led art-based health promotion campaign to inspire dialogue on why hope is so important during these times of the COVID-19 pandemic. The campaign launched on April 6, 2020 as a partnership between the Bridge for Health Co-operative, (on the unceded ancestral and traditional territories of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), Sə̓l̓ílwətaɬ (Tsleil-Waututh), q̓ic̓əy̓ (Katzie), and kʷikʷəƛ̓əm (Kwikwetlem) Nations) and the Dundas West Open Air Public Art Museum (on the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples and is now home to many diverse First Nations, Inuit and Métis peoples. We also acknowledge that Toronto is covered by Treaty 13 with the Mississaugas of the Credit), (10–12). Bridge for Health is a co-operative in Metro Vancouver that utilizes a community-based model to promote well-being and equity (10). The Dundas West Open Air Museum is an artist and community driven initiative that builds on mural art and shares the art and history of the diverse communities in the DundasWest neighbourhood in Toronto (11). By working in partnership, the campaign's goal was to find a way to encourage dialogue on hope during the COVID-19 pandemic.

The campaign organizers included a dedicated group of volunteers comprised of health promoters, public health professionals, community organizers, local artists, social entrepreneurs, and university students, of varying ages, abilities, gender and racial identities. The campaign consisted of four phases: Phase I: invitation to submit artwork on Bridge for Health social media platforms (Twitter, Facebook, Instagram) and through the Bridge for Health website (www.bridgeforhealth.org). Phase II: publication of artwork submitted to the campaign on Bridge for Health's website and social media channels using @Bridge4Health and hashtag #CreateHopeMural. Phase III: The design of a digital collage which captures all of the images collected into one digital collage with the word 'hope' as the backdrop. Phase IV: A physical mural to be painted on the streets of Toronto, in the Dundas West museum neighbourhood once the pandemic restrictions are lifted (Figure 1). In a 6-week period, from April to May 2020, we collected a total of 30 art pieces; the majority of submissions were from family members and individuals who primarily resided in Metro Vancouver and the Greater Toronto area, between the ages of 5 and 18 years (with prior consent).The following section will discuss some of the reflections and learnings that resulted from the Create Hope campaign.

Figure 1. Mockup image of the hope mural by Giovanni Zamora.

Reflections from campaign organizers

Health is political

What emerged as a response to provide hope during the current COVID-19 pandemic resulted in a deeply reflective process for the campaign organizers. Adaptability and resiliency surfaced as key themes and strategies for the organizers to navigate the complex realities of living through a pandemic. The COVID-19 pandemic has proven to be a difficult time for families, communities and professionals working to address its implications. At a time when uncertainty is heightened by a pandemic, the world is simultaneously witnessing a global movement to address police brutality, anti-Black violence and racism experienced by Black communities in the United States and echoed worldwide. In the early months of summer 2020, Black Lives Matter (BLM) protests took place across the globe, making it a pivotal and monumental moment in history. Moreover, the pandemic also made visible in the public eye, the brutality of how Indigenous peoples are treated in the health-care system across Canada. After an in-depth investigation, a report was released in November documenting racism, stereotyping and discrimination against Indigenous peoples in British Columbia (13). These events clearly illustrated the interconnectedness of social and health systems within society and their ramifications on the health of underserved communities.

For the Create Hope organizers, the calls for anti-racism work sparked conversations on how creating hope for the post-pandemic era necessarily required an examination of the colonial past and histories as a fundamental cause of health inequities and reinforced the notion that health is political. That is, it is necessary to conceptualize new possible outcomes as products of socio-political circumstances, while understanding the complex, often intersecting social and health systems (14).

Health promoters, public health professionals and community organizers cannot be divorced from the complex realities of our society. For health promotion interventions to be effective, they need to centre the experiences and voices of those impacted while being responsive to current events. As noted by Boutilier and Mason, health promotion practitioners can participate in collaborative reflection, leading to ongoing questioning of the complex and dynamic nature of practice, while paying attention to the process itself and issues that contribute to building trust among practitioners (15).

A critical learning for campaign organizers was to be attentive to the social context and to be responsive to current events and establish interventions that can be adaptable. Organizers had to shift their language, social media messages and thinking along the way, in order to respond to the context that was constantly changing at the height of the start of the pandemic. One of the key insights gained along the way was the need to understand their own social location as organizers and how the various identities, agencies and experiences of the team enriched (and challenged) the experience of organizing. The

organizers had not anticipated at the start that they would need a process to keep track of their dialogue and reflection. It was soon realized that for any kind of evaluation of their work in the future, they needed to have a mechanism to capture the dynamic decision making and thought processes that impacted how they continuously tailored and adapted their engagement strategy.

Health promotion campaigns need a decolonizing approach

The concept of decolonization ended up becoming a key principle of this campaign and continues to inform future directions of the Create Hope campaign. It was practised by questioning the colonial histories, as well as the dominant western ways of 'knowing' and 'doing'. Organizers had an opportunity to create their own understanding of how their experiences shaped their knowledge and vice-versa. Importantly, it meant working alongside communities impacted by the issue at hand and building meaningful and mutual relationships with diverse communities while understanding the colonial histories underpinning their social conditions (16). For the organizers leading the Create Hope campaign, critical reflexiveness on their social location and their own healing journeys was integral in informing the design and direction of this campaign. Their healing journeys centred around the importance of 'hope' itself, as well as nature, staying connected to the land and using art in their own coping and resilience strategies. In essence, the campaign unexpectedly served as a healing journey for the organizers.

Conclusion

This paper provides insights into critical elements of developing a health promotion campaign, centred on the reflexiveness of health promoters and campaign organizers, to support communities with dialogue around hope during the COVID-19 pandemic. It is hoped that the experiences shared by campaign organizers in developing this health promotion initiative will highlight the importance of reflective practice, as well as the dynamic nature of health promotion requiring adaptable and creative strategies that centre individuals and communities, and their expressions during a time of crisis.

Acknowledgements

The authors are very grateful to all the participants who generously contributed artwork to the Create Hope campaign. We would also like to thank campaign organizers Rodrigo Ardiles, Kristy Wai and Poonam Deol for all their work in addition to the dedicated support from the Public Health Association of BC.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iDs

Ilhan Abdullahi https://orcid.org/0000-0002-8612-8130

Paola Ardiles https://orcid.org/0000-0002-3519-2407

References

1. World Health Organization. WHO Director-General's opening remarks at the media briefing on COVID-19 [Internet]. 2020 [cited 2020 July 12]. Available from: https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19—11-march-2020
2. Faulkner L, Brown K, Quinn T. Analyzing community resilience as an emergent property of dynamic social-ecological systems. Ecol Soc. 2018; 23: 24.
3. Springett J, Masuda J. Participatory practice and health promotion in Canada. In: Rootman I, Pederson A, Frohlich K, Dupéré S (eds) Health Promotion in Canada: new perspectives on theory, practice, policy, and research . Vol. 4. Toronto: Canadian Scholars Press, 2017, pp. 390–407.
4. Olsson P, Folke C, Berkes F. Adaptive comanagement for building resilience in social-ecological systems. Environ Manag. 2004; 34: 75–90.
5. McKenzie J, Neiger B, Thackery R. Theories and models commonly used for health promotion interventions. In Planning, implementing & evaluating health promotion programs: A primer. 6th ed. Boston, MA: Pearson, 2017.
6. Labonté R. Health promotion in an age of normative equity and rampant inequality. Int J Health Policy Manag. 2016; 5: 675–682.
7. Mundel E, Chapman GE. A decolonizing approach to health promotion in Canada: the case of the urban Aboriginal community kitchen garden project. Health Promot Int. 2020; 25: 166–173.

8. Kornelson D. Decolonizing community engagement [Internet]. Medium. 2017 [cited 2020 July 12]. Available from: https://medium.com/knowledgenudge/decolonizing-community-engagement-85ee3ad5369d
9. Tuck E, Yang KW. Decolonization is not a metaphor. Decolonization: indigeneity, education and society. 2020; 1: 1–40.
10. Bridge for Health [Internet]. 2020 [cited 2020 July 8]. Available from: http://www.bridgeforhealth.org/www/bridge/
11. Dundas West Open Air Museum. About us - Dundas West Open Air Museum [Internet]. 2020 [cited 2020 July 12]. Available from: https://dundaswest.museum/about-us/
12. City of Toronto. Land acknowledgement. [Internet]. 2019 [cited 2020 November 25]. Available from: https://www.toronto.ca/city-government/accessibility-human-rights/indigenous-affairs-office/land-acknowledgement/
13. Community-Based Research Centre. In: Plain sight, addressing indigenous-specific racism and discrimination in B.C. health care [Internet]. 2020 [cited 2021 January 31]. Available from: https://www.cbrc.net/in_plain_sight_addressing_indigenous_specific_racism_and_discrimination_in_b_c_health_care
14. Gore R, Parker R. Analysing power and politics in health policies and systems. Glob Public Health. 2019; 14: 481–488.
15. Boutilier M, Mason R. The reflexive practitioner in health promotion: from reflection to reflexivity. In: Rootman I, Pederson A, Frohlich K, Dupere S (eds) Health promotion in Canada: new perspectives on theory, practice, policy, and research. Toronto: Canadian Scholars Press, 2017, pp. 499–509.
16. Chandanabhumma PP, Narasimhan S. Towards health equity and social justice: an applied framework of decolonization in health promotion. Health Promot Int. 2010; 25: 73–84.

COVID-19: implications for NCDs and the continuity of care in Sub-Saharan Africa

Oluwatomi Owopetu[1], Luther-King Fasehun[2] and Uzoma Abakporo[3]

Abstract: There has been a rise in non-communicable diseases (NCD) in Sub-Saharan Africa (SSA), driven by westernization, urbanization and unhealthy lifestyles. The prevalence of NCDs and their risk factors vary considerably in SSA between countries and the various sub-populations. A study documented the prevalence of stroke ranging from 0.07 to 0.3%, diabetes mellitus from 0 to 16%, hypertension from 6 to 48%, obesity from 0.4 to 43%, and current smoking from 0.4 to 71%. The numbers of these NCD cases are predicted to rise over the next decade. However, in the context of a global pandemic such as COVID-19, with the rising cases, lockdowns and deaths recorded worldwide, many people living with NCDs may find accessing care more difficult. The majority of the available resources on the subcontinent have been diverted to focus on the ongoing pandemic. This has caused interruptions in care, complication management, drug pick-up alongside the almost neglected silent NCD epidemic, with major consequences for the health system post the COVID-19 era. We explore the issues surrounding the continuity of care and offer some solutions for Sub-Saharan Africa.

Keywords: COVID-19, chronic disease/non-communicable disease, Sub-Saharan Africa

There has been a disproportionate increase in the burden of non-communicable diseases (NCDs) in Sub-Saharan Africa (SSA) over the last two decades, driven by the increasing incidence of risk factors such as tobacco use, unhealthy diets, reduced physical activity, hypertension, obesity, diabetes, dyslipidaemia, and air pollution. The prevalence of NCDs and their risk factors vary considerably in SSA between countries, urban/rural location and other sub-populations. A study documented the prevalence of stroke ranging from 0.07 to 0.3%, diabetes mellitus from 0 to 16%, hypertension from 6 to 48%, obesity from 0.4 to 43%, and current smoking from 0.4 to 71% (1). As a result, NCDs are projected to surpass communicable, maternal, neonatal, and nutritional diseases combined as the leading cause of mortality in Sub-Saharan Africa (SSA) by 2030 (2). NCDs account for over 70% of deaths globally, with a significant proportion occurring in low- and middle-income countries (3). In sub-Saharan Africa, this projected increased burden of NCDs exerts immense strain on already weakened health systems. (4). Global Burden of Disease studies show that the morbidity and age-standardized death rates from NCDs are higher in at least four SSA countries (the Democratic Republic of the Congo, Nigeria, Ethiopia, and South Africa) than in high-income countries (5).

Due to the chronic nature of the majority of these diseases, NCDs have attracted an appreciable portion of health expenditure in many countries in Sub-Saharan Africa. In rural Malawi, for example,

1. Department of Community Medicine, University College Hospital, Ibadan, Nigeria.
2. Temple University College of Public Health, Philadelphia, Pennsylvania, United States.
3. University of Minnesota, Minneapolis, Minnesota, United States.

Correspondence to: Oluwatomi Owopetu, Department of Community Medicine, University College Hospital, Queen Elizabeth Road, Ibadan, Ibadan 23402, Nigeria. Email: oluwatomifunbi@gmail.com

(This manuscript was submitted on 23 May 2020. Following blind peer review, it was accepted for publication on 15 January 2021.)

Global Health Promotion 1757-9759; Vol 28(2): 83–86; 992693 DOI: 10.1177/1757975921992693 journals.sagepub.com/home/ghp

out-of-pocket (OOP) expenditure for chronic non-communicable diseases constituted at least 22% of the monthly per capita household spending (6), while in Uganda, the monthly average costs for managing uncomplicated diabetes and hypertension is about US$33, which is a third of the average monthly income in the same country (7). Patients with these diseases require long-term management, mainly through regular clinic visits, consistent availability and use of prescribed medication, and lifestyle modification (8). In a report from Tanzania, for example, chronic diseases accounted for at least 58% of out-patients visits among adults, of which a quarter were for three NCDs (hypertension, diabetes, epilepsy) alone (9). Similarly, in a study in rural South Africa, at least 41% of healthcare use was for NCDs (10). In low- and middle-income countries of Africa, where the distribution of healthcare services is suboptimal, patients and their caregivers spend a significant amount of time on hospital visits, follow-up appointments, drug pick-ups, and complication management (11). It is against this backdrop that the COVID-19 pandemic has emerged, with the disease gradually spreading across the subcontinent.

As at August 23, 2020, there were 996,026 confirmed cases of COVID-19 spread across 47 countries in the World Health Organization African Region (WHO-AFRO) (12). While these numbers are relatively low, making up only 0.3% of global cases at that time (12), it is worth noting that this reflects only confirmed cases, and the true numbers might be hidden due to the iceberg effect from inadequate reporting and testing. This iceberg effect exists on background of existing weak local health systems among most countries in Sub-Saharan Africa (13,14). For these reasons, the COVID-19 situation had the potential to worsen very rapidly in Sub-Saharan Africa, a sentiment shared by the World Health Organization (15). Over the course of this pandemic, there has been a redeployment of healthcare resources – personnel, equipment, and finance – to directly combat and stem the global tide of accelerating numbers of COVID-19 infection. This effort is aimed at 'flattening the curve' (16) to buy time for already constrained health systems to cope with rising cases. Supply chain disruptions in the manufacturing of healthcare equipment (ventilators and personal protective gear) and rising morbidity and mortality of healthcare workers at the frontlines of this battle have placed even further pressure on these scarce resources. These factors contribute to increased healthcare burden for patients with NCDs as resources are repurposed for the acute problem of COVID-19 pandemic control; even worse, patients with NCDs are at greater risk of developing severe complications from a COVID-19 infection (17).

In many countries in the Sub-Saharan Africa region, patients with single or multiple NCDs have found themselves with no or unpredictable/disrupted clinic follow-up visits for the next few weeks or months (18). Drug pick-ups at some locations have become untenable or inaccessible. Routine clinic services are disrupted to focus on emergencies and the management of COVID-19 cases, and in most countries affected in the sub-region, the pandemic has led to lockdowns and movement restriction, often where a telehealth infrastructure is highly limited or non-existent (19).

These constraints, combined with an already resource-limited health system, can lead to increased morbidity and mortality for patients with NCDs in Sub-Saharan Africa. Furthermore, these constraints bring to the forefront the need to scale up health promotion efforts, specifically for the mitigation of the burden of disease of NCDs, and strengthening the continuity of care for NCDs, within the COVID-19 pandemic in Sub-Saharan Africa. It is, therefore, imperative to examine our response to the COVID-19 pandemic given this context, and to offer recommendations to mitigate the collateral problem of a 'silent' NCD pandemic.

We propose a patient-centered approach of healthcare delivery which we term modular healthcare that is premised on flexibility through modularity in sustaining health service delivery to vulnerable populations in the face of systemic disruptions such as the COVID-19 pandemic (20). This approach integrates appropriate technology, knowledge of existing supply chain networks, point of care testing, and deployment of community-based healthcare workers to ensure risk-proof service delivery.

The first component of this strategy is leveraging affordable and prevalent technology. Some interventions in this category include tele-consults (like phone consultations), telemonitoring through portable and wearable devices that can be used by the patient to measure and monitor vital signs, and

tele-pharmacy to support e-prescribing by qualified healthcare professionals (21,22).

The second component of this approach is to study and adapt existing supply routes for other products such as bottled water and soda which have established networks that already penetrate hard-to-reach geographical areas (23). This is invaluable in light of the limited transportation infrastructure and logistical challenges in many parts of Sub-Saharan Africa. This ensures services such as mobile clinics, essential medications, and home testing kits can be delivered to vulnerable populations where they live.

A third essential component is task shifting (24), which leverages less specialized health workers to deliver limited but essential services including risk communication, health education, and non-complex procedures. This is particularly important in Sub-Saharan Africa where highly skilled health professionals are in short supply (24). Finally, the political will to invest in the implementation of policies that support this framework and address behavioral risk factors for NCDs such as tobacco use and physical inactivity is important to buoy preventive efforts and ensure sustainability.

Sub-Saharan Africa is in dire need of a paradigm shift from a traditional approach of healthcare service delivery to a more innovative and robust strategy that has a better contextual fit to serve vulnerable populations such as patients with NCDs. The current COVID-19 pandemic has exposed the vulnerabilities of a traditional approach. Our proposal aims to contribute to the discourse and improve the continuity of quality care delivery to high-risk populations in the event of systemic disruptions such as an infectious disease pandemic. Given that the world is accumulating economic losses due to NCDs, and these losses could reach 75% of global GDP by 2030 (25), we hope that it will be worth considering the aforementioned recommendations in order to effectively mitigate the adverse outcomes of the future, through a strategic delivery of the interventions needed by the region that contributes a significant portion of the economic losses.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Oluwatomi Owopetu https://orcid.org/0000-0002-0921-5337

References

1. Dalal S, Beunza JJ, Volmink J, Adebamowo C, Bajunirwe F, Njelekela M, et al. Non-communicable diseases in sub-Saharan Africa: what we know now. Int J Epidemiol. 2011; 40: 885–901.
2. World Health Organization. Regional Office of Africa, Noncommunicable disease [Internet]; 2018 [cited 2020 May 1]. Available from: https://www.afro.who.int/health-topics/noncommunicable-diseases
3. World Health Organization. Non-communicable diseases; [Internet]; 2018 [cited 2020 May 4]. Available from: https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases
4. Juma PA, Mohamed SF, Matanje Mwagomba BL, Ndinda C, Mapa-Tassou C, Oluwasanu M, et al. Non-communicable disease prevention policy process in five African countries. BMC Publ Health. 2018; 18(Suppl 1): 961.
5. Shona D, Juan JB, Jimmy V, Clement A, Francis B, Marina N, et al. Non-communicable diseases in sub-Saharan Africa: what we know now. Int J Epidemiol. 2011; 40: 885–901.
6. Wang Q, Fu AZ, Brenner S, Kalmus O, Banda HT, De Allegri M. Out-of-pocket expenditure on chronic non-communicable diseases in sub-Saharan Africa: the case of rural Malawi. PLoS One. 2015; 10: 0116897.
7. Siddharthan T, Ramaiya K, Yonga G, et al. Noncommunicable diseases in East Africa: assessing the gaps in care and identifying opportunities for improvement. Health Aff (Millwood). 2015; 34: 1506–1513.
8. Singh T, Bhatnagar N, Moond GS. Lacunae in noncommunicable disease control program: need to focus on adherence issues! J Family Med Prim Care. 2017; 6: 610–615.
9. Peck R, Mghamba J, Vanobberghen F, Kavishe B, Rugarabamu V, Smeeth L, et al. Preparedness of Tanzanian health facilities for outpatient primary care of hypertension and diabetes: a cross-sectional survey. Lancet Glob Health. 2014; 2:e285–e292.
10. Soter A, Francesc Xavier G, Kathleen K, Stephen MT, Kerstin KG. Predictors of health care use by adults 50 years and over in a rural South African setting. Glob Health Action. 2014; 7: 24771.
11. Optimizing HIV, Tb & NCD Treatment in Five Sub-Saharan Africa Countries Evaluation of Dgd-Funded Projects: Guinea, Kenya, Mozambique, South Africa and Zimbabwe (2014-2016) by Stockholm Evaluation Unit [Internet]; 2018 [cited 2020 May 4]. Available from: http://evaluation.msf.org/sites/evaluation/files/attachments/seu_final_report_dgd_2017_final.pdf

12. Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU). [Internet]; ArcGIS website. 2020 [cited 2020 May 4]. Available from: https://gisanddata.maps.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6
13. Deaton AS, Tortora R. People in sub-Saharan Africa rate their health and health care among the lowest in the world. Health Aff (Project Hope). 2015; 34: 519–527.
14. Mennechet FJD, Dzomo GRT. Coping with COVID-19 in Sub-Saharan Africa: what might the future hold? Virol Sin. Epub ahead of print September 2020. DOI: 10.1007/s12250-020-00279-2.
15. WHO concerned as COVID-19 cases accelerate in Africa [Internet]. World Health Organization Regional Office for Africa website. 2020 [cited 2020 April 4]. Available from: https://www.afro.who.int/news/who-concerned-covid-19-cases-accelerate-africa
16. Fisher D, Heymann D. Q&A: the novel coronavirus outbreak causing COVID-19. BMC Med. 2020; 18: 57.
17. World Health Organization. Information Note. COVID-19 and NCDs. 2020 [cited 2020 April 3]. Available from: https://www.who.int/publications/m/item/covid-19-and-ncds
18. Akande OW, Akande TM. COVID-19 pandemic: a global health burden. Niger Postgrad Med J. 2020; 27: 147–155.
19. Wamala DS, Augustine K. A meta-analysis of telemedicine success in Africa. J Pathol Inform. 2013; 4: 6.
20. World Health Organization Releases Guidelines to Help Countries Maintain Essential Services during COVID-19 Pandemic [Internet]; 2020 [cited 2020 May 4]. Available from: https://www.who.int/news-room/detail/30-03-2020-who-releases-guidelines-to-help-countries-maintain-essential-health-services-during-the-covid-19-pandemic
21. Chauhan V, Galwankar S, Arquilla B, Garg M, Somma SD, El-Menyar A, et al. Novel Coronavirus (COVID-19): leveraging telemedicine to optimize care while minimizing exposures and viral transmission. J Emerg Trauma Shock. 2020; 13: 20–24.
22. Kamel MI. A view of the health services after COVID-19: an Egyptian perspective. Alexandria J Med. 2020; 56: 118–129.
23. Demetris V, Iain S. The strategic positioning of Coca-Cola in their global marketing operation. Mark Rev. 2003; 3: 289–309.
24. Joshi R, Alim M, Kengne AP, Jan S, Maulik PK, Peiris D, et al. Task shifting for non-communicable disease management in low and middle-income countries–a systematic review. PLoS One. 2014; 9: e103754.
25. Bloom D, Cafiero E, Jané-Llopis E, Abrahams-Gessel S, Bloom LR, Fathima S, et al. The Global Economic Burden of Non-communicable Diseases. Report, Harvard School of Public Health, 2011.

COVID-19, promotion and provision of palliative care: reaching out, accounting for linguistic diversity

Bilkis Vissandjée[1,2], Isabel Fernandez[1], Patrick Durivage[3], Zelda Freitas[3], Paule Savignac[4] and Isabelle Van Pevenage[3]

Abstract: The combined forces of economic globalization and international migration have resulted in specific challenges to palliative care systems. The COVID-19 pandemic has and is still greatly affecting elder populations as well as those across the age continuum living with long-standing chronic conditions or with pre-existing diverse unmet needs. While health promotion and palliative care may appear to be conceptually opposing fields, we argue that palliative care can and should fit under the umbrella of the health promotion continuum. This commentary seeks to discuss the importance of linguistic literacy and communication imperatives in the context of access to palliative care, given the broad, diversified and sensitive scope of care. While the pandemic has demonstrated that the public health responses of migrant host societies are deeply intertwined with policies as well as local rules and constraints, the promotion and provision of safe, timely and appropriate palliative care can be achieved through a sensitive assessment of differential contexts of diversity. The pandemic has painfully illustrated the need for a strong, respectful and equitable working partnership within the professions as well as with the civic society in order for the palliative needs of those exposed to a sustained risk not to be forgotten.

Keywords: COVID-19, linguistic diversity, palliative care, access to quality of care, communication, social determinants of health, strategies for health care providers

The combined forces of economic globalization and international migration have resulted in specific challenges to palliative care systems. These show up not only in the complexities of the rates and types of health conditions observed, but also with respect to addressing them within health care settings, which may not be adequately prepared, especially in times of crises (1). The unprecedented global crisis of the coronavirus pandemic (COVID-19) has significantly strained the health and social care systems beyond their capacity, precipitating challenges in the promotion and provision of quality palliative care (2). This worldwide pandemic has and is still greatly affecting elder populations as well as those across the age continuum living with long-standing chronic conditions or with pre-existing diverse unmet needs (2). Health promotion and palliative care may appear to be conceptually opposing fields (3). Selected critical reviews of the literature have questioned the conceptual foundations of health-promoting palliative care, proposing a separate emergence and evolution of palliative care and health promotion as distinct concerns in health care (4,5). However, we argue that palliative care can and should fit under the umbrella of the health promotion continuum.

1. School of Nursing, Université de Montréal, Montréal, Quebec, Canada.
2. SHERPA Community-based Research Centre, CIUSSS West-Central Montreal, Montréal, Quebec, Canada.
3. Centre for Research and Expertise in Social Gerontology, CIUSSS West-Central Montreal, Côte Saint-Luc, Quebec, Canada.
4. Réseau universitaire intégré de santé et de services sociaux de l'Université de Montréal, Montréal, Quebec, Canada.

Correspondence to: Bilkis Vissandjée, School of Nursing, Université de Montréal, 2375 Côte Sainte Catherine, Montréal, QC H3T 1A8, Canada. Email: bilkis.vissandjee@umontreal.ca

(This manuscript was submitted on 14 July 2020. Following blind peer review, it was accepted for publication on 6 January 2021.)

Global Health Promotion 1757-9759; Vol 28(2): 87–90; 989995 DOI: 10.1177/1757975921989995 journals.sagepub.com/home/ghp

The pandemic has exposed various and disproportionate scales of health inequities, which the World Health Organization (WHO) has defined as 'avoidable, unfair, or remediable' (6,7). It has also highlighted acute inequities in the differential allocation of opportunities, practices, resources and policies. In this regard, a number of public health institutions, at a global level, reacted swiftly to inform the public about the unfolding of the pandemic, including specific and hard-to-reach populations, in a proactive manner with information in diverse languages (2,8). The pandemic has demonstrated that the public health responses of migrant host societies are deeply intertwined with policies as well as local rules and constraints (2,6). If evidence is still needed in how well these responses are addressing the complex needs of populations living in vulnerable contexts, reaching out to them has become the utmost priority of health systems in many migrant host societies.

Addressing the needs of a diverse population requires an understanding of the dynamics and interactions which characterize one's life experiences (7,9). Intersecting social determinants of health create varying contexts of vulnerabilities for selected groups of populations (1,9). The term 'vulnerability' can hold a diversity of shapes and definitions. When it comes to cultural and linguistic diversity, stigma and inequities may arise when a person is not only unable to understand his or her rights in regards to access to health and social services, but is also unable to advocate on his or her own behalf for specific care (9,10). Linguistic barriers refer here to the inability to function throughout the health and social care systems in the official languages of immigration host societies (10).

This commentary seeks to discuss the importance of linguistic literacy and communication imperatives in the context of access to palliative care, given the broad, diversified and sensitive scope of care. Linguistic barriers represent one of the primary obstacles to accessing, understanding and receiving safe and culturally sensitive care in general.

Challenges related to access to, availability of and an adequate understanding of information related to palliative care existed long before the outbreak of COVID-19 (9,11). It is important to note that this state of affairs is not only true for those who live with linguistic challenges but as acute for a majority of the overall population. Despite the fact that the scope of palliative care has broadened in recent years in terms of the stages of the illness trajectory addressed, the increasing mix of expertise involved in the care continuum and the variety of the settings, the mere existence of this service remains an inaccessible mystery to most (11,12). Despite the fact that the promotion of palliative care through public education has been advocated for by international organizations such as the WHO, limited knowledge of palliative care regulations and policies is widespread (7,11,13). After the adoption of the Act respecting end-of-life care in Quebec (chapter S-32.0001), which came into force on December 10th, 2015, public health education on these matters remained limited (14). The Act represents the rights of people at the end of life and the organization of their care, including palliative care, continuous palliative sedation and medical assistance in dying (14). Media coverage of the Act has focused on medical assistance in dying, overshadowing the elements relating to palliative care. In fact, this continuing focus on medically assisted dying has led to misrepresentations about the continuum of palliative care services and its access for diverse populations. A similar scenario is occurring in the context of the pandemic: resources are made available piecemeal rather than according to a sustainable long-term plan, resulting in misconstructions of the nature and extent of palliative care available, delays in receiving the needed care and an inability to make informed decisions about palliative care wishes (8,15).

Navigating the complexities of a health care system — with its unending reforms and mergers, different needs and eligibility for services offered such as home care, palliative care, long-term care and support from the bereavement experience — has been reported to be a daunting experience even when linguistic barriers are not obvious (9,11). With the ever-evolving sanitary measures, palliative care is highly strained, especially with rising reports of psychological and mental health disorders within the core of the support care population within and outside the official health care system (15,16). Changes in the decision-making algorithms for admission to palliative care units and long-term care homes, as well as telemedicine consultations, have negatively affected access and the implementation of care in respect of linguistic diversity (15,17).

While investments in translating information related

to the evolving nature of sanitary measures such as hand washing were prominent during the unraveling stages of the pandemic, a widespread multi-pronged information strategy for the promotion and provision of palliative care did not occur to the same extent (6,18). It is argued here that the scope of the public health response could have benefited similar large-scale operations to bridge the growing gap in the access to linguistically appropriate information. Despite the lack of data related to the effectiveness of strategies used to promote and reach out to those in need of translation services, the early pandemic response demonstrated a capacity for such investments, resource mobilization and capacity building. In the COVID-19 pandemic context, interpreters' services had to be adjusted to accommodate the rigorous sanitary measures and visiting regulations adopted within most social and health facilities (8,18). In Quebec, the Interregional Interpreters Bank, a free of charge service to facilitate meetings with health care practitioners, attempted to offer interpretation by phone or videoconference via platforms such as Teams and Zoom (18). Yet, despite sustained efforts of this type, such services have been shown to be of limited use in addressing linguistic barriers under such circumstances (8,17). Access to the technology itself and assistance with its use quickly became a restriction to the availability of this service (17). As resources are made available using a piecemeal approach rather than a sustainable long-term plan, when it comes to addressing equity and diversity within a population, delays in understanding and receiving the needed care and inabilities to make informed decisions are greatly affected. There is a growing expectation from the civic society to address issues of equity and diversity in health promotion, public health and access to palliative care (3,5,6). The dynamics and intersections between perceived burden and ethical consequences of the pandemic in its evolving pathway have created emotionally charged contexts of interventions (6).

The pandemic has demonstrated that palliative care is not the exclusive domain of palliative care experts, whether at the local, provincial, national or global level (15,16). The response to the COVID-19 pandemic has attempted to apply the principles of diversity and inclusion, yet while the virus has affected everyone to some extent, it did not affect everyone equally (6). Given that patterns of power, privilege, and inequality affect the distribution of health services, it is more urgent than ever to invest in collaborative working relationships with multifaceted strategies to promote and provide sensitive, coherent, linguistically accessible and respectful palliative care, anchored in the specific and unique care trajectory of the individual (3,6,15).

Community-based organizations interact closely with members of the community and have a unique and important insight into differential lived challenges (19). These organizations are well positioned to develop wider outreach efforts, deliver information, advocate for the populations they serve, and use effective and adapted communication strategies for a proper understanding of palliative care, especially when information is subject to constant changes and updates — the COVID-19 pandemic being an evolving situation (19,20). The promotion and provision of safe, timely and appropriate palliative care can be achieved through a comprehensive and sensitive assessment of differential contexts of diversity and by developing a collaborative working relationship with the person and their family (7,9). The pandemic has painfully illustrated the need for a strong, respectful and equitable working partnership between professions and with the civic society in order for the palliative needs of those exposed to a sustained risk not to be forgotten (6).

But if we want to take health equity seriously, now is the time to think big. (6 p. e76[3])

Acknowledgements

The authors are grateful to M. Moldofsky for his 'holistic' proof-reading contribution of the final version.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The authors wish to acknowledge funding from Health Canada within the program related to Language-Awareness Healthcare: Challenges, Opportunities and Horizons 2019-2020 - HCALM (Health Care Access for Linguistic Minorities) Network. Project number: McGill University, # 1819-HQ-000019.

ORCID iD

Bilkis Vissandjée https://orcid.org/0000-0002-7064-0666

References

1. Wakefield MK. Nurse leadership in global health: new opportunities, important priorities. Int J Nurs Sc. 2018; 5: 6–9.
2. Arya A, Buchman S, Gagnon B, Downar J. Pandemic palliative care: beyond ventilators and saving lives. Can Med Assoc J. 2020; 195: E400–E404.
3. Rosenberg JP, Yates P. Health promotion in palliative care: the case for conceptual congruence. Crit Public Health. 2010; 20: 201–210.
4. Abu-Odah H, Molassiotis A, Lui J. Challenges on the provision of palliative care for patients with cancer in low- and middle-income countries: a systematic review of reviews. BMC Pall Care. 2020; 19: 55.
5. Brennan F. Palliative care as an international human right. J Pain Symptom Manage. 2007; 33: 494–499.
6. Berkowitz SA, Cené CW, Chatterjee A. Covid-19 and health equity - time to think big. N Engl J Med. 2020; 383: e76.
7. World Health Organization. Why Palliative Care is an Essential Function of Primary Health Care [Internet]. World Health Organization. 2018 [cited 2021 Feb 16]. Available from: https://apps.who.int/iris/handle/10665/328101
8. Way A, Haque R, Xie G, Gaspari F, Popovic M, Poncelas A. Rapid development of competitive translation engines for access to multilingual COVID-19 information. Informatics. 2020; 7: 19.
9. Green A, Jerzmanowska N, Thristiawati S, Green M, Lobb EA. Culturally and linguistically diverse palliative care patients' journey at the end-of-life. Palliat Support Care. 2018; 17: 1–7.
10. Green A, Jerzmanowska N, Green M, Lobb EA. 'Death is difficult in any language': a qualitative study of palliative care professionals' experiences when providing end-of-life care to patients from culturally and linguistically diverse backgrounds. Palliat Med. 2018; 32: 1419–1427.
11. Hawley P. Barriers to access to palliative care. Palliat Care. 2017; 10: 1–6.
12. Peled Y. Language barriers and epistemic injustice in healthcare settings. Bioethics. 2018; 32: 360–367.
13. De Lima L, Pastrana T. Opportunities for palliative care in public health. Annu Rev Publi Health. 2016; 37: 357–374.
14. LégisQuébec Act respecting end-of-life care. S-32.0001 (Dec 10, 2015).
15. Etkind SN, Bone AE, Lovell N, Cripps RL, Harding R, Higginson IJ, et al. The role and response of palliative care and hospice services in epidemics and pandemics: a rapid review to inform practice during the COVID-19 pandemic. J Pain Symptom Manage. 2020; 60: e31–e40.
16. Fusi Schmidhauser T, Preston NJ, Keller N, Gamondi C. Conservative management of COVID-19 patients - emergency palliative care in action. J Pain Symptom Manage. 2020; 60: e27–e30.
17. Ritchey KC, Foy A, McArdel E, Gruenewald DA. Reinventing palliative care delivery in the era of COVID-19: how telemedicine can support end of life care. Am J Hosp Palliat Care. 2020; 37: 992–997.
18. Gouvernement du Québec. Banque d'interprètes de la Capitale-Nationale: Services offerts pendant la pandémie de la COVID-19 [Internet]. 2020 [cited 2021 Feb 16]. Available from: https://www.ciusss-capitalenationale.gouv.qc.ca/services/bicn
19. Wilson MG, Lavis JN, Guta A. Community-based organizations in the health sector: a scoping review. Health Res Policy Syst. 2012; 10: 36.
20. Pritchard YV, Shaw A. 5 Ways NGOs are Working with Local Partners to Respond to COVID-19 [Internet]. 2020 [cited 2021 Feb 16]. Available from: https://www.bond.org.uk/news/2020/04/5-ways-ngos-are-working-with-local-partners-to-respond-to-covid-19

Abstracts

Development and assessment of the usefulness, usability and acceptability of educational resources produced in response to the COVID-19 crisis

N. Tessier, N. O'Callaghan, C. Fernandez Da Rocha Puleoto and D. Jourdan

Education is one of the main determinants of health. However, the health crisis has led to 90% of the world's student population, or 1.57 billion children and young people in 190 countries, being deprived of school. The consequences of school closures on learning and health are well established. The impact of confinement on the health of children and youth is greater than that of other age groups because peer interaction is an essential aspect of development. In addition, the consequences of closing schools are all the more important as the students are more socially vulnerable. The health promotion framework 'Succeed, be well, be together' is a process of co-construction of pedagogical tools in health education that takes into account cultural diversity, is based on existing practices, and shares them and enriches them with research contributions (design process continued in use). It was activated to develop with the actors, in a very short period of time, a set of tools for primary schools in order to ensure pedagogical continuity during the crisis. The evaluation of these tools with professionals in activity and in training (n = 50) shows that they have good usability with reference to existing classroom practices (score of 8.2 out of 10) and to the needs of students (score of 8 out of 10), usefulness for the development of skills and knowledge in health education (score of 8.4 out of 10), acceptability with regard to educational approaches, contextualized materials and their implementation (score 8.3 out of 10). This study shows that health promotion as an approach is likely to provide a framework for the development of appropriate intervention tools in times of health crisis. (Global Health Promotion, 2021; 28(2): 96–104)

Challenges and lessons for health promotion during the COVID-19 pandemic in Chile: a collective health analysis of local experiences

M.S. Anigstein, S. Burgos, S.M. Gay, K. Pesse-Sorensen, P. Espinoza, and C. Toledo

Health promotion is an essential function of public health that has been put in tension with the COVID-19 pandemic, given that discourses and strategies based in the prevention and treatment of the disease have made invisible the living conditions and inequity that are central to health promotion. The collective health of Latin America poses practical and epistemological questions about actions taken to confront the virus in the Global South, proposing alternative focuses to the biomedical paradigm and to what is understood as health promotion.

From the perspective of collective health, health promotion's central elements are community autonomy, the importance of community knowledge, and the fomenting of collective territorial actions. This article, using a critical timeline of the pandemic in two territories, describes documented situations that provide evidence for the unfolding of essential conditions to make possible a health promotion that begins with collective health: a role for social justice in community organization, territorial perspective, and the construction of autonomous and emancipatory processes. The two cases analyzed here are of an insular territory in southern Chile and an urban community in Chile's capital, developed with the direct involvement of the researchers and a review of documents and press. Its precedents and contextualization show the concrete modalities that health promotion take during the pandemic in two contexts with diverse characteristics, allowing us to identify challenges and lift initial lessons about the development of territorially located health promotion. (Global Health Promotion, 2021; 28(2): 115–123)

Global Health Promotion 1757-9759; Vol 28(2): 91; 1015139 DOI: 10.1177/17577597211015139 journals.sagepub.com/home/ghp

Quand la réponse mondiale à la pandémie de COVID-19 se fait sans la promotion de la santé

Linda Cambon[1,2], Henri Bergeron[3], Patrick Castel[3], Valéry Ridde[4] et François Alla[1,2]

Plus d'un an après les premiers cas déclarés de COVID-19, le monde est toujours plongé dans le marasme de la pandémie. De vagues en vagues, les mesures prises pour enrayer l'épidémie se répètent, incapables d'endiguer le phénomène dans la plupart des pays. Le monde peine contre le SARS-CoV-2, son pouls battant au rythme du nombre de cas, d'hospitalisations et de décès médiatisés. Cette publicisation continue et massive des chiffres de la COVID-19 ne constitue-t-elle pas un des problèmes clefs de la politique de crise ? À rendre sans relâche saillantes et visibles ces données épidémiologiques spécifiques, le risque est pris de rendre invisibles d'autres problèmes, troubles et maladies, au moins aussi graves ; un risque d'autant plus inquiétant que la crise se chronicise.

Les politiques publiques ont mobilisé, sans toujours efficacité, les outils classiques de la réponse aux phénomènes épidémiques aigus : dépister, isoler et, désormais, vacciner. Mais la COVID-19 n'est pas qu'une épidémie, c'est une syndémie (1). Elle est asymptomatique ou peu grave pour une très large majorité de la population et ne s'aggrave qu'à la rencontre d'autres facteurs de vulnérabilité, notamment la combinaison de l'âge, de la morbidité et des conditions sociales. Elle a des effets socialement stratifiés et certaines populations, du fait de leurs conditions de vie, d'emploi et de logement, sont particulièrement vulnérables (2). En cela, les mesures universelles n'ont quasiment jamais été adaptées aux singularités des différents contextes, qu'elles soient géographiques, culturelles, politiques, etc. (3). Dans la panique, une approche totale, universelle et centralisée a été choisie presque partout dans le monde. Fermeture des lieux de vie et d'enseignement, distanciation physique, confinement généralisé. Les déterminants du vivre ensemble ont été gelés sur une très longue période pour tenter de limiter la propagation du virus et éviter la saturation hospitalière en soins intensifs.

Pour quels résultats ? La COVID-19 a fait près de 3,2 millions de morts, quasi-exclusivement âgés de plus de 65 ans et/ou déjà malades (4). Il est à ce jour difficile de savoir dans quelle mesure ce taux a pu être infléchi par les mesures décidées. Des études soulignent l'efficacité sous conditions de certaines mesures sur la propagation du virus (5), quand d'autres pointent qu'elles n'influent pas ou négativement sur le taux de mortalité en population (6). En revanche, des données sont aujourd'hui disponibles sur les conséquences de ces mesures sur la santé de la population : 100 millions de nouvelles personnes dans l'extrême pauvreté (7), doublement du taux de chômage dans les pays de l'OCDE (8), accroissement des troubles mentaux et de l'anxiété (9–12), défaut de soins pour les patients atteints de maladies chroniques et ralentissement des activités de prévention (vaccination, dépistage) (13). Pire encore est le bilan concernant les enfants : 142 millions sont plongés dans la pauvreté (14), 463 millions n'ayant pu accéder à l'enseignement à distance subiront des retards d'apprentissage (15) et des problèmes de santé subséquents (16), une aggravation des problèmes de santé mentale (17,18) avec probablement des conséquences sur la croissance et le développement des plus jeunes (19). On craint un effondrement de décennies de progrès en santé infantile, conséquence de politiques de vaccination et d'administration des soins prénataux considérablement perturbées (20, 21) et d'une malnutrition induite par les mesures (22). Enfin, les mesures de confinement ont surexposé les enfants à

1. Inserm U1218, BPH, Bordeaux, France.
2. CHU Bordeaux, France.
3. Sciences Po, CSO, CNRS, Paris, France.
4. CEPED, IRD, France et ISED/UCAD Dakar, Sénégal.

Correspondance à : Linda Cambon, Inserm U1218, BPH, Bordeaux, France. Email : linda.cambon@u-bordeaux.fr

Global Health Promotion 1757-9759; Vol 28(2): 92–95; 1015131 DOI: 10.1177/17579759211015131 journals.sagepub.com/home/ghp

la violence intrafamiliale dans un contexte d'affaiblissement des services de protection de l'enfance (23,24). Ce constat saisissant par son ampleur, sa gravité et ses victimes, les plus jeunes et les plus vulnérables, interpelle au regard des principes de bienfaisance auxquels les interventions de santé publique devraient se référer (25). Comment a-t-on pu oublier que les déterminants sociaux de la santé sont dépendants les uns des autres, que la santé s'enracine dans le fait social et que par conséquent, sur le long terme, de telles mesures ne peuvent qu'être destructrices (26)?

La réponse pourrait être assez simple : la méthode utilisée. Rappelons un fait que les acteurs de la promotion de la santé connaissent parfaitement. La santé procède d'un processus d'*empowerment*, c'est-à-dire de capacitation des individus et des groupes à agir sur les conditions sociales, économiques, politiques ou écologiques auxquelles ils sont confrontés. Dans le contexte de la COVID-19 (7), pour être en mesure d'agir, les personnes concernées doivent avoir la possibilité de participer, de s'approprier et d'ajuster la réponse. Or, dans de très nombreux pays, l'ensemble de la communication publique sur l'épidémie s'est déployé avec intensité sans engager de dialogue avec la société civile ou les professionnels en promotion de la santé. L'objectif principal a paru être celui de susciter l'adhésion aux mesures gouvernementales en centrant la communication sur la responsabilité individuelle des personnes, et en mobilisant les registres éculés de la peur et de la culpabilisation (27). Or, les sciences politiques l'ont montré depuis longtemps : ce que le gouvernant croit gagner en capacité de décision autonome par la centralisation et la monopolisation de la décision, il le perd en capacité de mise en œuvre (28). De surcroît, les limites de cette stratégie anxiogène sont connues depuis longtemps, notamment lorsqu'elle n'est pas partagée et que, par conséquent, les communautés ne peuvent jouer le rôle de modérateur, de ressource ou de soutien (29–32) : stratégies d'évitement ou de repli sur soi, anxiété et comportements défensifs, voire pathologiques liés au stress chronique induit. C'est au niveau mondial que s'observe cette combinaison délétère de « fatigue pandémique » (33), affaiblissant la population et par conséquent la lutte contre la COVID-19. Pour lutter contre ce phénomène, l'Organisation mondiale de la Santé (7) appelle pourtant à modifier la méthode autour de quatre principes : i) faciliter les réponses communautaires par l'amélioration de la qualité et de la cohérence des approches, ii) baser les actions sur la mobilisation des preuves, mais aussi sur les spécificités des contextes, les capacités, perceptions et comportements de la communauté ; iii) renforcer les capacités et les solutions locales en facilitant les aptitudes et compétences des collectifs, et l'évaluation participative des mesures, iv) privilégier la collaboration et la mobilisation des intérêts communs entre groupes, structures et territoires dans l'effort de réponse à la COVID-19. Ces quatre principes, bonnes pratiques de la promotion de la santé identifiées de longue date, renvoient directement à la nécessité de croiser les expertises, les disciplines et les secteurs. Et c'est la deuxième faiblesse de la méthode utilisée jusqu'ici.

En privilégiant une approche biomédicale où il s'agit de supprimer ou contenir un virus plutôt que d'étudier sa rencontre avec une population faisant système (34), les professionnels de la prévention et promotion de la santé, les chercheurs en sciences humaines et sociales ainsi que les citoyens ont été exclus. Or, comment embarquer des centaines de millions d'individus dans une dynamique collective qui n'en concerne directement qu'une fraction, choisir la bonne communication sur le long terme, ajuster des mesures aux territoires, aux vulnérabilités, sans les acquis de ces spécialités. Voilà 50 ans que les guides en la matière s'égrènent de chartes en chartes, de conférences de consensus en conférences de consensus, pour rappeler que « l'action coordonnée de tous les intéressés » est nécessaire car « les programmes et les stratégies de promotion de la santé doivent être adaptés aux possibilités et aux besoins locaux des pays et des régions et prendre en compte les divers systèmes sociaux, culturels et économiques » (35). Des principes endossés par la plupart des nations aujourd'hui concernées; des principes qui n'ont pas été appliqués, sans doute inconnus des gouvernants et experts mobilisés dans la gestion de cette crise.

Dans l'approche comme dans la méthode, dans ses résultats comme dans ses impacts, la gestion de la pandémie de COVID-19 ne peut qu'interpeller les professionnels de la promotion de la santé. Pourquoi ne sont-ils pas entendus ? Certes, nous nous étions préparés pour un sprint et c'est un marathon que nous vivons. Certes, le virus est agile, sournois car silencieux et opportuniste, comme toujours. Certes, les hôpitaux sont essorés par des années de réformes néolibérales. Mais si la surprise, voire la sidération, pourraient

excuser les choix initiaux des personnes au pouvoir, l'entêtement et/ou l'aveuglement quant à leurs conséquences ne sont pas permis. Continuer de sacrifier, au nom de l'universalité des mesures, de nombreux segments de la population alors que des mesures proportionnées à la vulnérabilité des territoires et des personnes pourraient être mises en place n'est pas et plus permis. Si la mission de plaidoyer est centrale à la promotion de la santé, elle n'a jamais été aussi importante qu'aujourd'hui où le monde trébuche sur le SARS-CoV-2, générant de multiples fractures sociales, territoriales, générationnelles et communautaires, et où l'expertise jusqu'ici mobilisée prend conscience de ses limites (36).

Références

1. Horton R. Offline: COVID-19 is not a pandemic. Lancet. 2020; 396: 874.
2. Bambra C, Riordan R, Ford J, Matthews F. The COVID-19 pandemic and health inequalities. J Epidemiol Community Health. 2020; 74: 964–968.
3. Damme WV, Dahake R, Delamou A, Ingelbeen B, Wouters E, Vanham G, et al. The COVID-19 pandemic: diverse contexts; different epidemics—how and why? BMJ Glob Health. 2020; 5: e003098.
4. Omori R, Matsuyama R, Nakata Y. The age distribution of mortality from novel coronavirus disease (COVID-19) suggests no large difference of susceptibility by age. Sci Rep. 6 oct 2020;10(1):16642.
5. Haug N, Geyrhofer L, Londei A, Dervic E, Desvars-Larrive A, Loreto V, et al. Ranking the effectiveness of worldwide COVID-19 government interventions. Nat Hum Behav. 2020; 4: 1303–1312.
6. Rice K, Wynne B, Martin V, Ackland GJ. Effect of school closures on mortality from coronavirus disease 2019: old and new predictions. BMJ. 2020; 371: m3588.
7. COVID-19 global risk communication and community engagement strategy [Internet]. [cité le 9 février 2021]. Disponible sur: https://www.unicef.org/documents/covid-19-global-risk-communication-and-community-engagement-strategy
8. OECD Employment Outlook 2020 | Facing the jobs crisis [Internet]. OECD. [cité le 9 février 2021]. Disponible sur: http://www.oecd.org/employment-outlook/2020
9. Vindegaard N, Benros ME. COVID-19 pandemic and mental health consequences: systematic review of the current evidence. Brain Behav Immun. 2020; 89: 531–542.
10. Globalization and Health. Full Text [Internet]. Prevalence of stress, anxiety, depression among the general population during the COVID-19 pandemic: a systematic review and meta-analysis. [cité le 9 février 2021]. Disponible sur: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-020-00589-w?fbclid=IwAR1IsBbTX9f8g1bMRjVR2hoscN6QQEGuPK0IQNaqBht80gi0hQ_9KtuAXTA
11. Krishnamoorthy Y, Nagarajan R, Saya GK, Menon V. Prevalence of psychological morbidities among general population, healthcare workers and COVID-19 patients amidst the COVID-19 pandemic: a systematic review and meta-analysis. Psychiatry Res. 2020; 293: 113382.
12. Serafini G, Parmigiani B, Amerio A, Aguglia A, Sher L, Amore M. The psychological impact of COVID-19 on the mental health in the general population. QJM Int J Med. 2020; 113: 531–537.
13. Rapid assessment of service delivery for NCDs during the COVID-19 pandemic [Internet]. [cité le 9 février 2021]. Disponible sur: https://www.who.int/publications/m/item/rapid-assessment-of-service-delivery-for-ncds-during-the-covid-19-pandemic
14. UNICEF DATA. Children in monetary poor households and COVID-19 [Internet]. 2020. [cité le 9 février 2021]. Disponible sur: https://data.unicef.org/resources/children-in-monetary-poor-households-and-covid-19/
15. UNICEF DATA. Impact of COVID-19 on multi-dimensional child poverty [Internet]. 2020 [cité le 9 février 2021]. Disponible sur: https://data.unicef.org/resources/impact-of-covid-19-on-multidimensional-child-poverty/
16. Christakis DA, Van Cleve W, Zimmerman FJ. Estimation of US children's educational attainment and years of life lost associated with primary school closures during the coronavirus disease 2019 pandemic. JAMA Netw Open. 2020; 3: e2028786.
17. Golberstein E, Wen H, Miller BF. Coronavirus disease 2019 (COVID-19) and mental health for children and adolescents. JAMA Pediatr. 2020; 174: 819.
18. Phelps C, Sperry LL. Children and the COVID-19 pandemic. Psychol Trauma Theory Res Pract Policy. 2020; 12(S1): S73–S75.
19. Araújo LA de, Veloso CF, Souza M de C, Azevedo JMC de, Tarro G. The potential impact of the COVID-19 pandemic on child growth and development: a systematic review. J Pediatr. Epub ahead of print September 2020. DOI: 10.1016/j.jped.2020.08.008.
20. Roberton T, Carter ED, Chou VB, Stegmuller AR, Jackson BD, Tam Y, et al. Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study Lancet Glob Health. 2020; 8: e901–e908.
21. Worldwide measles deaths climb 50% from 2016 to 2019 claiming over 207,500 lives in 2019 [Internet]. [cité le 9 février 2021]. Disponible sur: https://www.unicef.org/press-releases/worldwide-measles-deaths-climb-50-2016-2019-claiming-over-207500-lives-2019
22. COVID-19 and maternal and child food and nutrition insecurity: a complex syndemic -Pérez-Escamilla - 2020 - Maternal & Child Nutrition - Wiley Online Library [Internet]. [cité le 9 février 2021]. Disponible sur: https://onlinelibrary.wiley.com/doi/full/10.1111/mcn.13036
23. Parental Burnout and Child Maltreatment During the COVID-19 Pandemic. SpringerLink [Internet]. [cité le

9 février 2021]. Disponible sur: https://link.springer.com/article/10.1007/s10896-020-00172-2
24. Combatting COVID-19's effect on children [Internet]. OECD. [cité le 9 février 2021]. Disponible sur: http://www.oecd.org/coronavirus/policy-responses/combatting-covid-19-s-effect-on-children-2e1f3b2f/
25. Éthique et santé publique. Enjeux, valeurs et normativité | Raymond Massé | Société, cultures et santé [Internet]. Presse de l'Université Laval. [cité le 9 février 2021]. Disponible sur: https://www.pulaval.com/produit/ethique-et-sante-publique-enjeux-valeurs-et-normativite
26. Paul E, Brown GW, Ridde V. COVID-19: time for paradigm shift in the nexus between local, national and global health. BMJ Glob Health. 2020; 5: e002622.
27. Witte K, Allen M. A meta-analysis of fear appeals: implications for effective public health campaigns. Health Educ Behav Off Publ Soc Public Health Educ. 2000; 27: 591–615.
28. Bergeron H, Borraz O, Castel P, Dedieu F. Covid-19 : une crise organisationnelle [Internet]. Presses de Sciences Po; 2020. [cité le 22 février 2021]. Disponible sur: https://www.cairn.info/covid-19-une-crise-organisationnelle–9782724626650.htm
29. Lazarus RS. Psychological Stress and the Coping Process. New York, NY, US: McGraw-Hill; 1966.
30. Wray RJ, Becker SM, Henderson N, Glik D, Jupka K, Middleton S, et al. Communicating With the Public About Emerging Health Threats: Lessons From the Pre-Event Message Development Project. Am J Public Health. 2008; 98: 2214–2222.
31. Aldao A, Dixon-Gordon KL, De Los Reyes A. Individual differences in physiological flexibility predict spontaneous avoidance. Cogn Emot. 2016; 30: 985–998.
32. Movius HL, Allen JJB. Cardiac Vagal Tone, defensiveness, and motivational style. Biol Psychol. 2005; 68: 147–162.
33. WHO Regional Office for Europe. Pandemic fatigue: reinvigorating the public to prevent COVID-19: policy considerations for Member States in the WHO European Region. 2020. [cité le 12 février 2021]. Disponible sur: https://apps.who.int/iris/handle/10665/335820
34. Rajan D, Koch K, Rohrer K, Bajnoczki C, Socha A, Voss M, et al. Governance of the Covid-19 response: a call for more inclusive and transparent decision-making. BMJ Glob Health. 2020; 5: e002655.
35. World Health Organization. Ottawa Charter for Health Promotion. Geneva: WHO; 1986.
36. Atlani-Duault L, Lina B, Chauvin F, Delfraissy J-F, Malvy D. Immune evasion means we need a new COVID-19 social contract. Lancet Public Health. 2021; 6: e199–e200.

Élaboration et évaluation de l'utilité, de l'utilisabilité et de l'acceptabilité de ressources éducatives produites en réponse à la crise de la COVID-19

Nicolas Tessier[1,2], Nathalie O'Callaghan[1,2], Carmella Fernandez Da Rocha Puleoto[1] et Didier Jourdan[1]

Résumé : L'éducation est l'un des principaux déterminants de la santé. Or, la crise sanitaire a conduit à ce que 90 % de la population étudiante mondiale, soit 1,57 milliard d'enfants et de jeunes dans 190 pays, soient privés d'école. Les conséquences de la fermeture des écoles sur les apprentissages et la santé sont bien établies. L'impact du confinement sur la santé des enfants et des jeunes est plus marqué que celui sur d'autres groupes d'âge car l'interaction entre pairs est un aspect essentiel du développement. De plus, les conséquences de la fermeture des écoles sont d'autant plus importantes que les élèves sont plus vulnérables socialement. Le dispositif de promotion de la santé « Réussir, être bien, être ensemble » est une démarche de co-contruction d'outils pédagogiques en éducation à la santé qui prend en compte la diversité culturelle, s'appuie sur les pratiques existantes, les partage et les enrichit des apports de la recherche (processus de conception continuée dans l'usage). Il a été activé pour élaborer avec les acteurs, et dans un temps très court, un ensemble d'outils à destination des écoles primaires en vue de s'assurer de la continuité pédagogique pendant la crise. L'évaluation de ces outils auprès des professionnels en activité et en formation (n = 50) montre qu'ils ont une bonne utilisabilité en référence aux pratiques de classe existantes (score de 8,2 sur 10) et aux besoins des élèves (score de 8 sur 10), une utilité pour le développement de compétences et de connaissances en éducation à la santé (score de 8,4 sur 10), une acceptabilité par rapport aux approches pédagogiques, aux supports contextualisés et à leur mise en œuvre (score de 8,3 sur 10). Cette étude montre que la promotion de la santé comme approche est susceptible d'offrir un cadre pour l'élaboration d'outils d'intervention adaptés en période de crise sanitaire.

Mots-clés : promotion de la santé, COVID-19, continuité pédagogique, participation, utilité, utilisabilité, enseignement primaire

Introduction

Agir sur les milieux de vie et développer les compétences de chacun afin de créer les conditions, pour les personnes et les communautés, de prendre en charge leur santé, telle est la finalité de la promotion de la santé (1). Comme discipline au sein de la santé publique et comme champ de pratiques, la promotion de la santé est appelée à contribuer à la mobilisation collective face à la crise de la COVID-19. Comme le souligne Stephan Van den Broucke, elle intervient en aval, en mettant l'accent sur le changement de

1. Chaire UNESCO et centre collaborateur OMS « ÉducationS & Santé », Université Clermont-Auvergne, Nouméa, Nouvelle-Calédonie
2. DENC (Direction de l'enseignement de la Nouvelle-Calédonie)

Correspondance à : Nicolas Tessier, chaire UNESCO et centre collaborateur OMS « ÉducationS & Santé », Université Clermont-Auvergne, 19 avenue Foch - Immeuble Foch, BP M2, Nouméa, 98800, Nouvelle-Calédonie. Email : nicolas.tessier@province-sud.nc

(Ce manuscrit a été soumis le 13 juillet 2020. Après évaluation par des pairs, il a été accepté pour publication le 28 janvier 2021.)

Global Health Promotion 1757-9759; Vol 28(2): 96–104; 996133 DOI: 10.1177/1757975921996133 journals.sagepub.com/home/ghp

comportement individuel et la littératie en santé, au niveau intermédiaire via des interventions touchant les organisations et les communautés, et en amont en informant les politiques touchant la population (2).

Cet article explore les potentialités de la mise en œuvre d'un dispositif de promotion de la santé en milieu scolaire visant à limiter les conséquences de la fermeture des écoles sur les élèves, en particulier les plus vulnérables d'entre eux. En effet, l'éducation est l'un des principaux déterminants de la santé. Or, la crise sanitaire a conduit à ce que 90 % de la population étudiante mondiale, soit 1,57 milliard d'enfants et de jeunes dans 190 pays, soient privés d'école (3). Les conséquences de la fermeture des écoles sur les apprentissages (4) et la santé (5) sont bien établies. L'impact du confinement sur la santé des enfants et des jeunes est plus marqué que celui sur d'autres groupes d'âge car l'interaction entre pairs est un aspect essentiel du développement. De plus, l'effet de la fermeture des écoles est d'autant plus important que les élèves sont plus vulnérables socialement (6) ou du fait de problèmes de santé (7). Des enquêtes menées auprès des enseignants ont montré que les élèves défavorisés ont appris de 25 à 50 % de moins qu'ils ne l'auraient fait en classe. La même étude montre que l'écart de réussite entre les élèves favorisés et les élèves défavorisés a triplé pendant le confinement (8).

Créer les conditions de l'apprentissage et de la socialisation à distance, renforcer le lien école-famille pendant le confinement apparaissent ainsi comme des enjeux majeurs (9).

Le dispositif de promotion de la santé « Réussir, être bien, être ensemble » (REBEE) développé en Nouvelle-Calédonie s'appuie sur la participation des acteurs de terrain de la santé et de l'éducation, un partage des savoirs entre ces différents partenaires et la recherche, un pilotage local et réactif sur la base d'une organisation fortement soutenue par le gouvernement calédonien (10). Il s'agit d'une démarche de formation, d'accompagnement et de co-contruction d'outils pédagogiques en éducation à la santé qui prend en compte la diversité culturelle, s'appuie sur les pratiques existantes, les partage et les enrichit des apports de la recherche (processus de conception continuée dans l'usage). Il a été activé pour co-élaborer avec les acteurs, et dans un temps très court, un ensemble d'outils à destination des écoles primaires en vue de s'assurer de la continuité pédagogique. Ces outils ont été partagés non seulement avec les enseignants et les parents, mais également avec les acteurs de santé à l'échelle des communautés de façon à soutenir leur utilisation sur le terrain.

Cet article vise à décrire les modalités de développement des outils d'accompagnement des écoles pendant la crise de la COVID-19 et à présenter les résultats de l'évaluation préliminaire dont ils ont été l'objet. Destinés à l'accompagnement des professionnels en exercice, mais également à la formation des futurs professionnels, ces outils ont été présentés à des enseignants sur le terrain et à des étudiants.

Après avoir présenté le contexte spécifique de la Nouvelle-Calédonie, puis les caractéristiques du dispositif de promotion de la santé REBEE, nous détaillerons les modalités d'élaboration des outils pédagogiques et décrirons les résultats de l'évaluation de l'utilité, de l'utilisabilité et de l'acceptabilité des outils.

Contexte

Le contexte néo-calédonien

Notre étude s'est déployée en Nouvelle-Calédonie, archipel français du Pacifique voisin de l'Australie et de la Nouvelle-Zélande. Sa population est de 282 200 habitants (11). Politiquement, le pays dispose d'une grande autonomie suite aux Accords de Nouméa et une répartition des compétences est mise en œuvre entre les différentes institutions du territoire (12). Très diversifié sur le plan culturel et des modes de vie sociétaux, l'archipel se caractérise par un très haut niveau d'inégalités avec, par exemple, une espérance de vie supérieure de 4 ans en province Sud par rapport aux îles Loyauté (13).

En 2016, les élus du Congrès ont adopté la Charte d'application des orientations de politique éducative de la Nouvelle-Calédonie. Cette Charte comprend un plan d'action visant à atteindre les quatre ambitions fixées par le projet éducatif de la Nouvelle-Calédonie : développer l'identité de l'école calédonienne, considérer la diversité des publics pour une école de la réussite pour tous, ancrer l'école dans son environnement pour un climat scolaire au service de l'épanouissement de l'élève, et ouvrir l'école sur la région Océanie et sur le monde (14). Fin 2018, le pays s'est doté d'un plan de santé intitulé « Do Kamo, Être épanoui » qui vise à réformer le modèle économique et la gouvernance du système de protection sociale et de santé pour la période 2018 - 2028. Ce plan s'appuie sur la prise en compte des déterminants de la santé

des populations et vise l'amélioration de la santé de tous et la réduction des inégalités de santé (15,16). Ces deux textes de référence constituent les éléments clés sur lesquels s'appuie le dispositif REBEE.

Les enseignants et la promotion de la santé à l'école primaire

Les études réalisées dans l'enseignement primaire montrent que, selon les contextes, les enseignants s'emparent différemment des problématiques de santé. Dans beaucoup de cas, ils rencontrent des difficultés (17). Ils n'accordent habituellement qu'une faible priorité à la promotion de la santé et n'ont pas toujours conscience de leur rôle en éducation à la santé (18). De multiples facteurs conditionnent à la fois le sentiment pour les enseignants d'être légitimes à éduquer à la santé et leurs pratiques dans ce domaine (19).

Selon Bryk (20), le meilleur moyen pour faire évoluer les pratiques professionnelles est d'amorcer une collaboration chercheur/enseignant le plus tôt possible dans la conception d'un outil pour connaître et mieux intégrer les habitudes professionnelles des enseignants. En effet, l'intégration de pratiques innovantes dépendraient de deux facteurs principaux : la compatibilité avec les pratiques habituelles des professeurs et l'efficience de l'intervention, c'est-à-dire du rapport entre son coût pour les enseignants et ses bénéfices (21). Des études montrent que les outils doivent (22, 23) :

- répondre aux préoccupations des enseignants et aux besoins des élèves ;
- s'intégrer sans trop de bouleversements dans les conditions d'exercice des enseignants ;
- inclure des justifications théoriques et empiriques pour en comprendre les principes.

Sur la base de ces données, le dispositif REBEE accorde ainsi une place centrale à la conception, à la formation et à l'accompagnement de l'utilisation d'outils professionnels.

Le dispositif « Réussir, être bien, être ensemble »

REBEE est un dispositif de promotion de la santé qui vise spécifiquement la co-construction d'outils pédagogiques en éducation à la santé pour l'école primaire (24). En se basant sur les travaux relatifs à la conception continuée dans l'usage, il a été lancé en 2018. Il est ancré dans une démarche de promotion de la santé à l'école (25) et est structuré autour de trois grands axes : le rapport à soi, le rapport aux autres et le rapport à l'environnement.

Ce travail a conduit à la co-production de fiches détaillées et opérationnelles destinées à tous les enseignants afin qu'ils puissent soit les utiliser en l'état, soit les adapter à leur projet de classe. Pour cela, des scenarii pédagogiques aux ressources diverses, ancrages disciplinaires multiples et aux approches pédagogiques variées sont proposés (10).

Ce dispositif s'appuie sur un pilotage partagé (direction de l'éducation et agence sanitaire) qui rend possible la participation de tous les partenaires décisionnels et acteurs du terrain. L'ensemble génère un partage des savoirs et des pratiques. Les acteurs du secteur de la santé, de par leur expertise, procurent un appui scientifique, un soutien opérationnel et des ressources pour le monde de l'éducation (2,26). L'implication du monde de l'éducation favorise les chances de réussite d'une innovation pédagogique ou de la diffusion d'un outil.

La mise en œuvre du dispositif s'est organisée en trois temps successifs.

Le premier temps (octobre 2018 à mai 2019) était la co-conception d'un premier prototype par un groupe constitué d'enseignants, de cadres de l'éducation et de professionnels de santé.

Le second temps (avril 2019 à septembre 2019) correspondait à la phase de mise en œuvre des activités du prototype dans 46 écoles de Nouvelle-Calédonie et à la formation des enseignants. Les enseignants disposaient d'éléments pour expérimenter l'outil, faire leurs propositions de séances et partager leurs retours sur celles du prototype. Pendant cette phase, ils étaient accompagnés à l'échelon local par 14 directeurs d'écoles et 3 conseillers pédagogiques.

La troisième étape (septembre 2020) prévoit la diffusion des différents outils, l'évaluation de son impact sur les compétences des élèves et l'amélioration de l'outil sur la base des contributions d'un plus grand nombre d'enseignants.

La crise sanitaire a conduit à accélérer la diffusion des fiches pour assurer la continuité pédagogique.

Le développement des outils de continuité pédagogique

En Nouvelle-Calédonie, la période de confinement total sur l'ensemble du territoire a débuté le 25 mars 2020. Le travail sur les outils de continuité pédagogique en éducation à la santé a commencé la semaine précédente, dès l'annonce du confinement. Nous avons pris en compte deux éléments qui nous apparaissaient cruciaux : les représentations des enseignants sur l'éducation à la santé et les compétences des élèves devant être développées en période de COVID-19. Nous nous sommes appuyés sur une étude qualitative réalisée en février 2020 : nous avions interrogé en présentiel via un entretien semi-guidé 17 enseignants répartis sur l'ensemble du territoire et exerçant dans différents milieux (urbain aisé, urbain défavorisé, urbain mixte, village, tribu) afin d'identifier leurs représentations de l'éducation à la santé et leurs pratiques de classe. Leurs réponses ont orienté la définition des contenus proposés lors de la continuité pédagogique. Nous avons ensuite mobilisé les acteurs du dispositif REBEE. Un travail collectif a été engagé de façon à identifier, parmi les ressources déjà élaborées dans le cadre de ce dispositif, des supports permettant aux enseignants et aux familles d'aborder les problématiques suivantes en période de pandémie et de confinement : éviter la propagation des virus, gérer ses émotions et son bien-être, construire un esprit critique face aux informations. D'autres ressources ont été identifiées et mises à disposition. Un site internet (27) a été créé et est accessible via le site Internet de la Direction de l'Enseignement de la Nouvelle-Calédonie (DENC). Ce site dédié regroupe 36 fiches destinées aux éducateurs des enfants entre 6 et 11 ans (parents, enseignants et professionnels de la santé intervenant dans les écoles) avec pour objectif de leur permettre d'aborder les thématiques de santé suivantes : microbes et gestes d'hygiène, bien-être et connaissance de soi, médias et information, santé et attitude. En ce qui concerne les parents, c'est l'enseignant, dans le cadre de sa progression, qui les invite à travailler telle ou telle fiche à la maison. Différentes solutions ont été expérimentées pour permettre aux gens sans connexion Internet d'accéder aux ressources : permanence dans les écoles, distribution des activités sous format papier ou sur clé USB dans le respect des gestes barrières par les enseignants, ou les gendarmes pour les lieux isolés.

Toutes les fiches proposées étaient construites selon un modèle identique afin de favoriser leur utilisation. Le recto, destiné à la classe, aux élèves, supportant essentiellement un ou plusieurs documents iconographiques (photo, dessin, reproduction d'affiches, texte). Le verso, destiné à l'enseignant et aux parents, présente la trame de l'exploitation pédagogique du document iconographique. En fonction de l'intention pédagogique, chaque fiche pouvait être téléchargée indépendamment. Ces ressources sont complétées par des vidéos de personnels de la santé et de l'éducation qui proposent aux enseignants et aux familles des éléments sur leur utilisation.

Fin juin 2020 le site avait accueilli 1900 visiteurs différents pour 16 000 pages consultées. Les fiches les plus téléchargées sont celles relatives aux microbes, au lavage des mains et à l'eau. Les visites d'une durée supérieure à 30 minutes représentent 17,3 %, 31,5 % et 44,8 % de l'ensemble en avril, mai et juin.

Évaluation de l'utilité, de l'utilisabilité et de l'acceptabilité des outils

Dans le but de s'assurer de la pertinence des ressources proposées, un dispositif d'évaluation a été élaboré. Cet article rend compte de la première phase de l'évaluation centrée sur l'utilité, l'utilisabilité et l'acceptabilité des outils. Une évaluation à long terme incluant l'impact sur les compétences des enfants est également en cours, ses résultats seront disponibles courant 2021.

Le questionnaire

Les outils étant destinés à la fois à des professionnels en activité et à des étudiants en formation initiale, cette évaluation a été réalisée avec des enseignants calédoniens non impliqués dans le dispositif de co-conception ainsi qu'avec des étudiants en promotion de la santé.

Cette étude qualitative est basée sur un questionnaire administré en ligne. Trente enseignants des trois provinces ont été invités par email à participer à cette évaluation. Ces enseignants ont été contactés à notre demande par les équipes de circonscriptions de l'archipel et ne constituent pas un échantillon représentatif. Le questionnaire incluait 9 questions et a été ouvert entre le 10 avril 2020 et le 27 mai 2020. Les questions portaient sur : l'adaptabilité des fiches, l'attractivité des activités,

la pertinence des scénarios pédagogiques, la nécessité d'une formation pour utiliser ces fiches, les points positifs et les points à améliorer. Pour chaque question, les enseignants se positionnaient sur une échelle de 1 à 10 et explicitaient leur positionnement par un commentaire. Cette approche mixte selon Creswell (28) permet de disposer de données qualitatives et quantitatives fournissant différents types d'informations pour prendre en compte la complexité des dispositifs (29) malgré un faible échantillon.

S'appuyant sur les travaux de Tricot (30,31) et de Goigoux (32), ce questionnaire vise à mesurer en quoi les outils répondent aux attentes des professionnels en matière de santé, en période de crise sanitaire. Les données recueillies ont été catégorisées, saisies sur des tableurs et codées pour être analysées de façon quantitative selon 3 critères différents mais complémentaires : l'utilité, l'utilisabilité et l'acceptabilité.

L'utilité a pour but de définir l'efficacité pédagogique de l'outil. Autrement dit de savoir si les activités proposées dans l'outil permettent d'atteindre l'objectif visé et si elles sont pertinentes en termes de motivation et d'apprentissages pour les élèves.

L'utilisabilité mesure la possibilité offerte à l'enseignant d'utiliser, de réutiliser l'outil dans l'état actuel, voire de le modifier ou de l'adapter à ses pratiques et/ou ses élèves.

L'acceptabilité concerne la décision d'utiliser ou non l'outil proposé. Il s'agit de mesurer si l'outil répond aux prescriptions institutionnelles, son intérêt, et la compatibilité avec ses représentations du métier en termes de styles et démarches pédagogiques.

Résultats

Cinquante personnes ont rempli le questionnaire (30 enseignants calédoniens et 20 étudiants de master première année en santé publique).

Le point de vue des enseignants

Les enseignants interrogés sont expérimentés : 80 % enseignent depuis plus de 10 ans et 20 % ont entre 5 et 10 ans d'ancienneté. Ils exercent en moyenne depuis 6,5 ans dans leur niveau d'enseignement actuel au sein de différents cycles et niveaux de l'école primaire : trois enseignants en maternelle (enfants de 3 à 6 ans), 13 enseignants en cycle 2 (enfants de 6 à 9 ans), 17 enseignants sont au cycle 3 (enfants de 9 à 11 ans) et deux enseignants exercent sur plusieurs cycles à la fois.

L'utilisabilité de l'outil est mise en avant par les enseignants. Ils déclarent que les fiches sont adaptées ou facilement adaptables à leurs pratiques de classe (score de 8,2 sur 10) ainsi qu'à leurs élèves (score de 8 sur 10). L'adaptabilité des fiches aux pratiques et aux élèves est souvent mise en avant :

> *Les documents sont suffisamment ouverts et conçus pour le cycle, ce qui nous laisse une marge d'adaptation. Ces documents sont accessibles tout en conservant une certaine résistance pour prolonger la réflexion.*
> *Le niveau de connaissances et de réflexion de mes élèves leur permettrait de participer activement à ses activités et ils seraient intéressés par les thèmes proposés. Certaines activités sont toutefois un peu difficiles pour mes élèves.*

Par ailleurs, la question autour de la nécessité d'être formé pour utiliser cet outil montre que la plupart des enseignants n'en n'éprouvent pas le besoin (4,2 sur 10). En effet, les symboles de chaque étape, leur concision en font un outil intuitif et facilement utilisable selon leurs dires (« Le déroulement des séances est très détaillé, les notions abordées sont simples et des pistes sont données aux enseignants pour se documenter. »). À noter que six enseignants mentionnent la nécessité d'une formation dans le but de favoriser une plus large diffusion de l'outil et de permettre de mieux comprendre les enjeux de l'éducation à la santé.

L'utilité des fiches est mentionnée par les enseignants pour ce qui concerne le développement de compétences et de connaissances en éducation à la santé pour leurs élèves (score de 8,4 sur 10). Les enseignants mentionnant par ailleurs que ces notions sont très peu abordées à l'école (« Permet d'aborder des notions souvent mises de côté dans les apprentissages car vu comme acquises au sein des familles comme le lavage des mains, le temps devant les écrans. »). Ces fiches pourront leur permettre également de mettre en relation les activités qu'ils mènent déjà avec les questions d'éducation à la santé. Le but étant alors de les utiliser pour approfondir certaines notions et participer ainsi de manière importante à la construction de compétences en santé.

L'aspect motivationnel leur est apparu aussi comme un vecteur important pour permettre à leurs élèves de rentrer dans les activités (score de 8,3 sur

10). Ces fiches sont jugées comme intéressantes et motivantes de par la variété des supports et la contextualisation de l'apprentissage suscitant chez les élèves curiosité et questionnement.

Enfin, l'acceptabilité de l'outil semble bonne, en particulier sur les aspects suivants :

- L'approche ludique : *« Elles abordent de façon ludique les notions en permettant aux élèves d'échanger leur point de vue et d'apprendre ensemble. » ; « Les documents proposés à l'étude sont pertinents, les activités ludiques, la construction des fiches est claire et fonctionnelle, je trouve que c'est un très bel outil. » ;*
- Une complémentarité avec les pratiques existantes due à la variété des supports et des situations : *« La pluralité des supports et les débats en fin de séances très intéressantes. » ; « Ces fiches peuvent venir en complément de ce qui est déjà mis en place dans la classe ou pour des notions qui pourraient être abordées. » ;*
- La construction des fiches : *« Ces fiches comportent plusieurs phases qui correspondent à ma pratique : un retour au calme et à la concentration, une phase de débat, des lectures ou vidéos documentaires qui pourraient être transformées en cartes mentales. » ; « Le déroulement "découverte/activité/pour aller plus loin" similaire à celui pratiqué en classe. » ;*
- La contextualisation de l'outil : *« Les activités sont contextualisées à la Calédonie et l'enfant est au centre des questions ou des activités proposées (on lui demande d'agir, de donner son avis.). »*

Le point de vue des étudiants en santé

L'utilisabilité du site et des fiches est mise en avant dans les différents retours en termes de facilité, de confort, de flexibilité et d'ajustement. En effet, les fiches proposées sur le site internet sont jugées facilement utilisables ou adaptables par le monde de la santé. L'organisation thématique du site et la description de l'ensemble des activités et des supports proposés (images, vidéos) sont très appréciées.

Le contenu des activités semble adapté aux élèves et faisable en famille dans le contexte sanitaire de la COVID-19.

En ce qui concerne l'utilité, les compétences et les connaissances ciblées en éducation à la santé dans le contexte de la COVID-19 ainsi que le choix des supports d'apprentissage sont jugés très pertinentes et en lien avec les déterminants de santé ciblés.

Par rapport à d'autres outils utilisés par le monde de la santé, des spécificités de l'outil ont également mis en avant notamment l'adaptation des fiches au contexte, la présence d'activités complémentaires permettant d'approfondir la notion, la présence d'un déroulement détaillé se rapprochant du monde de l'enseignement.

Enfin, en termes d'acceptabilité, les fiches sont majoritairement compatibles avec la vision de l'éducation à la santé qu'ont les étudiants, particulièrement en ce qui concerne le développement des compétences psychosociales. Le traitement des différents aspects de l'éducation à la santé comme étant une vision globale et pas uniquement hygiéniste est aussi un élément mis en avant.

La figure 1 récapitule les données relatives à l'utilité, à l'utilisabilité et à l'acceptabilité des outils.

Discussion

Dans le contexte de la pandémie, nous avons développé un ensemble d'outils destinés à soutenir les parents, les enseignants et les professionnels de santé travaillant au sein des communautés. L'évaluation de l'utilité, de l'utilisabilité et de l'acceptabilité des outils tant par des enseignants expérimentés que par des professionnels en formation montre que ceux-ci sont perçus comme pertinents. Cependant, la faible taille de l'échantillon nous amène à considérer les résultats comme indicatifs. De plus, cette première évaluation ne prend pas en compte l'impact sur les enfants ni le taux d'implantation de l'outil par les enseignants. Cela fera l'objet d'une autre étude dont les résultats seront disponibles courtant 2021.

Les enseignants non impliqués dans ce processus de co-construction de cet outil ont accueilli de manière positive un outil « clé en main ». Il est perçu comme utile pour aborder l'éducation à la santé ; utilisable car simple et clair ; acceptable car en lien avec les pratiques existantes et contextualisé aux problématiques de leurs classes. Cet accueil positif de l'outil peut donc permettre de penser que les enseignants pourront mieux aborder l'éducation à la santé en classe et en comprendre les enjeux pour leurs élèves, notamment en ce qui concerne la réduction des inégalités. Même si à l'heure actuelle nous ne disposons pas d'éléments pour évaluer

Questions	Moyenne formation continue	Moyenne formation initiale
Question 1 : Trouvez-vous ces fiches adaptées à vos pratiques ?	8,2	9
Question 2 : Trouvez-vous ces fiches adaptées à vos élèves ?	8	8,5
Question 3 : Trouvez-vous les activités intéressantes et motivantes pour vos élèves ?	8,3	8,9
Question 4 : Pensez-vous que ces fiches permettent à vos élèves de développer des compétences en éducation à la santé ?	8,4	9
Question 5 : Pensez-vous utiliser ces fiches ?	8,7	9,1
Question 6 : Pensez-vous que les enseignants utiliseraient facilement ces fiches ?	8,3	9
Question 7 : Pensez-vous que les activités proposées soient réalisables en famille ?	8,2	8,2

Figure 1. Moyenne des scores attribués pour chacune des questions par les enseignants en poste (formation continue) et les étudiants (formation initiale) pour l'utilité, l'utilisabilité et l'acceptabilité des outils.

l'impact de l'outil REBEE sur ces inégalités, son accueil favorable par les enseignants dans les différentes provinces de l'archipel, notamment dans les tribus les plus éloignées des centres urbains, apparaît comme un indicateur de sa cohérence culturelle et pédagogique au sein des différents espaces de Nouvelle-Calédonie. Il a donc le potentiel de contribuer au développement de connaissances et de compétences des élèves les plus vulnérables.

Il est possible d'identifier les conditions du succès d'une telle entreprise. Il s'agit d'abord du soutien politique à une telle approche intersectorielle et une gouvernance adaptée. Dans le cas du dispositif REBEE-COVID-19 :

- un soutien politique via le plan Do Kamo adopté en 2016 à l'unanimité par le congrès de la Nouvelle-Calédonie ;
- un pilotage local et réactif, réunissant la chaire UNESCO « ÉducationS & Santé » et des cadres locaux de l'éducation et de la santé ;
- une participation des acteurs de terrain de la santé et de l'éducation. Dans le contexte de la promotion de la santé, les acteurs de la santé, de par leur expertise, procurent un appui scientifique et des ressources pour le monde de l'éducation ;
- un partage des savoirs entre ces différents partenaires et la recherche.

Par ailleurs, la mise à disposition d'un outil co-conçu par la santé et l'éducation a permis de consolider le rôle de l'école dans la promotion de la santé en période de crise sanitaire. Sans l'outil REBEE-COVID-19, un message uniquement sanitaire aurait été porté par l'ensemble des institutions sanitaires et sociales du pays.

Des difficultés ont néanmoins été observées. Il s'agit tout d'abord de l'injonction hiérarchique qui a communiqué principalement en début de confinement autour de la mise en place d'activités autour du français et des mathématiques. La question de l'éducation à la santé étant alors jugée secondaire à différents niveaux alors que de nombreuses recherches évoquées précédemment ont montré un lien fort entre la santé et la réussite scolaire. Il s'agit ensuite de la difficulté à contacter les parents pendant le confinement pour diverses raisons (absence de connexion ou de matériel numérique, numéros ou adresses email non valides, impossibilité à réaliser les tâches demandées car trop complexes ou non adaptées aux élèves sans la présence de l'enseignant), ce qui n'a pas toujours permis aux enseignants de pouvoir élargir cette continuité pédagogique.

Il apparaît que la démarche conduite dans un cadre temporel très contraint a bénéficié de son insertion dans une dynamique partenariale associant l'ensemble des acteurs autour du dispositif REBEE. Le fait de pouvoir s'appuyer sur une démarche en cours de promotion de la santé a permis de produire des outils adéquats et compatibles avec les différents contextes culturels et pratiques pédagogiques en Nouvelle-Calédonie. Visée émancipatrice, ancrage dans une stratégie visant les différents déterminants de la santé, sensibilité aux enjeux culturels et territoriaux, appui et valorisation des pratiques existantes, prise en compte des données de la recherche, partage des savoirs et participation sont les constituants de l'approche mise en place.

Conflit d'intérêts

Aucun conflit d'intérêt déclaré.

Financement

Aucun financement déclaré.

ORCID iD

Nicolas Tessier https://orcid.org/0000-0001-7952-7486

Références

1. Didier J. Réinterroger et approfondir les fondements épistémologiques de la recherche en promotion de la santé, un enjeu de structuration du champ de recherche [Internet]. 2019 janv 30 [cité 13 juill 2020] ; Conférence magistrale à l'École de santé publique de l'Université de Montréal. Disponible sur : https://espum.umontreal.ca/lespum/evenements/evenement/news/eventDetail/Event/conference-de-didier-jourdan/
2. Van den Broucke S. Why health promotion matters to the COVID-19 pandemic, and vice versa. Health Promot Int. 2020; 35: 181–186.
3. Education: From disruption to recovery [Internet]. UNESCO. 2020 [cité 13 juill 2020]. Disponible sur: https://en.unesco.org/covid19/educationresponse
4. Megan K. The learning curve Revisiting the assumption of l.pdf [Internet]. [cité 13 juill 2020]. Disponible sur : https://www.nwea.org/content/uploads/2020/05/Collaborative-Brief_Covid19-Slide-APR20.pdf
5. Orben A, Tomova L, Blakemore S-J. The effects of social deprivation on adolescent de.pdf [Internet]. [cité 13 juill 2020]. Disponible sur : https://www.thelancet.com/action/showPdf?pii=S2352-4642%2820%2930186-3
6. Kim JS, Quinn DM. The effects of summer reading on low-income children's literacy achievement from kindergarten to grade 8: a meta-analysis of classroom and home interventions. Rev Educ Res. 2013; 83: 386–431.
7. Jourdan D, Gray N, Laporte R. Comment organiser le retour des élèves atteints de maladies chroniques ? [Internet]. The Conversation. [cité 13 juill 2020]. Disponible sur : http://theconversation.com/comment-organiser-le-retour-des-eleves-atteints-de-maladies-chroniques-139327
8. Baker J. Students « need $1.1 billion to close remote-learning gap » [Internet]. The Sydney Morning Herald. 2020 [cité 13 juill 2020]. Disponible sur : https://www.smh.com.au/national/students-need-1-1-billion-to-close-remote-learning-gap-20200612-p5525e.html
9. Jourdan D, Marmot M, Gray N. Coronavirus: there is an urgent need to re-open schools – this is how to make it happen [Internet]. The Conversation. [cité 13 juill 2020]. Disponible sur : http://theconversation.com/coronavirus-there-is-an-urgent-need-to-re-open-schools-this-is-how-to-make-it-happen-137818
10. Rebee and Réussir, être bien, être ensemble [Internet]. [cité 13 juill 2020]. Disponible sur : https://rebee.chaireunesco-es.org/
11. ISEE - Démographie [Internet]. [cité 13 juill 2020]. Disponible sur : https://www.isee.nc/population/demographie
12. Les accords de Nouméa [Internet]. 1998. Disponible sur : https://www.ac-noumea.nc/IMG/pdf/accordsNoumea.pdf
13. Situation sanitaire en Nouvelle-Calédonie [Internet]. DASS - Direction des Affaires Sanitaires et Sociales ; 2015. Disponible sur : https://dass.gouv.nc/file/942/download?token=JJTFZ8PJ
14. Gouvernement de la Nouvelle-Calédonie. Charte d'application des orientations de politique éducative de la Nouvelle-Calédonie. Délibration n°186 déc 1, 2016.
15. Congrès de la Nouvelle-Calédonie. Délibération n°114. Mars 24, 2016.
16. synthese_du_plan_dactions_do_kamo.pdf [Internet]. [cité 13 juill 2020]. Disponible sur : https://gouv.nc/sites/default/files/atoms/files/synthese_du_plan_dactions_do_kamo.pdf
17. Simar C, Jourdan D. Éducation à la santé à l'école : étude des déterminants des pratiques des enseignants du premier degré. Rev Sci L'éducation. 2011; 36: 739–760.
18. Pommier J, Guével M-R, Jourdan D. Evaluation of health promotion in schools: a realistic evaluation approach using mixed methods. BMC Public Health. 2010; 10: 43.
19. Violon N, Jourdan D, Darlington E, Salabot L, Charron A, Pironom J, et al. Analyse des déterminants de l'implantation d'un dispositif de promotion de la santé dans différents contextes scolaires. Éducation Santé Sociétés. 2016; 2: 17–42.
20. Bryk AS. Accélérer la manière dont nous apprenons à améliorer. Éducation Didact. 2017; 11: 11–29.
21. Cèbe S, Goigoux R. Lutter contre les inégalités : outiller pour former les enseignants. Rech Form. 2018; 87: 77–96.

22. Vinatier I, Rinaudo J-L. Rencontres entre chercheurs et praticiens : quels enjeux ? [Internet]. Armand Colin; 2015 [cité 14 avr 2020]. (Carrefours de l'éducation). Disponible sur : https://hal.archives-ouvertes.fr/hal-01201634
23. Perez P, Rogalski J. Interférences et conflits de schèmes dans l'usage d'outils professionnels : le cas d'un fichier cartographique de navigation. Trav Hum. 2001; 64: 145.
24. Eurisouké V, Iekawé H, Jourdan D. Renewing the intersectoral framework for Health Promotion in Schools in New Caledonia, multiculturality, equity and inclusion at the very core of the process. 2019; IUHPE, 23rd World Conference on Health Promotion.
25. St Leger L, Young I, Blanchard C, Perry M. Promoting health in schools: from evidence to action and UNESCO HIV and Health Education Clearinghouse [Internet]. [cité 13 avr 2020]. Disponible sur : https://hivhealthclearinghouse.unesco.org/library/documents/promoting-health-schools-evidence-action
26. Turan-Pelletier G. Qu'attendent les acteurs de l'école en matière de santé ? Adm Educ. 2018; 157: 25–34.
27. Réussir, être bien, être ensemble and Assurer la continuité pédagogique en éducation à la santé [Internet]. [cité 13 juill 2020]. Disponible sur : https://covid19.rebee.chaireunesco-es.org/
28. Creswell JW. Research Design: Qualitative, Quantitative, and Mixed Methods Approaches. 4th ed. Thousand Oaks: SAGE Publications; 2014, 273 p.
29. Guével M-R, Pommier J, Jourdan D. Évaluation d'un dispositif de formation et d'accompagnement en promotion de la santé dans les écoles primaires françaises : implications pour la pratique. Glob Health Promot. 2013; 20(2_Suppl): 13–19.
30. Tricot A, de Midi-Pyrénées I, Lafontaine J. Une méthode pour évaluer conjointement l'utilisation un outil multimédia et l'apprentissage réalisé avec celui-ci. 2002; 17.
31. Tricot A, Plégat-Soutjis F, Camps J-F, Amiel A, Lutz G, Morcillo A. Utilité, utilisabilité, acceptabilité : interpréter les relations entre trois dimensions de l'évaluation des EIAH. 13.
32. Goigoux R. Associer chercheurs et praticiens à la conception d'outils didactiques ou de dispositifs innovants pour améliorer l'enseignement. Éducation Didact. 2017; 11: 8.

Résumés

« Retour à un mieux » : accroître l'équité en santé et les perspectives des déterminants de la santé durant la pandémie de COVID-19

Sume Ndumbe-Eyoh, Pemma Muzumdar, Claire Betker et Diane Oickle

Introduction : L'équité et la justice sociale ont longtemps été des principes fondamentaux des pratiques, des politiques et de la recherche en promotion de la santé. La promotion de la santé met en avant la pertinence de la vie sociale, économique, culturelle, politique et spirituelle pour créer et maintenir la santé. Cela nécessite une perspective structurelle critique des déterminants de la santé qui implique activement les expériences de santé et de bien-être des diverses populations. Les impacts inéquitables des pandémies sont bien documentés, de même que les appels pour de meilleures réponses à ces pandémies. Cependant, la pandémie actuelle et les plans de préparation aux situations d'urgence ne tiennent pas suffisamment compte des déterminants sociaux et structurels de la santé et de l'équité en santé.
Méthodes : À travers cinq conversations d'une heure que se sont tenues en ligne en avril 2020, nous avons impliqué 13 responsables des pratiques, des politiques, de la recherche et de la communauté au sujet des points d'intersection entre la COVID-19 et le genre, le racisme, le problème des sans-abris, la santé et les connaissances des populations autochtones, l'insécurité alimentaire des ménages, le handicap, l'éthique et les futurs équitables après la COVID-19. Nous avons mené une analyse thématique des contributions des intervenants et des participants afin d'examiner les impacts et l'influence de la COVID-19 par rapport aux déterminants structurels et sociaux de la santé. Nous avons analysé quelles politiques, pratiques et réponses accroissaient ou compromettaient l'équité et la justice sociale, et identifié les opportunités d'améliorer l'action.
Résultats : L'analyse de la pandémie de COVID-19 a mis en évidence quatre grands thèmes :

- les systèmes oppressifs et injustes, et les inégalités de santé et sociales existantes ;
- les systèmes de santé et sociaux sous contrainte et non pertinents pour l'équité ;
- les impacts disproportionnés de la COVID-19 causés par les inégalités structurelles et socioéconomiques sous-jacentes ; et
- le regain d'élan pour la mobilisation collective, les innovations politiques et la transformation sociale.

Discussion : Nous avons constaté une profonde aspiration pour une société plus juste et plus équitable dans le monde de l'après-COVID-19, une envie de « revenir à un mieux » plutôt que de « revenir à la normale ». Notre analyse démontre que l'équité n'a pas été bien intégrée dans la planification et les réponses apportées à la pandémie. Les théories des mouvements et des systèmes sociaux fournissent des éléments de compréhension concernant les manières de s'appuyer sur la mobilisation communautaire existante et les ouvertures politiques pour une transformation sociale durable. (Global Health Promotion, 2021; 28(2): 7–16)

Les ressources d'adaptation individuelles, sociales et nationales, et leurs relations avec la santé mentale et l'anxiété : une étude comparative menée en Israël, en Italie et aux Pays-Bas durant la pandémie de coronavirus

Adi Mana, Sabina Super, Claudia Sardu, Dolors Juvinya Canal, Neuman Moran et Shifra Sagy

En utilisant le modèle salutogène, nous nous sommes demandé comment les individus de différents pays faisaient face à la crise de la COVID-19 et restaient en bonne santé. Nous voulions examiner les ressources individuelles (le sens de la cohérence) de même que sociales et nationales (le soutien social, le sens de la cohérence national, et la confiance dans les institutions gouvernementales) susceptibles d'expliquer les niveaux de santé mentale et d'anxiété durant la flambée épidémique. La collecte de données a été menée au moyen d'un échantillonnage de commodité sur des plateformes en ligne à la fin du mois de mars et au début du mois d'avril 2020. Les données incluaient quatre échantillons : 640 participants israéliens (319 hommes),

Global Health Promotion 1757-9759; Vol 28(2): 105–110; 1015140 DOI: 10.1177/17577592110151 40 journals.sagepub.com/home/ghp

622 participants néerlandais (177 hommes), 924 participants italiens (338 hommes) et 489 participants espagnols (117 hommes) ; les participants étaient âgés de 18 à 88 ans. Les questionnaires incluaient des outils standard (MHC-SF, GAD-7, SOC, SONC). Plusieurs questions ont été adaptées au contexte du coronavirus et mesuraient les niveaux d'exposition à la COVID-19, la confiance vis-à-vis des institutions gouvernementales, et le soutien social. Les résultats ont confirmé de manière significative le modèle salutogène suggéré concernant la contribution aux ressources d'adaptation individuelles et nationales aux niveaux d'anxiété et à la santé mentale. Les schémas des ressources d'adaptation pour expliquer l'anxiété et la santé mentale étaient similaires dans les quatre exemples, et le SOC était le principal indicateur de ces résultats. Malgré ces similitudes, un schéma différent ainsi que des ampleurs différentes de la valeur prédictive des ressources d'adaptation ont été trouvés pour les deux réactions différentes : anxiété par rapport à santé mentale. Tandis que le SOC et les facteurs situationnels (comme la menace financière) étaient significatifs pour expliquer les niveaux d'anxiété, le SOC et les ressources nationales se sont avérés significatifs pour expliquer les niveaux de santé mentale. Les résultats soutiennent l'approche salutogène pour étudier les réactions en période de pandémie. Ils mettent également en lumière la différence entre les mesures pathogènes et salutogènes pour étudier les réactions psychologiques aux situations stressantes. (Global Health Promotion, 2021; 28(2): 17–26)

La préparation de la promotion de la santé aux situations de crise sanitaire – possibilité ou nécessité ? Études de cas et enseignements tirés de la pandémie de COVID-19 à l'échelle mondiale

Diane Levin-Zamir, Kristine Sorensen, Tin Tin Su, Tetine Sentell, Gillian Rowlands, Melanie Messer, Andrew Pleasant, Luis Saboga Nunes, Shahar Lev-Ari et Orkan Okan

La pandémie actuelle de COVID-19 a révélé les connexions manquantes entre la promotion de la santé et les politiques nationales/mondiales en matière d'urgence sanitaire. En réponse, des initiatives de promotion de la santé ont été développées et mises en place dans l'urgence à travers le monde. Une sélection d'études de cas issues de cinq pays, d'après le modèle socio-écologique de promotion de la santé, illustre les actions et les difficultés en situation réelle pour les interventions, la recherche et les politiques de promotion de la santé durant la pandémie de COVID-19. Les interventions étaient variées et concernaient les individus/familles, les organisations et les communautés, dans les domaines des soins de santé, de la santé publique, des systèmes pédagogiques et médiatiques, des milieux de vie promoteurs de santé, et des politiques. Les enseignements tirés soulignent la nécessité de mettre l'accent sur l'équité, la confiance, l'approche systémique et l'action durable dans les stratégies futures de préparation aux situations d'urgence de la promotion de la santé. Des difficultés et des opportunités sont mises en lumière concernant la nécessité d'une réponse rapide, d'une communication claire basée sur la littératie en santé, et d'une collaboration entre les pays, les disciplines, et les systèmes pédagogiques et sanitaires pour des solutions efficaces aux crises sanitaires mondiales. (Global Health Promotion, 2021; 28(2): 27–37)

Le pouvoir qui vient de l'intérieur : les femmes leaders des *favelas* de Rio de Janeiro en période de pandémie

Nilza Rogeria De Andrade Nunes

Cet article a pour but de présenter la manière dont les femmes leaders des favelas de Rio de Janeiro, au Brésil, ont été actives pour faire face aux demandes résultant de la COVID-19. Cette ville compte environ 2 millions de personnes vivant dans 763 favelas. Il n'existe aucune planification stratégique de la part du gouvernement avec des actions coordonnées liées aux spécificités de ces territoires – ce qui donne lieu à une augmentation des demandes en raison des conditions de vie et de santé de ces habitants. C'est dans cette réalité multidimensionnelle, avec des crises et des situations d'urgence, que nous soulignons le rôle de la communauté

pour renforcer les réseaux de soutien locaux qui sont tissés comme des toiles à l'intérieur de la favela et au-delà. Notre observation est basée sur une étude qualitative qui a impliqué 111 femmes réparties à travers 105 favelas. En corrélant leurs pratiques, 97 % d'entre elles ont dit soutenir la promotion de la santé en renforçant la participation populaire au développement communautaire et à la défense des droits, et la mobilisation des services de santé pour répondre aux besoins de ces populations, entre autres actions. Avec la présence d'agents publics dans ces lieux confinés en période de pandémie, ces femmes assument souvent les responsabilités des autorités locales pour assurer la sécurité alimentaire, la bonne communication auprès des habitants au sujet des normes sanitaires, des mesures d'hygiène, de l'assistance aux plus vulnérables, etc. Perçues par les membres de la communauté comme assumant les responsabilités à la place des organismes gouvernementaux, elles développent une manière particulière de faire de la politique. En appelant à la résistance et à la solidarité, elles transforment ce micro-pouvoir en changements effectifs pour faire face aux inégalités, et en bénéfices pour les citoyens et les autres habitants des favelas où elles vivent. (Global Health Promotion, 2021; 28(2): 38–45)

Des partenariats entre acteurs communautaires et acteurs de la santé pour atténuer l'impact de la pandémie de COVID-19 sur les Roms et les Gens du voyage en Irlande

Jacopo Villani, Petra Daly, Ronnie Fay, Lynsey Kavanagh, Sandra McDonagh et Nurul Amin

En Irlande, les Roms et les Gens du voyage sont deux minorités ethniques qui connaissent des niveaux élevés d'inégalités de santé. Ces communautés présentent un risque plus important de développer la COVID-19 et de souffrir de symptômes plus sévères du fait de la mauvaise qualité de leurs milieux de vie et de leurs taux plus élevés de comorbidités. Cette étude examine les stratégies adoptées par des partenariats entre acteurs communautaires et acteurs de la santé de même que par des ONG afin de minimiser l'accroissement potentiel des inégalités de santé des Roms et des Gens du voyage durant la réponse initiale à la pandémie de COVID-19 en Irlande. Une approche descriptive qualitative a été utilisée pour fournir un compte rendu détaillé de trois réponses différentes apportées par des communautés et des partenariats. Les données ont été recueillies à partir de plusieurs sources et au travers d'une participation de première main aux réponses apportées à la COVID-19. Les données ont été analysées à l'aide d'une analyse thématique. Cette étude a trouvé que les principales interventions d'atténuation de la pandémie mises en œuvre étaient des mesures de santé publique, des communications culturellement sensibles, un lobbying en faveur du changement politique, et un soutien économique et social. Ces interventions, soutenues par les stratégies de promotion de la santé que sont les partenariats, le plaidoyer et l'autonomisation, se sont avérées extrêmement importantes pour réduire les inégalités potentielles en termes d'exposition au virus et d'accès aux soins de santé. Les résultats suggèrent que des partenariats communauté-santé entre les organisations des groupes minoritaires et les professionnels des soins de santé constituent une approche viable pour réduire les effets démesurés de la pandémie sur les Roms et les Gens du voyage. (Global Health Promotion, 2021; 28(2): 46–55)

Communication affective : un examen à méthode mixte de la communication autour de l'épidémie de COVID-19 par le biais de la page Facebook du gouvernement taïwanais

Chia Yu Lien et Yun-Hsuan Wu

L'épidémie de COVID-19 a généré des difficultés sans précédents pour les gouvernements qui doivent transmettre les informations au public, et les réseaux sociaux sont devenus un moyen de communication essentiel autour de la COVID-19 à Taïwan.

Objectifs : Cette étude examine un total de 1.128 publications de la principale autorité de santé taïwanaise sur Facebook entre le 1er décembre 2019 et le 31 mai 2020.

Méthodes : En utilisant des approches à la fois qualitative et quantitative, cette étude examine les stratégies utilisées par le gouvernement taïwanais pour communiquer au sujet de l'épidémie de COVID-19, et les réponses publiques par rapport à ces stratégies.
Résultat : Des utilisations novatrices de publications Facebook pour la communication autour de l'épidémie ont été identifiées, notamment pour la solidarité, les bilans des actions, les conférences de presse, et l'utilisation d'images représentant des animaux et des personnages dessinés. Les résultats quantitatifs ont montré que le public répondait de manière significativement plus fréquente aux messages qui généraient des affects positifs, comme les publications faisant état des actions gouvernementales et des efforts publics ; les publications qui exprimaient la gratitude, l'approbation ou la camaraderie ; et les publications qui associaient du texte à des photographies de travailleurs de première ligne ou d'animaux attachants.
Conclusion : Ces résultats suggèrent le fait que, en pleine épidémie, le public ne recherche pas seulement des mises à jour sur la situation et des conseils, mais aussi des affirmations affectives de la part des organismes gouvernementaux. (Global Health Promotion, 2021; 28(2): 56–66)

Inégalités de santé et solutions technologiques durant les premières vagues de la pandémie de COVID-19 dans les pays à revenus élevés

Muriel Mac-Seing et Robson Rocha de Oliveira

La pandémie de COVID-19 a provoqué des perturbations massives en termes de santé publique et de soins de santé, de même que dans les systèmes politiques et économiques au-delà des frontières nationales, ce qui a entraîné un besoin urgent d'adaptation. Dans le monde entier, les gouvernements ont pris une série de décisions politiques pour mettre en place des mesures de prévention et de contrôle. En tant que jeunes chercheurs analysant la pandémie dans une perspective d'équité en santé, nous souhaitons partager nos réflexions sur cette crise en évolution, en particulier : (a) les faibles intersections entre les réponses à la pandémie et les priorités de santé publique ; (b) l'exacerbation des inégalités de santé que connaissent les populations vulnérables suite à des décisions prises au niveau national et mondial ; et (c) les impacts des solutions technologiques mises en avant pour aborder la crise. Des exemples issus de pays à revenus élevés sont fournis à l'appui de nos trois problématiques. (Global Health Promotion, 2021; 28(2): 67–71)

Des approches transdisciplinaires peuvent-elles contribuer à la lutte contre la COVID-19 ?

Dilek Aslan

Le nouveau coronavirus (COVID-19) a soulevé de nombreuses questions nécessitant des réponses pour lutter contre le fardeau de la maladie à l'échelle mondiale. L'incertitude au sujet de la COVID-19 contribue à la complexité du fardeau sur les influences sociales, économiques, culturelles et de santé de la COVID-19. Dans ce contexte, toutes les disciplines connexes travaillent ensemble à atténuer les influences négatives de la maladie. La promotion de la santé, qui est une discipline de la santé publique, a un rôle tout particulier à jouer dans cette pandémie, car elle peut aborder les menaces à différents niveaux. Les stratégies de promotion de la santé utilisent principalement des efforts axés sur les solutions avec des approches inter- et pluridisciplinaires. Cependant, comme le fardeau de la COVID-19 a de nombreux déterminants pour lesquels le temps est un facteur critique, ces approches ne peuvent être suffisantes pour résoudre le problème. Une approche transdisciplinaire dans son sens plus large, utilisant presque tous les apports pour synthétiser et produire une solution intégrative, pourrait s'avérer extrêmement utile. Dans ce commentaire, l'importance des approches transdisciplinaires en promotion de la santé pour combattre la COVID-19 a été discutée. (Global Health Promotion, 2021; 28(2): 72–77)

L'art dans les périodes critiques : réflexions issues d'une initiative de promotion de la santé basée sur l'art durant la pandémie de COVID-19

Ilhan Abdullahi, Navneet Kaur Chana, Marco Zenone et Paola Ardiles

La pandémie actuelle de COVID-19 ayant un impact sur les communautés du monde entier, diverses stratégies de promotion de la santé sont nécessaires pour relever les défis de grande envergure auxquels nous sommes confrontés. L'art est un outil très engageant qui promeut le bien-être positif et accroît l'engagement et la participation de la communauté. La campagne « Create Hope Mural » (Fresque pour créer de l'espoir) est apparue comme une réponse de promotion de la santé basée sur l'art afin de susciter le dialogue sur l'importance de l'espoir pour les Canadiens en ces temps difficiles. Cette initiative est un partenariat entre un réseau de promotion de la santé basé à Vancouver et un musée d'art « à ciel ouvert » situé à Toronto. Des familles ont été invitées à soumettre en ligne des créations artistiques représentant le concept d'espoir. Ce commentaire présente les réflexions des organisateurs de cette initiative en promotion de la santé basée sur l'art au cours des premiers mois de la pandémie au Canada. Nos résultats révèlent l'importance de décoloniser les pratiques, de centrer les voix de ceux qui sont affectés par la crise, tout en étant attentifs au contexte social et politique. Ces enseignements peuvent être adoptés par les promoteurs de santé prospectifs qui tentent d'utiliser des méthodes basées sur l'art pour aborder les inégalités sociales et de santé. (Global Health Promotion, 2021; 28(2): 78–82)

COVID-19 : implications pour les MNT et la continuité des soins en Afrique subsaharienne

Oluwatomi Owopetu, Luther-King Fasehun et Uzoma Abakporo

En Afrique subsaharienne (ASS), on a assisté à une augmentation des maladies non transmissibles (MNT) du fait de l'occidentalisation, de l'urbanisation et des modes de vie néfastes pour la santé. La prévalence des MNT et de leurs facteurs de risque varie considérablement parmi les pays d'ASS et leurs différentes sous-populations. Une étude a documenté la prévalence des AVC, de 0,07 à 0,3 % ; du diabète sucré, de 0 à 16 % ; de l'hypertension, de 6 à 48 % ; de l'obésité, de 0,4 à 43 % ; et du tabagisme actuel, de 0,4 à 71 %. On s'attend à ce que les chiffres de ces MNT augmentent au cours de la prochaine décennie. Cependant, dans le contexte d'une pandémie mondiale telle que celle de la COVID-19, avec l'augmentation des cas, les confinements et les décès enregistrés partout dans le monde, de nombreuses personnes vivant avec des MNT peuvent rencontrer de plus grandes difficultés pour accéder aux soins. La majorité des ressources disponibles sur le sous-continent ont été réorientées pour être concentrées sur la pandémie en cours. Cela a causé des ruptures au niveau des soins, de la gestion des complications, de l'approvisionnement en médicaments, parallèlement à une épidémie silencieuse de MNT presque négligée, avec des conséquences majeures pour le système de santé après la période de la COVID-19. Nous examinons les questions qui entourent la continuité des soins et proposons quelques solutions pour l'Afrique subsaharienne. (Global Health Promotion, 2021; 28(2): 83–86)

COVID-19, promotion et prestation des soins palliatifs : atteindre, en tenant compte de la diversité linguistique

Bilkis Vissandjée, Isabel Fernandez, Patrick Durivage, Zelda Freitas, Paule Savignac et Isabelle Van Pevenage

Les forces combinées de la mondialisation économique et des migrations internationales ont donné lieu à des difficultés spécifiques pour les systèmes de soins palliatifs. La pandémie de COVID-19 a grandement affecté

et affecte toujours les populations âgées de même que celles des autres tranches d'âge qui vivent avec des affections chroniques de longue durée ou avec différents besoins préexistants non satisfaits. Si la promotion de la santé et les soins palliatifs semblent peut-être appartenir à des domaines opposés sur le plan conceptuel, nous soutenons que les soins palliatifs devraient s'inscrire dans la continuité de la promotion de la santé. Ce commentaire discute de l'importance de la littératie linguistique et des impératifs de communication dans le contexte de l'accès aux soins palliatifs, étant donné la portée large, variée et sensible de ces soins. Tandis que la pandémie a démontré que les réponses de santé publique des sociétés qui accueillent des migrants étaient profondément interconnectées avec les politiques de même qu'avec les règles et les contraintes locales, la promotion et la prestation de soins palliatifs sûrs, appropriés et en temps opportun, peuvent être atteintes à travers une évaluation sensible des contextes différentiels de diversité. La pandémie a douloureusement illustré la nécessité d'un partenariat de travail solide, respectueux et équitable au sein des professions de même qu'avec la société civile afin de ne pas oublier les besoins en soins palliatifs de ceux qui sont exposés à un risque durable. (Global Health Promotion, 2021; 28(2): 87–90)

Défis et apprentissages pour la promotion de la santé pendant la pandémie de la COVID-19 au Chili. Une analyse d'expériences locales sous l'angle de la santé collective

Maria Sol Anigstein, Soledad Burgos, Sebastián Medina Gay, Karen Pesse-Sorensen, Pamela Espinoza et Carolina Toledo

La promotion de la santé (PS) est une fonction essentielle de la santé publique mise à rude épreuve face à la pandémie de la COVID-19, étant donné que les discours et les stratégies de prévention et ceux concernant le traitement de la maladie ont rendu invisibles les conditions de vie et les inégalités qui sont au cœur de la PS. La santé collective latino-américaine pose des questions pratiques et épistémologiques sur les actions face à l'épidémie dans les pays du Sud mondial, en proposant des approches alternatives au paradigme biomédical et à ce qu'il entend par PS.

Du point de vue de la santé collective, l'autonomie des communautés, l'importance de leurs savoirs et le développement d'actions collectives territoriales sont au cœur de la PS. Cet article, à travers une chronologie critique de la pandémie dans deux territoires, décrit des situations documentées qui mettent en évidence le déploiement de conditions indispensables pour rendre possible la PS, telle que l'envisage la santé collective, c'est-à-dire le rôle de la justice sociale dans l'organisation communautaire, la perspective territoriale et les processus d'émancipation et de construction de l'autonomie. Les cas analysés concernent un territoire insulaire du sud du Chili et une commune urbaine de la capitale du pays, élaborés avec la participation directe des chercheurs et une revue documentaire et de presse. Les informations recueillies et leur contextualisation mettent en évidence les modalités concrètes que prend la PS pendant la pandémie dans deux contextes aux caractéristiques différentes, permettant d'identifier des défis et aboutissant à des premiers apprentissages sur le développement de la PS à l'échelon territorial. (Global Health Promotion, 2021; 28(2): 115–123)

Cuando la respuesta mundial a la pandemia de la COVID-19 no tiene en cuenta la promoción de la salud

Linda Cambon[1,2], Henri Bergeron[3], Patrick Castel[3], Valéry Ridde[4] y François Alla[1,2]

Más de un año después de haber declarado los primeros casos de la COVID-19, el mundo sigue sumergido en el marasmo de la pandemia. Entre olas y olas, las medidas que se han tomado para frenar la epidemia se repiten, incapaces de detener el fenómeno en la mayoría de los países. El mundo lucha contra el virus del SARS-CoV-2, su pulso late al ritmo del número de casos, de hospitalizaciones y de fallecimientos mediatizados. ¿El hecho de publicitar de forma continua y masiva las cifras de la COVID-19 no constituye uno de los problemas clave de la política de crisis? Al hacer que estos datos epidemiológicos específicos sean destacados y visibles sin descanso, se corre el riesgo de hacer invisibles otros problemas, trastornos y enfermedades, por lo menos igual de graves; un riesgo aún más preocupante cuando la crisis se hace más crónica.

Las políticas públicas han movilizado, sin gran eficacia todavía, las herramientas clásicas de la respuesta a los fenómenos epidémicos agudos: detectar, aislar y, a partir de ahora, vacunar. Pero la COVID-19 no es solo una epidemia, es una sindemia (1). Es asintomática o poco grave para una gran mayoría de la población y no se agrava sino con la asociación a otros factores de vulnerabilidad, en especial la combinación de la edad, la morbilidad y las condiciones sociales. Tiene efectos socialmente estratificados y ciertas poblaciones son particularmente vulnerables debido a sus condiciones de vida, de empleo y de habitación (2). En ese sentido, las medidas universales no fueron casi nunca adaptadas a las singularidades de los diferentes contextos, ya sean estos geográficos, culturales, políticos, etc. (3). En medio del pánico, en casi todo el mundo se eligió un enfoque total, universal y centralizado. Cierre de los lugares de encuentro y de enseñanza, distanciamiento físico, confinamiento general. Los determinantes de convivencia se congelaron durante un periodo muy largo para tratar de limitar la propagación del virus y evitar la saturación hospitalaria en cuidados intensivos.

¿Con qué resultados? La COVID-19 ha ocasionado cerca de 3,2 millones de muertes, casi exclusivamente de personas mayores de 65 años y/o ya enfermas (4). Hasta la fecha, es difícil saber en qué medida las decisiones que se tomaron pudieron influir en esta tasa. Hay estudios que subrayan la eficacia condicional de ciertas medidas sobre la propagación del virus (5), mientras que otros señalan que estas no influyen en nada o negativamente sobre la tasa de mortalidad en la población (6). En cambio, ya se dispone de datos sobre las consecuencias de estas medidas para la salud de la población: 100 millones de personas están ahora en la pobreza extrema (7), duplicación de la tasa de desempleo en los países de la OCDE (8), aumento de los problemas mentales y de ansiedad (9–12), fallas en la atención a pacientes que sufren de enfermedades crónicas y lentificación de las actividades de prevención (vacunación, detección) (13). El balance relacionado con los niños es aún peor: 142 millones están sumidos en la pobreza (14), 463 millones que no han podido acceder a la educación a distancia tendrán retrasos de aprendizaje (15) y problemas de salud subsiguientes (16), un deterioro de la salud mental (17,18) que probablemente traerá consecuencias en el crecimiento y el desarrollo de los más jóvenes (19). Se teme un colapso de décadas de progreso en la salud infantil, efecto de las políticas de vacunación y de administración de cuidados prenatales que han sido considerablemente perturbadas (20,21), así como de una malnutrición inducida por las medidas (22).

1. Inserm U1218, BPH, Bordeaux, France.
2. CHU Bordeaux, France.
3. Sciences Po, CSO, CNRS, Paris, France.
4. CEPED, IRD, France et ISED/UCAD Dakar, Sénégal.

Correspondencia a: Linda Cambon, Inserm U1218, BPH, Bordeaux, France. Email: linda.cambon@u-bordeaux.fr

Global Health Promotion 1757-9759; Vol 28(2): 111–114; 1015130 DOI: 10.1177/17577592110151 30 journals.sagepub.com/home/ghp

Finalmente, las medidas de confinamiento han sobreexpuesto a los niños a la violencia intrafamiliar en un contexto de debilitamiento de los servicios de protección de la infancia (23,24). Esta observación sobrecogedora por su magnitud, su gravedad y sus víctimas, los más jóvenes y los más vulnerables, llama la atención a la luz de los principios de beneficencia a los cuales las intervenciones de salud pública deberían referirse (25). ¿Cómo se puede olvidar que los determinantes sociales de la salud dependen unos de otros, que la salud se arraiga en el hecho social y que, por consiguiente, a largo plazo tales medidas solo pueden ser destructivas (26)?

La respuesta podría ser bien sencilla: el método utilizado. Recordemos un hecho que los actores de la promoción de la salud conocen perfectamente. La salud surge de un proceso de empoderamiento, es decir, de fortalecer la capacidad de los individuos y los grupos para actuar sobre las condiciones sociales, económicas, políticas o ecológicas a las que ellos se enfrentan. En el contexto de la COVID-19 (7), para poder actuar, las personas implicadas deben tener la posibilidad de participar, de apropiarse y de ajustar la respuesta. Sin embargo, en numerosos países, el conjunto de la comunicación pública sobre la epidemia se desplegó con intensidad sin entablar un diálogo con la sociedad civil o los profesionales de la promoción de la salud. El objetivo principal parecía ser el de suscitar la adhesión a las medidas gubernamentales, centrando la comunicación sobre la responsabilidad individual de las personas y movilizando los gastados registros del miedo y de la culpabilización (27). No obstante, la ciencia política lo ha mostrado desde hace mucho tiempo: lo que el gobernante cree ganar en capacidad de decisión autónoma, por la centralización y la monopolización de la decisión, lo pierde en capacidad de ejecución (28). Además, desde hace mucho tiempo se conocen los límites de esta táctica ansiógena, sobre todo, cuando no es comunicada y que, por tanto, las comunidades no pueden desempeñar el papel de moderador, de recurso o de apoyo (29–32): estrategias de evitación o de retraimiento, ansiedad y comportamientos defensivos, incluso patológicos, relacionados con el estrés crónico inducido. Esta nociva combinación de "fatiga pandémica" que se observa alrededor del mundo (33) debilita a la población y, por consiguiente, a la lucha contra la COVID-19. Para combatir este fenómeno, la Organización Mundial de la Salud (7) hace, sin embargo, un llamado para modificar el método en torno a cuatro principios: i) facilitar las respuestas comunitarias mediante la mejora de la calidad y la coherencia de los enfoques; ii) basar las acciones en la movilización de la evidencia, pero también en la especificidad de cada contexto, en las capacidades, percepciones y comportamientos de la comunidad; iii) fortalecer las capacidades y las soluciones locales facilitando las aptitudes y competencias de los colectivos y la evaluación participativa de las medidas; iv) privilegiar la colaboración y la movilización de los intereses comunes entre grupos, estructuras y territorios, en el esfuerzo de responder a la COVID-19. Estos cuatro principios, buenas prácticas de promoción de la salud que han sido identificadas desde hace mucho tiempo, remiten directamente a la necesidad de cruzar experticias, disciplinas y sectores. Esta es la segunda debilidad del método utilizado hasta ahora.

Al privilegiar un enfoque biomédico, donde se trata de suprimir o de contener un virus más que de estudiar su encuentro con una población que forma un sistema (34), fueron excluidos los profesionales de la prevención y la promoción de la salud, los investigadores en humanidades y ciencias sociales y los ciudadanos. Pero ¿cómo embarcar centenas de millones de individuos en una dinámica colectiva que solo concierne directamente a una fracción, elegir la buena comunicación a largo plazo, ajustar las medidas a los territorios, a las vulnerabilidades, sin los conocimientos de estas especialidades? Hace ya 50 años que los guías en la materia se engranan de cartas en cartas, de conferencias de consenso en conferencias de consenso, para recordar que "la acción coordinada de todos los interesados" es necesaria puesto que "los programas y las estrategias de promoción de la salud deben ser adaptados a las posibilidades y a las necesidades locales de los países y de las regiones y deben tener en cuenta los diversos sistemas sociales, culturales y económicos" (35). Son principios avalados por la mayoría de las naciones hoy implicadas, principios que no se han aplicado, sin duda desconocidos por los gobernantes y expertos movilizados para la gestión de esta crisis.

En el enfoque como en el método, en los resultados como en los impactos, el manejo de la pandemia de la COVID-19 solo puede llamar la atención de los profesionales de la promoción de la salud. ¿Por qué no han sido escuchados? Desde luego, estábamos preparados para un esprint y lo que estamos viviendo

es un maratón. Desde luego, el virus es ágil y traicionero, puesto que es silencioso y oportunista, como siempre. Desde luego, los hospitales se ven afectados por años de reformas neoliberales. Pero si la sorpresa, incluso el asombro, podrían justificar las decisiones iniciales de las personas en el poder, no se permiten ni la testarudez ni la ceguera en cuanto a las consecuencias de dichas elecciones. Tampoco se permite continuar sacrificando numerosos segmentos de la población en nombre de la universalidad de las medidas, mientras que se podrían poner en marcha aquellas que sean proporcionales a la vulnerabilidad de los territorios y de las personas. Si la misión de incidencia política es central para la promoción de la salud, esta no fue nunca más importante que ahora, cuando el mundo se tropieza con el SARS-CoV-2 generando múltiples fracturas sociales, territoriales, generacionales y comunitarias, donde la experticia movilizada hasta ahora toma conciencia de sus límites (36).

Referencias

1. Horton R. Offline: COVID-19 is not a pandemic. Lancet. 2020; 396: 874.
2. Bambra C, Riordan R, Ford J, Matthews F. The COVID-19 pandemic and health inequalities. J Epidemiol Community Health. 2020; 74: 964–968.
3. Damme WV, Dahake R, Delamou A, Ingelbeen B, Wouters E, Vanham G, *et al.* The COVID-19 pandemic: diverse contexts; different epidemics—how and why? BMJ Glob Health. 2020; 5: e003098.
4. Omori R, Matsuyama R, Nakata Y. The age distribution of mortality from novel coronavirus disease (COVID-19) suggests no large difference of susceptibility by age. Sci Rep. 2020; 10: 16642.
5. Haug N, Geyrhofer L, Londei A, Dervic E, Desvars-Larrive A, Loreto V, *et al.* Ranking the effectiveness of worldwide COVID-19 government interventions. Nat Hum Behav. 2020; 4: 1303–1312.
6. Rice K, Wynne B, Martin V, Ackland GJ. Effect of school closures on mortality from coronavirus disease 2019: old and new predictions. BMJ. 2020; 371: m3588.
7. COVID-19 global risk communication and community engagement strategy [Internet]. [Consultado el 9 de febrero del 2021]. Disponible en: https://www.unicef.org/documents/covid-19-global-risk-communication-and-community-engagement-strategy
8. OECD Employment Outlook 2020. Facing the jobs crisis [Internet]. OECD. [Consultado el 9 de febrero del 2021]. Disponible en: http://www.oecd.org/employment-outlook/2020
9. Vindegaard N, Benros ME. COVID-19 pandemic and mental health consequences: systematic review of the current evidence. Brain Behav Immun. 2020; 89: 531–542.
10. Globalization and Health. Full Text [Internet]. Prevalence of stress, anxiety, depression among the general population during the COVID-19 pandemic: a systematic review and meta-analysis. [Consultado el 9 de febrero del 2021]. Disponible en: https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-020-00589-w?fbclid=IwAR1IsBbTX9f8g1bMRjVR2hoscN6QQEGuPK0IQNaqBht80gi0hQ_9KtuAXTA
11. Krishnamoorthy Y, Nagarajan R, Saya GK, Menon V. Prevalence of psychological morbidities among general population, healthcare workers and COVID-19 patients amidst the COVID-19 pandemic: a systematic review and meta-analysis. Psychiatry Res. 2020; 293: 113382.
12. Serafini G, Parmigiani B, Amerio A, Aguglia A, Sher L, Amore M. The psychological impact of COVID-19 on the mental health in the general population. QJM Int J Med. 2020; 113: 531–537.
13. Rapid assessment of service delivery for NCDs during the COVID-19 pandemic [Internet]. [Consultado el 9 de febrero del 2021]. Disponible en: https://www.who.int/publications/m/item/rapid-assessment-of-service-delivery-for-ncds-during-the-covid-19-pandemic
14. UNICEF DATA. Children in monetary poor households and COVID-19 [Internet]. 2020 [Consultado el 9 de febrero del 2021]. Disponible en: https://data.unicef.org/resources/children-in-monetary-poor-households-and-covid-19/
15. UNICEF DATA. Impact of COVID-19 on multidimensional child poverty [Internet]. 2020 [Consultado el 9 de febrero del 2021]. Disponible en: https://data.unicef.org/resources/impact-of-covid-19-on-multidimensional-child-poverty/
16. Christakis DA, Van Cleve W, Zimmerman FJ. Estimation of US children's educational attainment and years of life lost associated with primary school closures during the coronavirus disease 2019 pandemic. JAMA Netw Open. 2020; 3: e2028786.
17. Golberstein E, Wen H, Miller BF. Coronavirus disease 2019 (COVID-19) and mental health for children and adolescents. JAMA Pediatr. 2020; 174: 819.
18. Phelps C, Sperry LL. Children and the COVID-19 pandemic. Psychol Trauma Theory Res Pract Policy. 2020; 12(S1): S73–S75.
19. Araújo LA de, Veloso CF, Souza M de C, Azevedo JMC de, Tarro G. The potential impact of the COVID-19 pandemic on child growth and development: a systematic review. J Pediatr. Epub ahead of print September 2020. DOI: 10.1016/j.jped.2020.08.008.
20. Roberton T, Carter ED, Chou VB, Stegmuller AR, Jackson BD, Tam Y, *et al.* Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study. Lancet Glob Health. 2020; 8: e901–e908.
21. Worldwide measles deaths climb 50% from 2016 to 2019 claiming over 207,500 lives in 2019 [Internet]. [Consultado el 9 de febrero del 2021]. Disponible en: https://www.unicef.org/press-releases/worldwide-measles-deaths-climb-50-2016-2019-claiming-over-207500-lives-2019

22. COVID-19 and maternal and child food and nutrition insecurity: a complex syndemic -Pérez-Escamilla - 2020 - Maternal & Child Nutrition - Wiley Online Library [Internet]. [Consultado el 9 de febrero del 2021]. Disponible en: https://onlinelibrary.wiley.com/doi/full/10.1111/mcn.13036
23. Parental Burnout and Child Maltreatment During the COVID-19 Pandemic. SpringerLink [Internet]. [Consultado el 9 de febrero del 2021]. Disponible en: https://link.springer.com/article/10.1007/s10896-020-00172-2
24. Combatting COVID-19's effect on children [Internet]. OECD. [Consultado el 9 de febrero del 2021]. Disponible en: http://www.oecd.org/coronavirus/policy-responses/combatting-covid-19-s-effect-on-children-2e1f3b2f/
25. Éthique et santé publique. Enjeux valeurs et normativité and Raymond Massé and Société cultures et santé [Internet]. Presse de l'Université Laval. [Consultado el 9 de febrero del 2021]. Disponible en: https://www.pulaval.com/produit/ethique-et-sante-publique-enjeux-valeurs-et-normativite
26. Paul E, Brown GW, Ridde V. COVID-19: time for paradigm shift in the nexus between local, national and global health. BMJ Glob Health. 2020; 5: e002622.
27. Witte K, Allen M. A meta-analysis of fear appeals: implications for effective public health campaigns. Health Educ Behav Off Publ Soc Public Health Educ. 2000; 27: 591–615.
28. Bergeron H, Borraz O, Castel P, Dedieu F. Covid-19 : une crise organisationnelle [Internet]. Presses de Sciences Po; 2020. [Consultado el 22 de febrero del 2021]. Disponible en: https://www.cairn.info/covid-19-une-crise-organisationnelle–9782724626650.htm
29. Lazarus RS. Psychological Stress and the Coping Process. New York, NY: McGraw-Hill; 1966.
30. Wray RJ, Becker SM, Henderson N, Glik D, Jupka K, Middleton S, *et al.* Communicating with the public about emerging health threats: lessons from the pre-event message development project. Am J Public Health. 2008; 98: 2214–2222.
31. Aldao A, Dixon-Gordon KL, De Los Reyes A. Individual differences in physiological flexibility predict spontaneous avoidance. Cogn Emot. 2016; 30: 985–998.
32. Movius HL, Allen JJB. Cardiac Vagal Tone, defensiveness, and motivational style. Biol Psychol. 2005; 68: 147–162.
33. WHO Regional Office for Europe. Pandemic fatigue: reinvigorating the public to prevent COVID-19: policy considerations for Member States in the WHO European Region. 2020 [Consultado el 12 de febrero del 2021]; Disponible en: https://apps.who.int/iris/handle/10665/335820
34. Rajan D, Koch K, Rohrer K, Bajnoczki C, Socha A, Voss M, *et al.* Governance of the Covid-19 response: a call for more inclusive and transparent decision-making. BMJ Glob Health. 2020; 5: e002655.
35. World Health Organization. Ottawa Charter for Health Promotion. Geneva: WHO; 1986.
36. Atlani-Duault L, Lina B, Chauvin F, Delfraissy J-F, Malvy D. Immune evasion means we need a new COVID-19 social contract. Lancet Public Health. 2021; 6: e199–e200.

Desafíos y aprendizajes para la promoción de la salud durante la pandemia de la COVID-19 en Chile. Un análisis de experiencias locales desde la salud colectiva

Maria Sol Anigstein[1,2], Soledad Burgos[1], Sebastián Medina Gay[1], Karen Pesse-Sorensen[3], Pamela Espinoza[1] y Carolina Toledo[1]

Resumen:
La Promoción de la Salud (PS) es una función esencial de la salud pública que se ha puesto en tensión frente a la pandemia de la COVID-19, dado que los discursos y estrategias basados en la prevención y curación de la enfermedad han invisibilizado las condiciones de vida e inequidad que son centrales para la PS. La salud colectiva latinoamericana plantea cuestionamientos prácticos y epistemológicos sobre las acciones ante la epidemia en los países del Sur Global, proponiendo enfoques alternativos al paradigma biomédico y a lo que este entiende como PS. Desde la salud colectiva, la PS tiene como elementos centrales la autonomía de las comunidades, la importancia de sus saberes, y el fomento de acciones colectivas territoriales. Este artículo, a través de una cronología crítica de la pandemia en dos territorios, describe situaciones documentadas que ponen en evidencia el despliegue de condiciones esenciales de posibilidad para una PS desde la salud colectiva, es decir, el papel de la justicia social en la organización comunitaria, la perspectiva territorial y los procesos emancipatorios y de construcción de autonomía. Los casos analizados corresponden a un territorio insular del sur de Chile y a una comuna urbana de la capital del país, elaborados mediante el involucramiento directo de los investigadores y una revisión documental y de prensa. Sus antecedentes y contextualización evidencian las modalidades concretas que toma la PS durante la pandemia en dos contextos con características diversas, permitiendo identificar desafíos y arribar a aprendizajes iniciales sobre el desarrollo de una PS territorialmente situada.

Palabras clave: promoción de la salud, acción comunitaria, determinantes de la salud, equidad / justicia social, Latinoamérica, empoderamiento / poder

Introducción

Para la salud pública hegemónica, la PS está basada predominantemente en la educación para la salud desde un enfoque biomédico, unidireccional e individual, orientado a cambiar "estilos de vida" considerados nocivos (1). En la pandemia de la COVID-19 esto se traduce en mensajes que enfatizan la responsabilidad individual para adoptar medidas de protección, sin considerar la inequidad estructural de nuestros países del Sur Global. En consecuencia, las medidas preventivas resultan imposibles de

1. Escuela de Salud Pública Salvador Allende G, Facultad de Medicina Universidad de Chile, Santiago, Chile.
2. Departamento de Antropología, Facultad de Ciencias Sociales, Universidad de Chile, Ñuñoa, Santiago, Chile.
3. Facultad de Medicina, Pontificia Universidad Católica del Ecuador, Quito, Ecuador.

Correspondencia a: Soledad Burgos, Escuela de Salud Pública Salvador Allende G, Facultad de Medicina Universidad de Chile, Av. Independencia 939, Santiago, 1025000, Chile. Email: sburgos@uchile.cl

(Este manuscrito fue presentado el 13 de julio de 2020. Tras revisión por pares, fue aceptado para la publicación el 17 de diciembre de 2020.)

Global Health Promotion 1757-9759; Vol 28(2): 115–123; 986700 Copyright © The Author(s) 2021, Reprints and permissions: http://www.sagepub.co.uk/journalsPermissions.nav DOI: 10.1177/1757975920986700 journals.sagepub.com/home/ghp

cumplir o traen serias consecuencias en la vida de grandes segmentos de la población, además de descrédito y desconfianza respecto de la institucionalidad política y las autoridades sanitarias.

Una perspectiva alternativa de la PS es la propuesta por la salud colectiva, la cual se funda en los principios de esta vertiente crítica de la salud pública en América Latina (2–5) que cuestiona la orientación positivista, funcionalista y reduccionista del enfoque hegemónico. La salud colectiva estudia los fenómenos de salud-enfermedad-atención desde una perspectiva histórica y política, como procesos dialécticos construidos y producidos colectivamente, cuyos elementos centrales son: reproducción social, producción económica, clase social, cultura, etnia y género (3,6).

Desde la salud colectiva, la emancipación de los colectivos (7) en relación con sus territorios es el motor central para transformar las condiciones de vida y de salud (8). Dicha emancipación incluye la construcción de autonomía en la producción y uso de los conocimientos (9), así como una justicia epistémica, esto es, la posibilidad de construir y validar la diversidad de narrativas acerca de la realidad y no sólo las aceptadas por la ciencia moderna (10).

Este artículo propone una reflexión crítica sobre las condiciones de posibilidad de la PS desde la salud colectiva en pandemia, basada en la descripción cronológica de la respuesta institucional y comunitaria ante la COVID-19 en dos territorios de Chile.

Materiales y métodos

Este artículo expone la primera etapa de un estudio mayor acerca de la PS en pandemia desde la salud colectiva, que corresponde a un estudio de caso múltiple con enfoque holístico y metodología cualitativa (11). Los casos fueron seleccionados respondiendo a un criterio de conveniencia: territorios en los cuales los/as investigadores/as han desarrollado trabajo académico y de activismo antes y durante la pandemia. Considerando la diversidad territorial de Chile, se decidió seleccionar un territorio urbano y uno rural, para generar contrapuntos en la reflexión, considerando que las problemáticas, los actores y las acciones son también diversas y responden a las condiciones estructurales y de la historia de cada territorio. Se suma como criterio de selección, el ser contextos de conflictividad social y ecológica que durante la pandemia se agudizan de forma diferencial en cada territorio: en el caso de Chiloé, insularidad y extractivismo, y en el caso de la Granja, pobreza y marginación.

Como elemento base para la reflexión, se confeccionó una cronología de la pandemia en los dos territorios a partir de una metodología común: 1) revisión bibliográfica acerca de la historia, demografía y características sociosanitarias locales, sobre la base de la información pública más actualizada en los sitios webs oficiales ministeriales y de los municipios (censo, datos del Ministerio de Salud, vivienda y reportes estadísticos por comuna, entre otros); 2) revisión de artículos en prensa local y nacional, publicados en la web privilegiando medios de comunicación 'alternativos' y prensa local, dada la escasa visibilización de este tipo de acciones comunitarias en los medios de comunicación masivos; y 3) revisión de redes sociales, como Facebook, Instagram, Twitter y YouTube, que abordaban acciones sociosanitarias locales, antes y durante la pandemia, comunicaciones creadas en su mayoría por las propias organizaciones de base. Tanto para artículos de prensa local como para redes sociales, se emplearon los términos pandemia, la COVID-19 y afines; Chile, La Granja, Chiloé, con el fin de localizar notas y comunicados atingentes al período.

Esta cronología no pretende linealidad sino relevar el espacio-tiempo social, dinámico, con múltiples recorridos y momentos críticos, lo cual permite un análisis comprensivo del contexto de vida de las personas (12). Para su confección, los puntos temporales claves abarcaron desde el 18 de octubre del 2019 hasta junio del 2020.

Resultados

Breve contextualización del Chile que despertó

Chile actualmente cuenta con una población de 19,5 millones de habitantes quienes, como consecuencia de la profundización del modelo neoliberal, experimentan graves y diversas desigualdades sociales, y ocupa el tercer lugar dentro de los países de la OECD con mayor inequidad (índice Gini de 0,47) y con menor gasto en protección social (11,2% del PIB) (13). Desde octubre del 2019 ocurren masivas manifestaciones en el llamado "estallido

social" por demandas sociales acumuladas desde la dictadura de 1973-90, lo que configura un escenario clave para una posible transformación social (14). Este movimiento se extendió con diversas intensidades en los diferentes territorios del país hasta marzo del 2020, momento en el que se presentaron los primeros casos de la COVID-19. La Granja es uno de los territorios donde las organizaciones sociales se desplegaron con gran intensidad en la revuelta social; misma que llegó también al territorio insular de Chiloé, pero con otras dinámicas y expresiones.

La Granja: urbanización popular

La Granja es una comuna (municipio) del sector suroriental de la ciudad de Santiago, con una población de 116.571 habitantes. Presenta alta densidad poblacional (11.657,1 habitantes/km2) en rápido aumento por migración (15). En múltiples indicadores la comuna supera los promedios nacionales, como en el índice de pobreza multidimensional, hacinamiento, y carencia de servicios básicos (16). Está emplazada en el denominado "Cordón Industrial Santa Ana", compuesto por una minera y una curtiembre, entre otras industrias, lo que representa un foco de contaminación ambiental y riesgos para la salud que han sido denunciados en reiteradas ocasiones por los vecinos (17).

En La Granja la inequidad es visible en la segregación territorial y en un ordenamiento, infraestructura y servicios que responden a lógicas de mercado. Su poblamiento comenzó en los años 1960 con viviendas autoconstruidas sobre terrenos rurales, con apoyo de la Corporación de Vivienda o mediante "tomas" y campamentos en terrenos que habían sido entregados a las familias en la "Operación Sitio" con participación de los comités de "Los Sin Casa". Inicialmente estas viviendas no contaban con servicios básicos como: agua potable y alumbrado público; estos se obtuvieron gracias al trabajo de sus pobladores. Con el Golpe de Estado de 1973, estas poblaciones dejaron de recibir ayuda y las condiciones de vida se precarizaron (18). Durante el "estallido social" del 2019 se constituyó la Asamblea Metro La Granja, instancia de organización social local desde la cual se han realizado varias acciones vinculadas principalmente a las detenciones de manifestantes (19).

Chiloé: insularidad y extractivismos

El archipiélago de Chiloé está ubicado en la X Región de Los Lagos, en el sur de Chile. Tiene 168.185 habitantes con casi un tercio residente en zonas rurales y 34,8% que declara pertenecer al pueblo mapuche-huilliche (15). Es un territorio atravesado por tensiones sociohistóricas y políticas, principalmente en relación con el Estado centralista, el extractivismo y las migraciones desde y hacia el continente. Entre los extractivismos (forestal, minero, energético y acuícola, entre otros), la acuicultura intensiva del salmón ha estado involucrada en los procesos más críticos de transformación socioambiental de los últimos 40 años, con impactos ecológicos derivados de la sobreexplotación, mal manejo de los recursos marinos, desechos y accidentes[1] (20). En relación con estas transformaciones han emergido diversas organizaciones sociales por la defensa del territorio, de base comunitaria, ecologistas e indígenas. Estas organizaciones se abocan a la defensa del agua (21) y se movilizan por daños o amenazas inminentes al medio ambiente y a la soberanía insular, como las movilizaciones del "mayo Chilote" en el año 2016 frente a la masiva mortandad de especies marinas (22,23). Durante el "estallido social" del 2019 se conformaron asambleas ciudadanas en las principales ciudades del archipiélago (Ancud, Castro, Chonchi, Quellón) que retoman, además del rechazo al gobierno y a la clase político- partidaria nacional, estas temáticas locales (24).

Cronología de una epidemia

En Chile, el primer caso de la COVID-19 se hizo público el día 3 de marzo (25), dando lugar a una serie de reacciones en las que se percibe una respuesta pasiva y errática por parte del gobierno. Inicialmente se intentaron acallar las voces que daban importancia al brote epidémico (26). Pocos días más tarde (el 18 de marzo), siendo innegable el arribo de la pandemia y con 238 casos diagnosticados, se decretó un "estado de excepción constitucional de catástrofe" en todo el país (27). Esto incorporó a "las fuerzas armadas en el control de la pandemia" con el fin de asegurar, entre otros puntos, la "restricción de reuniones en espacios públicos". Simultáneamente se intentó dar un mensaje de tranquilidad a la ciudadanía, asegurando que el país "está preparado". Luego se

añadió un "toque de queda" nacional desde las 22:00 hasta las 5:00 horas (28). Estas decisiones y acciones carecieron de participación de la comunidad y de los equipos de atención primaria, excluidos de la estrategia de contención de la epidemia, lo que implicó que fueran ampliamente cuestionadas por la población, la cual las asoció con la represión y el control de las movilizaciones durante el estallido social (29).

La siguiente estrategia del gobierno consistió en establecer cuarentenas dinámicas; al inicio en las comunas con mayor número de casos correspondientes a sectores socioeconómicos altos y, a medida que aumentaban los casos, en los sectores más vulnerables del Gran Santiago. Sin embargo, los casos continuaron aumentando exponencialmente, develando la ineficacia de esta medida, por lo que el 13 de mayo se decretó una cuarentena total en toda la Región Metropolitana. En esta etapa se verificó un acelerado aumento en las tasas de incidencia de la COVID-19 en las comunas más vulnerables, mientras que las inicialmente afectadas, lograban controlar mejor el aumento de casos. Esta situación se asoció con factores que impiden a la población cumplir con la cuarentena: hacinamiento, pobreza y alto porcentaje de empleos informales, entre otros (30,31).

Las deficiencias o ausencias de medidas de seguridad social para responder a algunas de las consecuencias de la enfermedad y de la crisis económica generada por esta, llevaron a nuevas movilizaciones sociales en varios sectores de Santiago. Las primeras "protestas por el hambre", en la comuna de El Bosque en mayo, marcaron un importante hito (32). Al mismo tiempo, surgieron respuestas solidarias enfocadas en la sobrevivencia, entre las que se destaca la organización de ollas comunes. Estas son iniciativas colaborativas entre vecinos de las poblaciones más vulnerables y afectadas por la crisis (33). El gobierno por su parte respondió con el anuncio de entrega de cajas de mercadería (alimentos) justamente a estos grupos poblacionales (34).

En La Granja, al igual que en otros territorios urbanos, las reacciones comunitarias ante la pandemia comenzaron durante los primeros días de marzo. En contexto de alerta, la Asamblea Territorial Metro La Granja constituyó un Comité de Emergencia (CE) de la Asamblea, que posteriormente se articuló con el Movimiento Salud en Resistencia (MSR). El MSR surgió en Santiago durante el estallido social de octubre 2019 como una brigada integrada por estudiantes y trabajadores del área de la salud que otorgaba primeros auxilios, atención médica, resguardo y apoyo a heridos durante las manifestaciones. Ante la pandemia sus actividades se volcaron a apoyar acciones sanitarias autogestionadas por distintas asambleas populares en sus territorios, como una estrategia de contención comunitaria y respuesta a la política gubernamental. (35) En este contexto, se realizó un primer operativo del MSR en La Granja, en conjunto con el CE local (26 de abril de 2020). Sus acciones iniciales fueron: un "catastro epidemiológico popular" realizado por los mismos vecinos, desinfecciones de casas y ollas comunes realizadas por jóvenes que hacían parte de la denominada "primera línea" durante el estallido social, educación preventiva en salud y articulación con personal de salud. Así se comenzó a desarrollar un complejo plan territorial frente a la COVID-19 bajo el lema "solo el pueblo ayuda al pueblo" (36,37).

A través de sus redes sociales, el CE ha expresado la importancia de enfrentar en forma solidaria lo que llaman la "cuarentena de hambre" impuesta por el gobierno. En redes sociales publican que no es posible afrontar esta cuarentena "sin pensiones, sin plata, sin posibilidad de abastecerse". Hacen un llamado a la autoorganización y articulación con otras organizaciones sociales para levantar Comités de Emergencia en nuevos territorios, y resolver en forma colectiva las necesidades de salud de la población que, desde su perspectiva, ha sido abandonada por el sistema de salud público y por los municipios (38).

En Chiloé la epidemia se hizo visible en los medios locales hacia fines de marzo, con el primer caso provincial de la COVID-19 (39). La reacción inicial ante el miedo al contagio fue que las comunidades se movilizaron para exigir, a través de bloqueo de carreteras y rampas, primero el cierre y luego la instalación de un "cordón sanitario" como medida estricta de control del acceso al archipiélago. En particular, se solicitaba control en el cruce sobre el Canal de Chacao, que une la isla grande con el continente chileno a través de barcos ferry de alta frecuencia y capacidad de carga, y en otras vías de acceso a las ciudades principales y a algunas empresas (40). Si bien esta acción fue percibida como necesaria, poco tiempo después se hizo inefectiva ya

que se observaba gran circulación de vehículos con trabajadores pese a la barrera sanitaria establecida por las autoridades, situación que fue denunciada como una irregularidad en el manejo de epidemia la pandemia (41). En particular, se describe el tránsito de camiones salmoneros, miticultores, forestales y que sacan "pompón" *(Sphagnum*, musgo vital para la homeostasis hídrica del suelo), lo que corresponde a las principales actividades extractivistas del territorio (42).

De este modo, las primeras tensiones se presentaron en la relación con el empresariado salmonero, mitilicultor y transportista, y sus propuestas de acciones mitigadoras para continuar con el flujo de camiones extractivistas. Algunas de las medidas implementadas plantearon dudas sobre sus posibles efectos adversos para la salud; por ejemplo, los "túneles sanitarios" utilizados para rociar vehículos y personas, los que tuvieron que ser suspendidos por la autoridad sanitaria ante los reclamos comunitarios (43). Asimismo, se evidenciaron respuestas represivas policiales que fueron informadas en declaraciones a los medios que exponen las condiciones de vida precarias para hacer frente a la pandemia (44).

Ya avanzada la pandemia, se abrieron espacios de reflexión en los círculos comunitarios (45,46). Uno de los más relevantes, corresponde a la iniciativa de la Escuela Superior Campesina que organiza el Quelcún constituyente que, en reacción a la pandemia y la invisibilización de las organizaciones sociales (47), ha creado espacios de formación ciudadana abordando las problemáticas socioambientales más críticas en el territorio.

Reflexión y conclusiones

Siguiendo las tres condiciones esenciales de la PS desde la perspectiva de la salud colectiva, a saber: justicia social, territorio y autonomía-emancipación, es posible abordar ciertas reflexiones a modo de conclusiones.

Una primera condición es la *justicia social* como motor de las acciones comunitarias y telón de fondo que parece atravesar toda la realidad nacional, adoptando diversas formas. En algunos casos se trata de un aspecto latente y fundido con reivindicaciones territoriales y culturales que, junto con demandas sociales relativas al trabajo, también compromete demandas por justicia ambiental (como en Chiloé). En otros (como en La Granja), se reinventa para constituir un discurso en torno a la desigualdad social y la violencia de Estado (48) en clave pandemia.

Este trasfondo en que la justicia social opera como movilizador, haría parte de lo que De Souza Porto (49) ha elaborado como "crisis de las utopías sociales emancipatorias por la justicia" que tienen expresión en diferentes escalas (local, nacional, regional, planetaria) y dimensiones de justicia: social, sanitaria, ecológica y cognitiva.

La segunda condición es la perspectiva *territorial* tanto en la problematización y toma de conciencia de las condiciones estructurales e injusticias, como en las estrategias y acciones que se llevan a cabo por parte de la comunidad. Dicha dimensión permite comprender cómo el modelo de ciudad neoliberal configura, en la comuna de La Granja, espacios urbanos de sacrificio social que poseen un efecto performativo sobre los territorios y sobre los cuerpos (50). Dichos espacios se caracterizan por expresiones de degradación de las zonas urbanas, tales como empobrecimiento, hacinamiento, condiciones precarias de vivienda, dificultad de acceso a servicios y marginalidad, componentes influyentes en la determinación social de los procesos de salud y enfermedad (50). En el caso de Chiloé, el modelo de desarrollo extractivista y la condición de insularidad configura este territorio como un enclave extractivista que depende de "redes de conectores": vías de transporte libre para la salida y entrada de recursos naturales, personal, insumos, maquinaria, energía, etc. (51).

La manera en la que el modelo de desarrollo y económico configura los territorios en Chile se vincula a la vez con los tipos de respuesta que parecen estar emergiendo en cada territorio. En el espacio urbano, la organización y las acciones prestan servicios que debieran ser proporcionados por el Estado, por medio de catastros, seguimientos, operativos de salud, desinfecciones y ollas comunes, lo cual es facilitado por la disposición urbana y la cercanía. En Chiloé la estrategia inicial es cortar caminos y crear un cordón sanitario comunitario, lo que, al transformarse en medida sanitaria estatal, se negocia con los empresarios y se permite la reanudación de la circulación de transporte.

La tercera condición esencial de posibilidad de la PS es que exista un despliegue de 'procesos emancipatorios y de construcción de autonomía'. En los casos analizados hay dos elementos que

parecen ser fundamentales. En primer lugar, la estrategia de afrontamiento de la pandemia por el gobierno, que plantea la retórica de "estamos preparados" sin disponer de acciones concretas de protección social. Se intenta continuar con la actividad económica, pero con un aumento de las medidas represivas, lo cual refuerza y abre el espacio para una organización comunitaria autogestionada dado el vacío estatal en la contención de la pandemia y la falta de apoyo a las comunidades. Esto es visible en los operativos de salud realizados por el MSR en La Granja, así como en los cordones sanitarios y los cortes de ruta comunitarios en Chiloé.

En segundo lugar, la trama recompuesta de la organización social y comunitaria durante el estallido social, la baja credibilidad y pérdida de legitimidad de las autoridades, así como la represión estatal sufrida por parte importante de la población, provocan que las medidas sanitarias establecidas por el gobierno central no resulten confiables y sean leídas como un intento por privilegiar la salud de la economía antes que la salud de la población. En tal sentido, la desconfianza y baja legitimidad, así como la desconexión de las autoridades, en sinergia con la ausencia del Estado y la exclusión de parte importante de la población, han implicado la construcción de otro mundo "paralelo", en lo que puede reconocerse una actitud emancipadora (7), en busca de mejorar las condiciones de vida (8). En Chiloé este parecía estar enfocado en prevenir la llegada de la enfermedad, las tensiones generadas por el no respeto de los cordones sanitarios activaron una red de organizaciones con demandas más amplias y anteriores a la pandemia.

Retomando los elementos que definimos como centrales para una PS desde la perspectiva de la salud colectiva, es posible sostener que en el contexto de la pandemia se han desplegado formas de organización colectiva arraigadas en procesos históricos de mayor alcance y vinculadas al estallido social en La Granja, y a demandas medioambientales e indígenas en Chiloé. Estas acciones han estado ancladas y responden a las características de cada uno de los territorios y, a la vez, han estado orientadas a la justicia social por un lado y a la posibilidad de construir autonomía por el otro. Es decir, parecieran estar en curso formas locales de PS, basadas en estos tres principios, búsqueda de justicia social, desde una perspectiva territorial, por medio de acciones autónomas que son parte de procesos emancipatorios de largo aliento, profundizados en el contexto de la pandemia.

Esta forma de comprender la PS presenta grandes desafíos y significa aprendizajes. En Chile, la PS como estrategia de Atención Primaria de Salud, si bien reconoce el enfoque de Determinantes Sociales en sus lineamientos, lo cual puede vincularse a la búsqueda de justicia en todos sus planos, ha sido cuestionada tanto por sus modos de comprensión como por su praxis. Esto se debe a que está sobrecentrada en la biomedicina y en enfoques preventivos (52) que se apoyan en discursos normativos relativos a estilos de vida saludables (53), muchas veces ajenos o descontextualizados de la realidad de los territorios, abriendo una brecha conceptual y operativa que se aleja de la perspectiva de salud colectiva como vertiente analítica. En el transcurso de la pandemia, no solo se visualiza la ausencia de una estrategia nacional y local a nivel territorial en todas las dimensiones del cuidado de la salud, sino un redireccionamiento de los recursos humanos, incluidos los de la PS, a tareas preventivas únicamente frente a la COVID-19, lo cual refuerza la ausencia y la necesidad de autogestión en salud de la propia comunidad. Consistente con ello, la participación social–otro eje central en las estrategias de PS declaradas en Chile (54)–no hace parte de instancias de decisión local, lo cual si bien puede entenderse como una deriva de la desarticulación funcional de los equipos de salud locales en la emergencia de la pandemia, también sugiere una interrelación empobrecida de los equipos de salud con la comunidad, ya previo a la pandemia, que restringiría la posibilidad de emprender acciones colectivas y mancomunadas. Esto pone en evidencia que, tanto para la política pública y la academia, como para los equipos de atención primaria en cada territorio, es necesario repensar la estrategia de PS desde un reposicionamiento que permita acompañar y potenciar este tipo de acciones ya desplegadas por las propias comunidades.

Declaración de conflicto de intereses

Ningún conflicto declarado.

Financiación

Ninguna financiación declarada.

ORCID iDs

Soledad Burgos https://orcid.org/0000-0001-9091-2588
Sebastián Medina Gay https://orcid.org/0000-0003-4659-680X

Notas

1. De alto volumen e intensidad, el extractivismo salmonero en la Región cosechó 923.900 toneladas en el año 2018 (55) y reportó ingresos de 1,78 mil millones de dólares (56).

Referencias

1. Carvalho SR. As contradições da promoção à saúde em relação à produção de sujeitos e a mudança social. Cien Saude Colet. 2004; 9: 669–678.
2. Almeida Filho N, Silva Paim J. La Crisis de la Salud Pública Y El Movimiento de la Salud Colectiva en Latinoamérica. Cuad Médico Soc. 1999; 75: 5–30.
3. Iriart C, Waitzkin H, Breilh J, Estrada A, Merhy EE. Medicina social latinoamericana: aportes y desafíos. Rev Panam Salud Pública. 2002; 12: 128–136.
4. Waitzkin H, Iriart C, Estrada A, Lamadrid S. Social medicine in Latin America: productivity and dangers facing the major national groups. Lancet. 2001; 358: 315–323.
5. Breilh J. La determinación social de la salud como herramienta de transformación hacia una nueva salud pública (salud colectiva). Rev Fac Nac Salud Pública. 2013; 31(Suppl 1): S13–S27.
6. Laurell Asa C. La Salud-Enfermedad como proceso social. Cuad Médicos Soc. 1982; 86: 2–10.
7. Zibechi R. Autonomías y emancipaciones América Latina en movimiento. Lima, Perú: Fondo Editorial de la Facultad de Ciencias Sociales, Unidad de Post Grado, UNMSM; 2007.
8. Chapela M del C. Promoción de la Salud Emancipadora. In: Unidad Xochimilco Universidad Autónoma Metropolitana (ed.) Promoción de la salud y emancipación. Ciudad de México; 2013.
9. Ratima M. Liderazgo para la salud del planeta y el desarrollo sostenible: la capacidad de la comunidad de promoción de la salud para trabajar con los pueblos indígenas en la aplicación de sus conocimientos. Glob Health Promot. 2019; 26: 114–117.
10. Santos B de S. Epistemologies of the South. Justice against Epistemicide. Epistemologies of the South. New York: Routledge; 2016.
11. Yin RK. Case Study Research - Design and Methods. 7th ed. Beverly Hills, CA: Sage Publications; 1987.
12. Kornblit AL. Metodologías cualitativas en ciencias sociales. Buenos Aires: Editorial Biblos; 2007.
13. OECD Data. Income Inequality [Internet]. 2020 [citado el 12 de julio de 2020]. Available from: https://data.oecd.org/inequality/income-inequality.htm.
14. Palabra Pública. El Estallido. In: Palabra Pública No16 (Especial). Santiago de Chile: Universidad de Chile; 2019.
15. Instituto Nacional de Estadísticas. Resultados definitivos Censo 2017 [Internet]. 2018 [citado el 28 de enero de 2021]. Available from: http://www.censo2017.cl/wp-content/uploads/2017/12/Presentacion_Resultados_Definitivos_Censo2017.pdf.
16. Biblioteca del Congreso Nacional de Chile. Reportes Estadísticos Comunas [Internet]. 2017 [citado el 12 de julio de 2020]. Available from: https://www.bcn.cl/siit/reportescomunales/comunal.html?unidad=Comunales&anno=2017.
17. El Desconcierto. Olor a curtiembre y polvo cancerígeno: 5 mil personas viven en permanente emergencia ambiental en La Granja. El Desconcierto [Internet]. 2016 Jun 30 [citado el 28 de enero de 2021]. Available from: https://www.eldesconcierto.cl/2016/06/30/olor-a-curtiembre-y-polvo-cancerigeno-5-mil-personas-viven-en-permanente-emergencia-ambiental-en-la-granja/.
18. Quiero mi Barrio. Orígenes y Memoria Histórica del barrio Millalemu de La Granja [Internet]. 2017 [citado el 10 de julio de 2020]. Available from: https://www.youtube.com/watch?v=42LTzGN0XtY.
19. Asamblea Popular Metro La Granja [Internet]. Facebook. 2020 [citado el 10 de julio de 2020]. Available from: https://www.facebook.com/asambleametro/.
20. Mondaca-Mansilla E. La soberanía política territorial como condición para una izquierda descolonial. Universidad Nacional de Córdoba; 2019.
21. Mapuexpress. Cabildo Por El Agua rechaza relleno sanitario en San Antonio De Huélden, Chiloé. 2019 Sep 3; Available from: https://www.mapuexpress.org/2019/09/03/cabildo-por-el-agua-rechaza-relleno-sanitario-en-san-antonio-de-huelden-chiloe/.
22. Cárdenas JC. A un año de "La Comuna de Chiloé." El desconcierto [Internet]. 2017 May 8 [citado el 28 de enero de 2021]. Available from: http://www.eldesconcierto.cl/2017/05/08/a-un-ano-de-la-comuna-de-chiloe/.
23. Instituto Nacional de Derechos Humanos. Informe misión de observación situacion socioambiental Región de Los Lagos. 2016.
24. Asamblea Territorial de Chonchi. Declaración pública Asamblea Territorial de Chonchi [Internet]. *Facebook*, 2020. Available from: https://www.facebook.com/a.t.chonchi/.
25. MINSAL. Ministerio de Salud confirma primer caso de coronavirus en Chile. 2020 Mar 3; Available from: https://www.minsal.cl/ministerio-de-salud-confirma-primer-caso-de-coronavirus-en-chile/.
26. Resumen. Gobierno errático, coronavirus y respuesta popular en Chile. Resumen Prensa Digital [Internet]. 2020 Mar 16 [citado el 28 de enero de 2021]. Available from: https://resumen.cl/articulos/gobierno-erratico-coronavirus-y-respuesta-popular-en-chile.
27. Ministerio del Interior. Decreto Núm. 104, Santiago, 18 de marzo de 2020. Declara Estado de Excepción Constitucional de catástrofe por calamidad pública en el territorio de Chile. 2020 Mar 18; Available from: http://bcn.cl/2dfup.
28. Gobierno de Chile. Gobierno de Chile decreta nuevas medidas sanitarias entre las que se cuentan toque de

queda nacional y controles más estrictos de desplazamiento. Noticias Gobierno de Chile [Internet]. 2020 Mar 22; Available from: https://www.gob.cl/noticias/gobierno-de-chile-decreta-nuevas-medidas-sanitarias-entre-las-que-se-cuentan-toque-de-queda-nacional-y-controles-mas-estrictos-de-desplazamiento/.
29. Diario UChile. La protesta social se reactiva pese a la pandemia. Diario Digital Radio Universidad de Chile [Internet]. 2020 Apr 29; Available from: https://radio.uchile.cl/2020/04/29/la-protesta-social-se-reactiva-pese-a-la-pandemia/.
30. Escuela de Salud Publica - Universidad de Chile. Actualización COVID-19 en Chile Análisis y recomendaciones ante la fase actual de la epidemia. Santiago de Chile; 2020.
31. MNSAL. Gobierno mantiene cuarentena para 38 comunas de la Región Metropolitana. 2020 May 27; Available from: https://www.minsal.cl/gobierno-mantiene-cuarentena-para-38-comunas-de-la-region-metropolitana/.
32. Diario UChile. Con represión incluida: vecinos de El Bosque protestan por la falta de alimentos en cuarentena. *Diario UChile Digital* [Internet]. 2020 Jul 13; Available from: https://radio.uchile.cl/2020/05/18/con-represion-incluida-vecinos-de-el-bosque-protestan-por-la-falta-de-alimentos-en-cuarentena/.
33. Reyes Jara J. Desigualdad y ollas comunes para combatir la pandemia. *CIPER* [Internet]. 2020 Jun 16; Available from: https://ciperchile.cl/2020/06/19/desigualdad-y-ollas-comunes-para-combatir-la-pandemia/.
34. Publimetro. "Alimentos para Chile": todo lo que tienes que saber sobre la caja con alimentos que entregará el Gobierno ante la crisis del coronavirus. *Publlimetro* [Internet]. 2020 May 22; Available from: https://www.publimetro.cl/cl/noticias/2020/05/22/caja-alimentos-que-donde-como.html.
35. El Desconcierto. Del estallido a la pandemia: la reconversión de las brigadas de salud de la Plaza Dignidad. *El Desconcierto* [Internet]. 2020 Jun 20; Available from: https://www.eldesconcierto.cl/2020/06/20/del-estallido-.
36. Prensa Opal. Salud solidaria y colectiva: solo el pueblo cuida al pueblo. 2020 Apr 21; Available from: https://prensaopal.cl/2020/04/21/salud-solidaria-y-colectiva-solo-el-pueblo-cuida-al-pueblo/.
37. Movimiento Salud en Resistencia. Mapa informativo Plan Territorial Covid19 [Internet]. Santiago de Chile; 2020. Available from: https://actua.greenpeace.org.mx/mapa-legislaciones.
38. Comité de Emergencia La Granja. Segundo operativo médico preventivo CETMLG. Facebook. 2020.
39. Meganoticias. Confirman primer caso de coronavirus en Chiloé. Meganoticias Televisión [Internet]. 2020 Mar 25; Available from: https://www.meganoticias.cl/nacional/296234-confirman-primer-caso-coronavirus-contagio-chiloe-castro-region-de-los-lagos.html.
40. La Opinión de Chiloé. Chiloé: «barrera sanitaria» por COVID-19 parte hoy jueves. Vecinos bloquean rampas en Chacao. La Opinión de Chiloé [Internet]. 2020 Mar 19; Available from: http://laopiniondechiloe.cl/chiloe-barrera-sanitaria-por-covid-19-parte-hoy-jueves-vecinos-bloquean-rampas-en-chacao/.
41. El Insular. Decretan prohibición de funcionamiento y retiro de trabajadores por irregularidades en ingreso a Chiloé. *El Insular Diario Digital* [Internet]. 2020 Apr 27; Available from: https://elinsular.cl/web/?p=10359.
42. DecimaTV. SAG Los Lagos certifica exportación de 1.500 toneladas de musgo pompón. DecimaTV Televisión Regional de Los Lagos [Internet]. 2020 Jul 4; Available from: https://www.decimatv.cl/2020/07/04/sag-los-lagos-certifica-exportacion-de-1500-toneladas-de-musgo-pompon/?fbclid=IwAR06O7k3iATLFLWfOWs6WR6RmVs_gqPQKxVW9EasPG40t_-7f3_tpPiTSN0.
43. Stuardo M. Suspenden uso de túnel sanitizador en Chiloé: Confirman que se aplicó químico no validado a personas. BioBioChile Chile [Internet]. 2020 Apr 21; Available from: https://www.biobiochile.cl/noticias/nacional/region-de-los-lagos/2020/04/21/suspenden-tunel-sanitizador-en-chiloe-no-tenia-validacion-y-desconocen-quimico-aplicado-a-personas.shtml.
44. Asamblea Archipiélago de Quinchao. Manifiesto Asamblea Social del Archipiélago de Quinchao. *Facebook* [Internet]. Jun; Available from: https://m.facebook.com/story.php?story_fbid=271333247638853&id=100042865400436&sfnsn=mo.
45. Radio del Mar. Encuentros desde el Fogón para la defensa de nuestras comunidades y su patrimonio sanitario. Radio Del Mar [Internet]. 2020 May 29; Available from: https://www.radiodelmar.cl/2020/05/encuentros-desde-el-fogon-para-la-defensa-de-nuestras-comunidades-y-su-patrimonio-sanitario/.
46. Centro de Estudios Sociales de Chiloé - CESCH. Conversatorio El futuro laboral de Chiloé:resistencias y luchas para el digno sustento insular. Facebook; Transmisión online [Internet]. 2020 Jul 7; Available from: www.facebook.com/watch/live/?v=984718838604605&ref=watch_permalink.
47. Fundación Curaco de Vélez. Quelcún constituyente [Internet]. 2020 [citado el 12 de julio de 2020]. Available from: http://www.fundacioncuracodevelez.cl/quelcun-constituyente/.
48. Instituto Nacional de Derechos Humanos. Informe Anual. Situación de los Derechos Humanos en Chile. Santiago de Chile; 2018, 278 p.
49. De Souza Porto MF. Crise das utopias e as quatro justiças: ecologias, epistemologias e emancipação social para reinventar a saúde coletiva. Cienc e Saude Coletiva. 2019; 24: 4449–4458.
50. Borde E, Torres-Tovar M. El territorio como categoría fundamental para el campo de la salud pública. Saúde em Debate. 2017; 41: 264–275.
51. Gudynas E. Extractivismos. Ecología, economía y política de un modo de entender el desarrollo y la Naturaleza. Cochabamba, Bolivia: Centro de Documentación e Información Bolivia (CEDIB); 2015.

52. Calventus Salvador J, Bruna González B. Promoción de la salud como práctica psico-social comunitaria en la política social chilena. Límite. 2018; 13: 67–79.
53. Ferrer Lues M. ¿La salud como responsabilidad individual ? Análisis del concepto de salud en los Programas de Gobierno de la Concertación en Chile. In: Acta Científica del XXIX Congreso de la Asociación Latinoamericana de Sociología. 2013.
54. Ministerio de Salud. Participacion Social en Salud: Reflexiones y Herramientas para la Acción desde Chile. Departamento de Participación Social y Trato al Usuario. Subsecretaría de Redes Asistenciales, (ed.) 2009. Available from: http://www.bibliotecaminsal.cl/wp/wp-content/uploads/2016/03/Participacion-Social-en-Salud.pdf
55. SERNAPESCA. Anuarios Estadísticos de Pesca y Acuicultura 2018 [Internet]. Servicio Nacional de Pesca y Acuicultura. 2020 [citado el 10 de julio de 2020]. Available from: http://www.sernapesca.cl/informacion-utilidad/anuarios-estadisticos-de-pesca-y-acuicultura.
56. Observatory of Economic Complexity. Fish Fillets in Chile [Internet]. 2020 [citado el 8 de julio de 2020]. Available from: https://oec.world/en/profile/bilateral-product/10304/reporter/chl.

Resúmenes

‘Regreso a lo mejor’: ampliar la equidad en salud y las perspectivas de los determinantes de la salud durante la pandemia de la COVID-19

S. Ndumbe-Eyoh, P. Muzumdar, C. Betker y D. Oickle

Introducción: La equidad y la justicia social han sido durante mucho tiempo los principios claves de la práctica, las políticas y la investigación en promoción de la salud. La promoción de la salud destaca la importancia de la vida social, económica, cultural, política y espiritual para crear y mantener la salud. Esto requiere una perspectiva crítica de los determinantes estructurales de la salud que se conjugue activamente con las experiencias de salud y de bienestar entre las diferentes poblaciones. Los impactos desiguales de la pandemia están bien documentados, así como los llamados para mejorar las respuestas. Sin embargo, los planes de preparación para pandemias y emergencias todavía no responden de forma adecuada a los determinantes sociales y estructurales de la salud y de la equidad en salud.
Método: A través de cinco conversaciones de una hora, en línea, realizadas en abril del 2020, trabajamos con 13 líderes de la práctica, de la política, de la investigación y de la comunidad sobre las intersecciones de la COVID-19 y el género, el racismo, la carencia de vivienda, la salud y el conocimiento indígenas, la inseguridad alimentaria en el hogar, las discapacidades, la ética y un futuro equitativo pos-COVID-19. Dirigimos un análisis temático de las contribuciones de los oradores y participantes para investigar los impactos y la influencia de la COVID-19 relacionados con los determinantes estructurales y sociales de la salud. Analizamos qué políticas, prácticas y respuestas ampliaron o debilitaron la equidad y la justicia social, e identificamos las oportunidades para mejorar la acción.
Resultados: El análisis de la pandemia de la COVID-19 reveló cuatro temas generales:

- Sistemas opresivos e injustos, así como inequidades sociales y en salud existentes
- Sistemas sociales y de salud sometidos a coacción y que no responden a la equidad
- Impactos desproporcionados de la COVID-19 motivados por una desigualdad estructural y socioeconómica subyacente
- Mayor impulso a las movilizaciones colectivas, a las innovaciones normativas y a la transformación social

Discusión: Hubo un fuerte anhelo por una sociedad más justa y equitativa en un mundo pos-COVID-19, un ‘regreso a lo mejor’ en lugar de un ‘regreso a lo normal’. Nuestro análisis demuestra que la equidad no ha sido bien integrada en la planificación ni en las respuestas a la pandemia. Las teorías de los movimientos y sistemas sociales proporcionan información sobre la forma de aprovechar la movilización comunitaria existente y la apertura de políticas para una transformación social sostenida. (Global Health Promotion, 2021; 28(2): 7–16)

Recursos individuales, sociales y nacionales de afrontamiento y sus relaciones con la salud mental y la ansiedad: un estudio comparativo en Israel, Italia, España y los Países Bajos durante la pandemia por el coronavirus

A. Mana, S. Super, C. Sardu, D. Juvinya Canal, N. Moran y S. Sagy

Basados en el modelo salutogénico, averiguamos cómo los habitantes de diferentes países afrontan la crisis de la COVID-19 y se mantienen saludables. Nos interesamos en explorar los recursos individuales (como el sentido de coherencia), sociales y nacionales (como el apoyo social, el sentido de coherencia nacional y la confianza en las instituciones gubernamentales) que podrían explicar los niveles de salud mental y de ansiedad durante el brote de la pandemia. La recolección de los datos se realizó mediante un muestreo por conveniencia en las plataformas en línea, entre el final de marzo y el comienzo de abril del 2020. Se tomaron cuatro

Global Health Promotion 1757-9759; Vol 28(2): 124–129; 1015141 DOI: 10.1177/17579759211015141 journals.sagepub.com/home/ghp

muestras: 640 participantes de Israel (319 hombres), 622 de los Países Bajos (177 hombres), 924 de Italia (338 hombres) y 489 de España (117 hombres), con un rango de edades entre 18 y 88 años. Los cuestionarios incluyeron las escalas estándar (MHC-SF, GAD-7, SOC y SONC). Varias preguntas fueron adaptadas al contexto del coronavirus para medir los niveles de exposición a la COVID-19, la confianza en las instituciones gubernamentales y el apoyo social. Los resultados confirmaron de manera significativa el modelo salutogénico sugerido en relación con la contribución de los recursos individuales y nacionales para afrontar los niveles de ansiedad y de salud mental. Los patrones de estos recursos de afrontamiento para explicar la ansiedad y la salud mental fueron similares en las cuatro muestras y el Sentido de Coherencia (SOC) fue el principal predictor de estos resultados. A pesar de estas similitudes, se encontraron un patrón y unas magnitudes diferentes del valor predictivo de los recursos de afrontamiento para las dos reacciones: ansiedad *vs.* salud mental. Si bien el SOC y los factores situacionales (como la amenaza financiera) fueron significativos para explicar los niveles de ansiedad, el SOC y los recursos nacionales lo fueron para explicar los niveles de salud mental. Estos resultados respaldan el modelo salutogénico al estudiar las reacciones durante la época de pandemia y, además, arrojan algo de luz sobre la diferencia entre las medidas patogénicas y salutogénicas en el estudio de las reacciones psicológicas a situaciones estresantes. (Global Health Promotion, 2021; 28(2): 17–26)

La preparación de la promoción de la salud para una crisis de salud: ¿'imprescindible' o 'bueno tenerla'? Estudios de caso y lecciones aprendidas de la pandemia de la COVID-19

D. Levin-Zamir, K. Sorensen, T. T. Su, T. Sentell, G. Rowlands, M. Messer, A. Pleasant, L. Saboga Nunes, S. Lev-Ari y O. Okan

La pandemia de la COVID-19 ha sacado a la luz las conexiones que faltaban entre la promoción de la salud y las políticas nacionales/mundiales de emergencia sanitaria. Como respuesta, varias iniciativas de promoción de la salud fueron desarrolladas e implementadas de forma urgente alrededor del mundo. Una selección de estudios de caso en cinco países, basada en el Modelo Socio-ecológico de la Promoción de la Salud, ejemplifica la acción y los desafíos del 'mundo real' para la intervención, la investigación y las políticas de la promoción de la salud durante la pandemia de la COVID-19. Las intervenciones se enfocaron en individuos/familias, organizaciones, comunidades y en los sistemas de atención en salud, salud pública, educación y medios de comunicación, entornos promotores de la salud, y políticas. Las lecciones aprendidas resaltan la necesidad de hacer énfasis en la equidad, la confianza, el enfoque de sistemas y la acción sostenida en futuras estrategias de preparación de la promoción de la salud. Los desafíos y las oportunidades se destacan con relación a la necesidad de una respuesta rápida, una comunicación clara basada en el alfabetismo para la salud y una colaboración entre países, disciplinas y sistemas de salud y educación para encontrar soluciones significativas a las crisis mundiales de salud. (Global Health Promotion, 2021; 28(2): 27–37)

El poder que viene de adentro: líderes femeninas en las favelas de Río de Janeiro en época de pandemia

N. R. De Andrade Nunes

Este artículo destaca cómo las líderes femeninas de las favelas de Río de Janeiro (Brasil) han sido protagonistas al afrontar las exigencias que surgen de la COVID-19. La ciudad tiene unos 2 millones de habitantes que viven en 763 favelas. No hay una planificación estratégica por parte del gobierno con acciones coordinadas en relación con las especificidades de estas zonas, lo cual produce una escalada de demandas debido a las condiciones de vivienda y salud de los residentes. Es en esta realidad multifacética, con urgencias y emergencias,

en la que destacamos el papel de la comunidad mediante el fortalecimiento de las redes de apoyo local que se han construido como telarañas, dentro y más allá de las favelas. Basamos nuestra afirmación en un estudio cualitativo que involucró 111 de estas mujeres, distribuidas en 105 favelas. Al correlacionar sus prácticas, el 97% dice que apoya la promoción de la salud a través del fortalecimiento de la participación popular hacia el desarrollo comunitario y la defensa de los derechos, y la movilización de los servicios de salud para, entre otras acciones, responder a las necesidades de la población. Con la presencia de agentes públicos en dichos espacios restringidos en época de pandemia, estas mujeres asumen a menudo las obligaciones de las autoridades locales para garantizar la seguridad alimentaria y la buena comunicación entre los residentes locales sobre normas de salud, medidas de higiene, asistencia a los más vulnerables, etc. Percibidas por los miembros de la comunidad como el reemplazo del papel de las agencias gubernamentales, ellas desarrollan una forma particular de hacer política. Con un llamado a la resistencia y a la solidaridad, transforman este micropoder en cambios efectivos para afrontar las inequidades en beneficio de la ciudadanía y de los otros residentes de las favelas donde ellas viven. (Global Health Promotion, 2021; 28(2): 38–45)

Una respuesta de la alianza comunidad-salud para mitigar el impacto de la pandemia de la COVID-19 en nómadas y romaníes de Irlanda

J. Villani, P. Daly, R. Fay, L. Kavanagh, S. McDonagh y N. Amin

Los nómadas irlandeses y los romaníes son dos minorías étnicas que se ven afectadas por altos niveles de inequidades en salud. Estas comunidades tienen más riesgo de contraer la COVID-19 y de sufrir los síntomas de forma más severa, debido a sus precarias condiciones de vida y a tasas más altas de comorbilidades. Este estudio explora las estrategias adoptadas por las alianzas entre la comunidad y la salud y por las ONG para minimizar el creciente potencial de inequidades en salud en las comunidades nómadas y romaníes durante la respuesta inicial a la pandemia de la COVID-19 en Irlanda. Se utilizó un método descriptivo cualitativo para proporcionar un reporte detallado de tres respuestas diferentes lideradas por la comunidad y las alianzas. Los datos fueron recopilados de diferentes fuentes y a través de la participación directa en las respuestas a la COVID-19, y se examinaron mediante un análisis temático. Este estudio encontró que las principales intervenciones que se implementaron para mitigar la pandemia fueron las medidas de salud pública, una comunicación culturalmente sensible, la presión para exigir cambios políticos y el apoyo social y económico. Estas intervenciones, basadas en las estrategias de promoción de la salud como alianzas, incidencia política y empoderamiento, demostraron ser supremamente importantes para reducir las potenciales inequidades en los niveles de exposición al virus y en el acceso a los servicios de salud. Los resultados sugieren que las alianzas comunidad-salud entre organizaciones de grupos minoritarios y profesionales de la atención en salud representan una solución viable para mitigar los efectos desproporcionados de la pandemia en los nómadas y los romaníes. (Global Health Promotion, 2021; 28(2): 46–55)

La comunicación afectiva: un método mixto de investigación sobre la comunicación del brote de la COVID-19 en la página de Facebook del gobierno taiwanés

C. Y. Lien y Y.-H. Wu

El brote de la COVID-19 ha creado un desafío sin precedentes para los gobiernos a la hora de transmitir la información al público, y las redes sociales se han convertido en un medio crucial de comunicación sobre la COVID-19 en Taiwán.
Objetivos: Este estudio examina un total de 1.128 publicaciones en Facebook de la principal autoridad de salud de Taiwán entre el primero de diciembre del 2019 y el 31 de mayo del 2020.

Métodos: Utilizando tanto los enfoques cualitativos como los cuantitativos, este estudio investiga las estrategias utilizadas por el gobierno de Taiwán para comunicar sobre el brote de la COVID-19 y las respuestas del público hacia dichas estrategias.
Resultados: Se identificaron nuevos usos de las publicaciones en Facebook sobre la comunicación del brote, entre ellos, la solidaridad, las reseñas de las acciones, las ruedas de prensa y la utilización de imágenes de animales y dibujos animados. Los resultados cuantitativos mostraron que el público respondía significativamente con más frecuencia a los mensajes que generaban afectos positivos como las publicaciones que reportaban las acciones del gobierno y los esfuerzos del público; las que expresaban agradecimiento, aprobación o camaradería, y las que combinaban textos y fotografías de los trabajadores de primera línea o de tiernos animales.
Conclusión: Estos resultados sugieren que, en medio de un brote de enfermedad, el público no solo busca situaciones y directrices actualizadas, sino también una afirmación afectiva de las agencias gubernamentales. (Global Health Promotion, 2021; 28(2): 56–66)

Inequidades en salud y soluciones tecnológicas durante las primeras olas de la pandemia de la COVID-19 en países de ingreso alto

M. Mac-Seing y R. Rocha de Oliveira

La pandemia de la COVID-19 ha ocasionado perturbaciones masivas en la salud pública, la atención en salud y en los sistemas políticos y económicos, más allá de las fronteras nacionales, lo que requiere una necesidad urgente de adaptación. En todo el mundo, los gobiernos han tomado una serie de decisiones políticas para aplicar medidas preventivas y de control. Como investigadores junior que analizan la pandemia a través de una lente de equidad en salud, queremos compartir nuestras reflexiones a propósito de esta crisis en evolución, específicamente: a) las tenues intersecciones entre las respuestas a la pandemia y las prioridades de salud pública; b) la exacerbación de las inequidades en salud que sufren las poblaciones vulnerables tras las decisiones adoptadas a nivel nacional y mundial, y c) los impactos de las soluciones tecnológicas propuestas para hacer frente a la crisis. Incluimos ejemplos extraídos de países de ingreso alto con el fin de sustentar estos tres puntos. (Global Health Promotion, 2021; 28(2): 67–71)

¿Los enfoques transdisciplinarios pueden contribuir a la lucha contra la COVID-19?

D. Aslan

La COVID-19 ha hecho surgir muchas preguntas que requieren solución para superar la carga mundial de morbilidad. La incertidumbre con relación a la COVID-19 contribuye a la complejidad de la carga sobre sus influencias en la salud, en lo social, lo económico y lo cultural. En este contexto, todas las disciplinas relacionadas están trabajando unidas para mitigar los efectos negativos de la enfermedad. En particular, la promoción de la salud – una disciplina de la salud pública – es importante en la pandemia, pues puede hacer frente a las amenazas en diferentes niveles. Las estrategias de la promoción de la salud en su mayoría despliegan esfuerzos orientados a la solución con enfoques inter y multidisciplinarios. Sin embargo, como la carga de la COVID-19 tiene muchos determinantes inmediatos, estos enfoques no son suficientes para superar el problema. Un modelo transdisciplinario en su sentido más amplio, que utilice prácticamente todos los aportes para sintetizar y producir una solución integral, podría ser de gran ayuda. En este artículo se discutió la importancia de los enfoques transdisciplinarios en la promoción de la salud para combatir la COVID-19. (Global Health Promotion, 2021; 28(2): 72–77)

El arte en tiempos difíciles: reflexiones a partir de una iniciativa de promoción de la salud basada en una experiencia artística durante la pandemia de la COVID-19

I. Abdullahi, N. K. Chana, M. Zenone y P. Ardiles

En esta pandemia de la COVID-19 que afecta a las comunidades de todo el mundo, se necesita implementar diversas estrategias de promoción de la salud para superar los desafíos de amplio alcance a los que nos enfrentamos. El arte es una herramienta bastante atractiva que promueve el bienestar positivo e incrementa el compromiso y la participación de la comunidad. La campaña del 'Mural para crear esperanza' surgió como una respuesta artística de la promoción de la salud para inspirar el diálogo sobre por qué la esperanza es tan importante para los canadienses en estos tiempos desafiantes. La iniciativa, una colaboración entre una red de promoción de la salud con base en Vancouver y un museo de 'arte al aire libre' de Toronto, invita a las familias a enviar obras en formato digital que representen el concepto de esperanza. Este artículo analiza las reflexiones de los organizadores de esta iniciativa artística de promoción de la salud puesta en marcha durante los primeros meses de la pandemia en Canadá. Nuestros hallazgos revelan la importancia de las prácticas de descolonización, enfocados en las voces de los afectados por la crisis, mientras se presta atención al contexto social y político. Estos aprendizajes pueden ser adoptados por los futuros promotores de la salud que intenten utilizar métodos basados en el arte para abordar las inequidades sociales y en salud. (Global Health Promotion, 2021; 28(2): 78–82)

COVID-19: consecuencias para las ENT y la continuidad de la atención en el África subsahariana

O. Owopetu, L.-K. Fasehun y U. Abakporo

Ha habido un aumento en las enfermedades no transmisibles (ENT) en el África subsahariana, impulsado por la occidentalización, la urbanización y los estilos de vida nocivos para la salud. La prevalencia de las ENT y sus factores de riesgo varían considerablemente entre los países de esta región y sus numerosas subpoblaciones. Un estudio documentó la prevalencia de accidentes cerebrovasculares entre 0.07% y 0.3%, de diabetes mellitus entre 0 y 16%, de hipertensión entre 6 y 48%, de obesidad entre 0.4 y 43% y de consumo de tabaco entre 0.4 y 71%. Se prevé que el número de casos de estas ENT siga creciendo durante la próxima década. Sin embargo, en el contexto de una pandemia mundial como la de la COVID-19, con el aumento de casos, confinamientos y registro de decesos en el mundo, el acceso a los cuidados médicos puede ser más difícil para muchas personas con ENT. La mayoría de los recursos disponibles en el subcontinente han sido dirigidos a la actual pandemia, lo que ha causado interrupciones en los servicios de salud, en el manejo de las complicaciones, la distribución de los medicamentos, junto con la epidemia silenciosa de las ENT, prácticamente desatendida, con graves consecuencias para el sistema de salud en la era pos-COVID-19. Analizamos las preocupaciones en torno a la continuidad de los servicios de atención y ofrecemos algunas soluciones para el África subsahariana. (Global Health Promotion, 2021; 28(2): 83–86)

COVID-19, promoción y prestación de cuidados paliativos: llegar a otros teniendo en cuenta la diversidad lingüística

B. Vissandjée, I. Fernandez, P. Durivage, Z. Freitas, P. Savignac y I. Van Pevenage

Las fuerzas combinadas de la globalización económica y la migración internacional han dado lugar a desafíos específicos para los sistemas de prestación de cuidados paliativos. La pandemia de la COVID-19 ha afectado

y sigue afectando ampliamente a las poblaciones de adultos mayores así como a quienes a través de los años han vivido con condiciones crónicas de larga duración o con necesidades preexistentes no satisfechas. Si bien la promoción de la salud y los cuidados paliativos pueden parecer campos conceptualmente opuestos, sostenemos que los cuidados paliativos pueden y deben encajar en el continuo de la promoción de la salud. Este comentario busca discutir la importancia del alfabetismo lingüístico y los imperativos de la comunicación en el contexto del acceso a los cuidados paliativos, dado el amplio, diversificado y sensible alcance de la atención. Si bien la pandemia ha demostrado que las respuestas de la salud pública de las sociedades que acogen a los migrantes están profundamente entrelazadas con las políticas, así como con las limitaciones y normas locales, se puede lograr una promoción y una prestación de cuidados paliativos seguros, oportunos y apropiados a través de una evaluación sensible de los contextos diferenciales de diversidad. La pandemia ha evidenciado de forma dolorosa la necesidad de una alianza de trabajo sólida, respetuosa y equitativa con las profesiones y la sociedad civil para que las necesidades paliativas de quienes están expuestos a un riesgo sostenido no sean olvidadas. (Global Health Promotion, 2021; 28(2): 87–90)

Elaboración y evaluación de la utilidad, la usabilidad y la aceptabilidad de los recursos educativos producidos como respuesta a la crisis de la COVID-19

N. Tessier, N. O'Callaghan, C. Fernandez Da Rocha Puleoto y D. Jourdan

La educación es uno de los principales determinantes de la salud. Sin embargo, la crisis sanitaria ha hecho que el 90% de la población estudiantil mundial, es decir, 1.57 mil millones de niños y jóvenes se vean privados de la escuela en 190 países. Las consecuencias del cierre de las escuelas en el aprendizaje y la salud están bien establecidas. El impacto del confinamiento en la salud de los niños y los jóvenes es más marcado que en la de otros grupos de edad, puesto que la interacción entre pares es un aspecto esencial del desarrollo, y las consecuencias del cierre de las escuelas son aún más graves porque los estudiantes son más vulnerables socialmente. El dispositivo de promoción de la salud '*Réussir, être bien, être ensemble*' (Tener éxito, estar bien, estar juntos) es un proceso de co-construcción de herramientas pedagógicas en educación para la salud que tiene en cuenta la diversidad cultural y se basa en las prácticas existentes, las comparte y las enriquece de aportes de la investigación (proceso de creación continuada). Se activó para elaborar, entre todos los actores y en un muy corto tiempo, un conjunto de herramientas destinadas a las escuelas primarias de Nueva Caledonia, con el objetivo de garantizar la continuidad pedagógica durante la crisis. La evaluación de dichas herramientas entre los profesionales en actividad y en capacitación (n = 50) demuestra que tienen una buena usabilidad con relación a las prácticas existentes de clase (puntaje de 8.2 sobre 10) y a las necesidades de los alumnos (puntaje de 8 sobre 10), una utilidad para el desarrollo de competencias y de conocimientos en educación para la salud (puntaje de 8.4 sobre 10) y una aceptabilidad con relación a los métodos pedagógicos, a los apoyos contextualizados y a su ejecución (puntaje de 8.3 sobre 10). Este etudio demuestra que la promoción de la salud es susceptible de ofrecer un marco para la elaboración de herramientas de intervención adaptadas en tiempos de crisis sanitaria. (Global Health Promotion, 2021; 28(2): 96–104)