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Perspectives

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Equity at a time of pandemic

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Summary

Health promotion has long aspired for a world where all people can live to their full potential. Yet, COVID-19 illuminates dramatically different consequences for populations bearing heavy burdens of systemic disadvantage within countries and between the Global South and Global North. Many months of pandemic is entrenching inequities that reveal themselves in the vastly differential distribution of hospitalization and mortality, for example, among racialized groups in the USA. Amplified awareness of the intimate relationship between health, social structures, and economy opens a window of opportunity to act on decades of global commitments to prioritize health equity. Choices to act (or not act) are likely to accelerate already vast inequities within and between countries as rapidly as the COVID-19 pandemic itself. Recognizing the inherently global nature of this pandemic, this article explores how *determinants of equity* are embedded in global responses to it, arguing that these determinants will critically shape our global futures. This article aims to stimulate dialogue about equity-centered health promoting action during a pandemic, using the Canadian Coalition for Global Health Research (CCGHR) Principles for Global Health Research to examine equity considerations at a time of pandemic. Attentiveness to power and the relationship between political economy and health are argued as central to identifying and examining issues of equity. This article invites dialogue about how equity-centered planning, decision-making and action could leverage this massive disruption to society to spark a more hopeful, just, and humane collective future.

Key words: health equity, social determinants of health, health policy, political economy, health inequities

Equity at a time of pandemic is at once more attainable and more vulnerable than ever. Months into this pandemic, data repeatedly reveal ways in which the COVID-19 crisis entrenches health inequities to deepen social, economic, and racial divides both within countries and between those of the Global North and South (Table 1). Before the pandemic, more than one billion people were living in overcrowded slums or refugee camps and already suffering severe instability, deprivation, lack of access to basic human rights (e.g., health care, water, sanitation, or food), and high risk for disease (Raju and Ayeb-Karlsson, 2020; United Nations, 2020). These communities face grim limitations in their capacity to respond to COVID-19 while navigating dangerous misinformation campaigns (Poole *et al.*, 2020). In Canada, outbreaks among migrant agricultural workers illuminate the inequitable working and living conditions of farmworkers who, despite being deemed an

Lay summary

The COVID-19 pandemic affects different people in disproportionate and unfair ways. Though pandemic burdens vary in different settings, pre-existing disadvantages are made worse as particular groups of people, especially those who are part of communities or countries that were previously colonized, cope with greater economic and health hardships. Equity is a goal of a world where all people, regardless of where they are born or what they look like, have a fair chance of living to their full potential. At a time of pandemic, governments and health leaders are making many difficult decisions. It is important that those decisions take into consideration the ways in which the pandemic unfairly affects particular people, and how action or inaction might worsen living conditions that were already unfair. This article uses a set of principles to examine these kinds of equity considerations in planning, decision-making, and action in response to the pandemic. It argues that collective futures will be shaped by how equity is brought into the pandemic policy dialogue.

'essential service', bear a disproportionate burden of cases while navigating power imbalances that compromise their access to healthcare (Haley *et al.*, 2020). In the USA and UK, data consistently show disproportionately higher case and mortality rates among Black, Hispanic, and Asian populations (Bhala *et al.*, 2020; Oppel *et al.*, 2020; Tai *et al.*, 2021). In some settings, the pandemic is fueling racialized divisiveness, fear, and hatred (Matache and Bhabha, 2020). It is clear that this virus and its fallout create far greater burdens for some populations than others, especially for those who are part of communities or countries that were previously colonized.

Despite clear inequities, heavy emphasis on epidemiological data underappreciates the impact of structural and social determinants of health (SSDH) (Abrams and Szefler, 2020; Thakur *et al.*, 2020) or the collateral impacts of COVID-related public health interventions (Tyndall, 2020; van der Ploeg, 2020; Zar *et al.*, 2020). Public discourse and media coverage, including preprint scientific publications, have played an important role in influencing how the pandemic is understood by the public and decision makers (Karalis Noel, 2020; Majumder and Mandl, 2020). For example, media reports described data on racial differences in COVID-19 hospitalizations and deaths in the US as 'startling' (Dam, 2020), framing it as a partisan issue and dismissing calls for race-based data on COVID-19 (Betz, 2020). Trevor Noah, political commentator and host of *The Daily Show*, was quick to challenge claims that the data did not make sense, pointing to systems of social and economic disadvantage. Noting Black Americans were less likely to have health insurance and more likely to have pre-existing chronic health conditions or be employed in high-contact service jobs that preclude working from home, Noah argued:

> . . .the Black community in America is being slammed by the corona virus. And it is not because there is anything special about corona virus, it is because any widespread crisis in America is bound to hit the most vulnerable and disadvantaged groups the hardest (Noah, 2020).

Far from perplexing, racial differences in COVID-19 cases and outcomes are actually unsurprising symptoms of SSDH.

Other unsurprising symptoms of SSDH are illuminated by this pandemic. While the wealthiest Americans saw their net worth gain $434 billion USD in the first two months of the pandemic, more than 38 million Americans lost jobs (Institute for Policy Studies: Program on Inequality and the Common Good, 2020). In July 2020, the United Nations reported that 'COVID-19 is reversing decades of progress on poverty, healthcare and education', with an estimated 71 million people pushed into extreme poverty in 2020 and millions more at risk for hunger (United Nations Department of Economic and Social Affairs-Statistics Division, 2020). Access to primary health care is eroded or under threat of collapse in countries around the world, compromising access to basic healthcare for billions of people (Garg *et al.*, 2020; GFATM, 2020) and interrupting core and life-saving vaccination programs (Dinleyici *et al.*, 2021). In West African countries with relatively low burdens of COVID-19, tens of millions of people face worsening poverty as pandemic measures strain informal economies, disrupting already fragile food systems by interrupting access to supplies, daily income, and food (Ali *et al.*, 2020).

Table 1: Key definitions

Advantage, disadvantage	Social structures produce norms, patterns, and access that work for or against groups of people, usually in unearned ways. These structures therefore produce particular advantages for some people, while producing disadvantages for others (Nixon, 2019).
Critical	Refers to an intentional analytical position of questioning issues of power, its distribution, and effects on policy, health, and society; invites consideration of collective analysis and dialogue that aims for action and change (Freire, 1997; Kemmis, 2008).
Global North, Global South	Refers to global power positions: 'global North' or 'Northern' refers to countries or populations that have been principal benefactors of colonization, and 'global South' or 'Southern' to those that have been previously colonized. Australia, for example, is geographically situated in the Southern hemisphere, and Aboriginal populations of Australia were colonized. The country's dominant powers and populations are benefactors of colonization and therefore Australia would be considered to fall into the 'global North', though the Aboriginal populations within Australia experience power disadvantage as others in the global South.
Health inequality	Measurable differences in health and well-being between individuals, groups or communities (National Collaborating Centre for Determinants of Health, 2015).
Health equity	An aspiration. 'Means all people (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic and environmental conditions' (National Collaborating Centre for Determinants of Health, 2015).
Health inequities	Extends health inequalities to assert they are human-caused and actionable (WHO), framing the 'differences in health associated with social disadvantages that are modifiable, and considered unfair' (National Collaborating Centre for Determinants of Health, 2015).

Pandemic-related economic strains reveal the depth of globally-driven structural drivers of health equity. Economic fallout has been severe enough to motivate socially protective policy interventions in virtually all countries, with those of the Global North providing economic relief to significantly greater portions of their populations than those of the Global South (Gentilini *et al.*, 2020). As countries of the Global North stockpile and procure privileged access to health products and protect their economies by making more (imaginary) money through their national banks, Southern countries positioned as 'aid recipients' grapple with collapsed global supply chains in what were already severely under-funded healthcare systems and crippling debt servicing obligations (Otu *et al.*, 2020; Yaya *et al.*, 2020). Inequities in the distribution of power, resources, and wealth are mounting while public awareness of the intimate relationship between health, social structures, and economy are heightened.

This article aims to stimulate dialogue about equity-centered health promoting action during a pandemic. Though the dominant framing of the pandemic leans on epidemiological analysis and mathematical modeling to portray trends and make predictions in isolation of SSDH, I identify and examine determinants of equity. My analysis uses the CCGHR Principles for Global Health Research (Plamondon and Bisung, 2019) as an organizing framework for identifying and exploring equity implications to extend consideration of the pandemic as a complex public health problem better understood through critical, interdisciplinary analyses of political economy.This invitation for dialogue is inspired by the hopeful optimism of Paulo Freire, who imagined a world 'less ugly, more beautiful, less discriminatory, more democratic, less dehumanizing, and more humane' [(Freire, 1997), p. 25]. I invite readers to consider these principles in a way that balances logic, critical analysis, and compassion.

POWER, POLITICAL ECONOMY, AND PANDEMIC

Political economy deals with the intersecting mechanisms, political ideologies, and systems of power that structure public policy to distribute health resources and shape healthcare delivery. In turn, these policies give rise to the differential experiences of populations occupying 'specific social locations such as social class, gender, age, and race' [(Raphael and Bryant, 2019), p. 61]. Social locations are complex and intersecting, created by the identities that any person, group, or community occupies in relation to others (Crenshaw, 1997; Nixon, 2019). Civil society, corporate sectors, organized labor, along with ideological and economic systems, all influence political systems though multiple pathways that direct distributive policies (Raphael and Bryant, 2019).

Evidence shows that distributive policies contribute to health differentially, such that populations with histories of colonization, displacement, or disenfranchisement consistently experience poorer health and live shorter lives than others (Came and Griffith, 2018; Commission of the Pan American Health Organization on Equity and Inequalities in the Americas, 2019; Jacklin *et al.*, 2017; WHO Commission on Social Determinants of Health, 2008). These histories, and their relationships to conditions of living, are the SSDH that shape *how* resources, wealth, and power are distributed within and between societies. Differences in health and life trajectories among populations with different social positions are thereby embedded in political economy, avoidable, and unfair (Commission of the Pan American Health Organization on Equity and Inequalities in the Americas, 2019; Marmot and Bell, 2012). They are not simply inevitable and unequal, but human-caused and actionable. Equity-centered health promotion action, when understood as necessarily concerned with the root causes of inequities, focuses on understanding (and responding to) how differential advantage and disadvantage are produced.

Differential advantage and disadvantage are created and re-created through the forces of political economy involved in shaping the *determinants of equity*. People decide, through different forces of power and influence, how resources, wealth, and power are distributed. Similarly, *people can do something* about the degree of equity or inequity produced within and between societies. Equity work is optimistic, future-driven work! Thinking about equity in health promotion extends policy considerations and power analyses beyond health or illness metrics and policies to include the multiple competing social sectors acting as determinants of equity and influencing SSDH. Policies related to income, employment, housing, and food are all relevant to considering equity in health promotion, as well as policies related to the complex governance systems involved in the global distribution of power, resources, and wealth. Equity analysis includes, for example, interrogating systems of advantage and disadvantage produced by power imbalances between communities navigating inequities and the well-resourced corporate sector (Brisbois *et al.*, 2019; Ottersen *et al.*, 2014; Raphael, 2015), or populations over-represented in positions of authority.

During a pandemic, the forces of political economy play an amplified and instrumental role in directing public health positions and interventions because they elevate some interests and issues over others. These forces are, in essence, *determinants of equity*. Public health interventions rapidly deployed to curb the spread of COVID-19 sparked immediate political and public attention for their impacts on economies worldwide. Risk of economic collapse was real—with countries of the Global North far better positioned to withstand the collateral impacts of pandemic measures, including (among others) reduced workforce, self-isolation and quarantine, and school closures (Fernandes, 2020; Gentilini *et al.*, 2020; Nicola *et al.*, 2020; Otu *et al.*, 2020). Early in the pandemic, acts of national protectionism by Northern countries quickly overshadowed calls for global solidarity—with power struggles compromising already over-stretched, inequitable, and fragmented global health governance platforms (Eyawo and Viens, 2020). Preliminary policy on the distribution of COVID-19 products, including vaccine, was troublingly inequitable for the Global South (Johri *et al.*, 2020). 'Vaccine nationalism', characterized by bidding wars and competing interests, is a pressing issue of political economy and equity, with countries of the Global North unapologetically pre-purchasing vaccine in deals with major pharmaceutical companies poised for massive economic gain (Torjesen, 2020). The mere possibility of access to vaccine, in essence, fueled (and continues to fuel) a political economy storm. Combined with posturing in global governance bodies such as the World Health Organization (Gostin *et al.*, 2020), racial tensions, mass social protest and counter-protest (Colebrook, 2020), this pandemic is paralled by ominous signals of States and sectors competing to assert themselves in a reorganization of the global distribution of power. Below, these and other issues of power are used as examples to demonstrate how groups might engage in critically reflective dialogue toward more equitable action as the world continues to grapple with the challenges of COVID-19.

THE CCGHR PRINCIPLES FOR GLOBAL HEALTH RESEARCH AS A FRAMEWORK FOR DIALOGUE

Promoting health equity at a time of pandemic requires attention to *how* planning, decision-making, and action are carried out—with an emphasis on identifying equity implications and prioritizing more equity-promoting options. The CCGHR Principles for Global Health Research provide a framework for dialogue with equity as the aspirational core of research, practice, and knowledge translation in global health. Developed through dialogue-based research, the six equity-centered principles reflect normative values in a diverse, interdisciplinary field and tend to resonate across many kinds of

settings and are being used by municipalities, universities, students, public health officials and officers, and others whose work aligns with health promotion (Plamondon & Bisung, 2019). They invite critical consideration of equity choices and implications of any given action or effort. Using these principles to guide dialogue invites people to deeply reflect, with compassion, on how they themselves are positioned in systems of power and unearned advantage and disadvantage. Below, I draw on policy examples to examine the uncomfortable, messy ways power and political economy create differential experiences for people in different social positions, organized by the actions guided by these six principles.

Partner authentically

Much of the work of pandemic responses involves some kind of partnership between individuals, organizations, communities, and countries—all with significantly different positions of power and resources. Partnering authentically invites consideration of how people involved in partnerships examine and respond to issues of authority, power, resources, needs, and norms (Plamondon & Bisung, 2019). Critical reflection on this principle guides consideration of how issues of political economy and power in *how we work together* can give rise to inequities that hinder capacity to advance a collective global good. Though pandemic responses included massive mobilizations and coordination for health-related funding and resources, partnerships established during a crisis are nonetheless prone to complex power and economic forces. Any partnership working during this pandemic will navigate risks of exclusion, paternalism, and tokenism—just as global health partnerships would at any time. The search for rapidly deployable and profit-maximizing sites for clinical trials can create risk for advancing research practices in countries of Global South that would be ethically unacceptable in the Global North (Bompart, 2020). If we return to the example of vaccine nationalism, the countries standing to benefit *most* from these trials are often *not* the countries absorbing the risk. Further, countries that stand to benefit most from trade agreements 'designed to protect intellectual property in a context of liberalized global trade' currently oppose international trade waivers that would elevate equity in access to vaccine over profitability though patent systems during this pandemic (Labonte and Johri, 2020). Global partnerships for vaccine, and other pandemic-related products, present complex conundrums and ethical challenges. It is never reasonable or equitable to expect people struggling for survival to serve research interests that are not doing something about their basic needs, or worse, exploits them for the benefit of the Global North (or of elites within countries of the North or South).

Governance mechanisms for global health reflect hierarchies of power and political influence, with little relationship between those who make decisions and those affected by them. The crisis of pandemic, though rapidly evolving, does not obfuscate the responsibility to be attentive to equity in decision-making. Partnering authentically invites active inclusion of many disciplinary and community perspectives. Inherently global health issues are, by nature, wickedly complex and therefore characterized by multiple competing interests and require wickedly creative strategies of inclusion (Mathur, 2020; Waddock, 2013). In this context, partnering authentically means embracing this pandemic as *everyone's shared concern* wherein disproportionate suffering is unacceptable, avoidable, and risks greater vulnerability for everyone. Partnering authentically means avoiding national protectionism at the expense of the global public good and avoiding elevated self-interest that compromises equity.

Foster inclusion

This principle invites consideration of who gets to be part of the policy dialogue and who is excluded, with specific action taken to include populations marginalized 'by virtue of their social, cultural, and economic identities such as Indigeneity, sexual identity, race, gender, ability, class, nationality, social status, et cetera' (Plamondon & Bisung, 2019, p. 2). Fostering inclusion requires sectors with interest and influence over political economy of health, including universities and funding agencies, philanthropic agencies, and other governance mechanisms to carefully consider incentive structures and small-scale policies that may be serving to systematically distribute power, resources and influence to those who are already comparatively over-resourced. Those who are comparatively over-resourced are often not positioned to identify how a policy may result in differential benefits or harms. Including the voices of the most affected, those who are likely under-represented in elected positions and positions of leadership, is an act of equity action.

Racialized populations, for example, are more affected by COVID-19, and are often the least represented in governance bodies making decisions that directly affect them most. In Canada, public health planning inclusive of care aides, who provide direct care to adults living in long-term care—both among the populations

hardest hit by the pandemic—would reveal the many ways in which their working and living conditions play a role in spreading this virus. Many of these workers represent racial and ethnic minorities, are primary income earners for extended families, and hold multiple casual positions in low-wage work with inadequate sick leave (Shippee *et al.*, 2020). Workplace policies directed at improving their working and living conditions would be good for the health of the entire population. Considering the equity options and implications of policy requires active mitigation to overcome and overamplify voices that are systematically excluded. We need to ask what *can* we do, seek diverse perspectives, invite input and respond with genuine receptivity to challenges on policy or action proposals. Fostering inclusion requires people holding positions of power and authority to ask questions differently, to create meaningful platforms for hearing from those often excluded, and to not avoid difficult truths or conversations about how racism, sexism, classism (or other -isms) shapes assumptions about priorities, needs, impacts, or collateral consequences of policy decisions.

Create shared benefits

Public policy and responses to the pandemic are not *de facto* beneficial, and any effort to follow media reporting about supports made available to citizens in any country will reveal that their distributions do not benefit all people equally. At a time of pandemic, considering how to create shared benefits raises questions about the distribution of benefits, resources, and products (such as vaccine, medications, masks). Returning to the example of vaccine development, equitable benefits would ensure that communities serving as clinical trial recruiting sites have equal and sufficient access to vaccine and the healthcare resources required to deliver vaccination programs. Access to other basic products, including testing kits and personal protective equipment, should not have different standards for the Global North than are expected of the Global South. Sharing benefits would position COVID-related technological and scientific advances as global public goods that require equitable global distribution. In two different scenarios posed by recent modeling of global vaccine allocation, for example, prioritizing distribution of vaccine to the Global North first would result in 28% more deaths than a cooperative distribution proportional to population size (Chinazzi *et al.*, 2020). In this model, elevating collective global interests over the short-term interests of wealthy countries could save millions of lives. Political rhetoric of nationalism and protectionism may, on the surface, seem to serve the interests of some—but, because of the inherently global nature of this pandemic—ultimately serves few, and only temporarily. Considering shared benefits invites critical examination of both the beneficiaries and those collaterally impacted by policy. For example, political commitment to the premise that eradication or complete containment is possible may be serving particular interests. With the principle of sharing benefits in mind, an equity-centered political economy analysis would interrogate this position by asking: *how does it serve to protect the interests of some over others?*

Sharing benefits also invites reflection about how data are handled and interpreted. The sheer volume of media exposure and messaging (including misinformation) about the pandemic has been associated with increased anxiety and stress (Garfin *et al.*, 2020; Tasnim *et al.*, 2020). As people cope with a general public narrative that questions the safety of basic living routines, there may be an inevitable confirmation bias built into the rapidly established norms of epidemiological surveillance displayed daily on a public stage. Diverse epistemological foundations across disciplines means that different disciplinary analyses of the same data may lead to contrasting interpretations and recommendations (Carter and Little, 2007; Grundy *et al.*, 2014; Mtenga *et al.*, 2016; Povall *et al.*, 2014). How we look at our current and evolving data matters. Equity analysis requires examining the data from different perspectives and with different methodologies, and questioning assumptions with an explicit goal to identify where and how benefits are being distributed. This means epidemiological analysis of the pandemic must consider how public health benefits (or detriments) are related to other excellent public health data, always pausing to ask questions about who benefits and who loses from particular policies.

Plan with a commitment to the future

Commitment to the future, as a principle, is about avoiding short-term and fragmented projects *and* about considering the impacts of decisions on the future of humanity—the latter of which is inspired by the Haudenosaunee Great Law[1] that guides consideration of decisions for their impact on the next seven generations (The Haudenosaunee Confederacy, 2019). This implies that there are global health priorities that, because of their long-term global impacts, merit attention.

1 The Haudenosaunee Confederacy includes five Indigenous Nations (whose traditional territories span the lands often referred to as Ontario, Quebec, and the state of New York).

Climate crisis, rising inequities, and migration are all pressing crises that existed *before* the pandemic, and all these crises compound and are made more vulnerable by it. Examining political economy and health, with the principle of planning with a commitment to the future in mind, cautions over-confidence in policies that lead to short-term gains in pandemic control. For example, it is problematic to protect health systems from short-term burdens if the collateral impacts of doing so generate massive and delayed waves of demand that will manifest as greater future strain. An example of this can be drawn from the overdose crisis in British Columbia, Canada. Despite years of advocacy for harm reduction policies, pandemic policies for self-isolation and physical distancing are leading to more people using drugs alone, while supply chain disruptions led to an unpredictable drug market (Tyndall, 2020). The combination has created a catastrophic exacerbation of an already dire epidemic. In September 2020, the BC Centre for Disease control reported 1571 deaths due to opioid overdose, with the vast majority of deaths among people aged 19–59 years (BC Centre for Disease Control, 2020b). In the same time period, 235 COVID-19 deaths were recorded, the vast majority among people aged 80 years or older (BC Centre for Disease Control, 2020a). Though the importance of responding to the pandemic is beyond question, there is a need for routine critical[2] analysis of the pandemic as just one among many issues of central concern for promoting and protecting the health of people across a spectrum of social positions.

Though lock-downs, social–physical distancing, and border closures are all correlated with stemming the spread of COVID-19, evidence of their impact does not confirm these measures as the *only* things that work. Further, tracking COVID-19 data alone risks underestimating the long-term harms of pandemic policies that may, in actuality, outweigh short-term benefits. The only way to identify and understand the potential for such harms is to invite critical and inclusive contemplation of the long-term equity implications of any given policy decision. Considering the long-term health of the entire planet, as inter-reliant, could encourage creativity in leveraging systems of inter-reliance (versus creating friable ones) to promote health beyond the pandemic (Espejo *et al.*, 2020; Naguib *et al.*, 2020). The more humanity accepts our collective agency and interdependence, the more likely we are to create solutions that serve the collective future of the planet.

2 See definition of critical in Table 1, emphasis on the inclusion of power analysis from a political economy lens.

Act on causes of inequities

As discussed earlier, health inequities have known causes: they are rooted in the unfair distribution of power, resources, and wealth both within and between countries. Acting to eliminate inadvertent (or willful) blindness to differential impacts of policies requires informing decisions with both the best available evidence (e.g., epidemiological surveillance data) and the best available evidence about the distribution and nature of inequities. The effects of structural racism as a determinant of health persist, even when data are controlled for age, sex, birthplace, or education (Paradies *et al.*, 2015). Acting on structural racism and other SSDH demands actions aimed at dismantling unfair systems of power and injustice at a population level (Came and Griffith, 2018; Egede and Walker, 2020), which, in turn, requires capacity to engage in critical analysis of power and its distribution (Came and Griffith, 2018; Crenshaw, 1997; Nixon, 2019). Adding race and gender analysis to epidemiologic surveillance, for example, shifted how the pandemic and its differential impacts were understood (Bhala *et al.*, 2020; Wenham *et al.*, 2020). There is much room to go to shift pandemic responses in ways that act on causes of inequities, particularly to respond to the structural forces of political economy that are resulting in deeply inequitable experiences of pandemic impacts.

Among the forces of power and political economy influencing pandemic decision-making are the elevation of biomedical and epidemiological perspectives on the pandemic, which were criticized for their influence on limiting public health action on the causes of inequities (Bryant *et al.*, 2011; Hanson, 2017; Raphael *et al.*, 2008) before COVID-19. Many of the predictive mathematical models presented during this time are marked by problematic assumptions, sometimes even acknowledged (e.g., Flaxman *et al.*, 2020), that overlook issues of equity, yet risk being considered singularly reliable for informing decision-making. Modeling is only one way to consider possible futures. If we approached our pandemic planning in an inclusive, dialogic way, we could have robust public debate that would elucidate unintended harms. Though essential to deliberation about the pandemic and how its effects are understood, narrowing efforts to work with data and interpret, predict, or respond to the pandemic narrow the imaginative possibilities of solutions. Collecting racial data for equity-promoting intentions (Govendar, 2020), or other data that reveals social positions implicated though a political economy framework (Raphael and Bryant, 2019), opens opportunities to understand and improve relationship between public policy and

inequities. This opportunity will be lost if data that could provide insight into pandemic-related inequities are overlooked, masked, or never gathered.

Practice humility

Practicing humility is an active commitment to adopting a position of learning, rather than knowing, and of listening rather than telling. It requires those who hold power and authority to step into intentional acts of solidarity, curiosity, and openness (Plamondon and Bisung, 2019). Practicing humility early in 2020 by approaching China's actions with curiosity rather than judgment could have changed the trajectory of this pandemic (Plamondon, 2020). As pandemic fatigue seems to settle in over populations around the world, there are increasing trends of public vigilantes who shame or stigmatize others who they perceive as not acting as they should (e.g., Porter, 2021). A general narrative of the carelessness of young people, for example, unfairly blames youth for the persistence of this pandemic. Public health and political leaders risk contributing to this general narrative by repeatedly emphasizing interventions that focus on individual behaviours, avoiding structural interventions that would address SSDH, and adhering to the idea that there is some way around the pandemic.

Research conducted during the pandemic showed Asian and Black Americans reported increased experiences of racism, including 'people acting uncomfortable around them, being subjected to slurs or jokes, and fearing threats or physical attack' [(Cheng and Conca-Cheng, 2020), p. 1]. Shaming, ostracizing, and virtue posturing against people who are in different social positions is leading to increased violence and discrimination by people who feel legitimized to do so. But this virus is unlikely to disappear this year, or next, or even in five years (Scudellari, 2020). Even if the globe reaches some state of containment or more consistent control, the globalized nature of human interactions alongside impacts of climate change and human encroachment on wild habitats create conditions in which other pandemics are likely to arise (Espejo *et al.*, 2020). Pandemics are inherently global health issues that, like the climate crisis, demand global efforts focused on learning together. Hanging hope on something unattainable while using *othering* to place blame, whether racialized or generational or something else, only serves to erode social cohesion and public trust. Practicing humility means avoiding divisive shaming and acts that distance ourselves from others, while actively embracing a stance of compassion and listening to understand.

CONCLUSION

The COVID-19 pandemic dramatically illuminates the scope and scale of inequities worldwide, as populations already bearing heavy burdens of systemic disadvantage bear disproportionate hardship. Further, it illuminates the short-sightedness of eroding public health systems and the fragility of a political economy built on the imaginaries of unrestrained growth. In these tumultuous days, the choices faced by leaders around the world are extraordinarily difficult. A measly virus brought the world to a rapid halt, shining intense light on the depth and injustice of social and economic inequities worldwide. Recognizing the inherently global nature of this pandemic, likely to persist for the foreseeable future, the *determinants of equity* embedded in global responses to it will critically shape our global futures. Doing so requires reflection about issues of power and unearned advantage and disadvantage, which can be uncomfortable and difficult. And so worthy. It is not coincidental or inevitable that this crisis is affecting particular groups more—rather, it is a predictable outcome of unfair social systems and structures that shape a political economy of injustice.

Choices to act (or not act) will to continue to accelerate vast inequities within and between countries as rapidly as the COVID-19 pandemic itself—if it is allowed to do so. Absence of equity considerations will limit our collective creativity in solution seeking, trapping us in all-or-none thinking and shaping a future of even wider inequities. I invite communities, advocates, health professionals, health promotion practitioners, health systems leaders, governments (of all levels), and anyone who considers themselves as affected by the COVID-19 pandemic to contemplate how they can be part of shifting public policy and dialogue to be both evidence-informed *and* equity-centered. Critical and inclusive dialogue about the equity implications of policies and action can transform the global epidemiological picture of COVID-19, away from tragic and avoidable entrenchment of health inequities and toward a better future for all of humanity. This pandemic presents the most powerful disruption to society in a century: the question is whether we, as a collective humanity, will act collectively to make the world more beautiful, just, and humane.

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