Preface

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We would be remiss not to mention that the novel coronavirus COVID-19 emerged after we had written this book, as we were finalizing for publication, and how “in only a short period of time, the COVID-19 pandemic has unleashed an unprecedented crisis” globally (1 para1) and nationally (2). The pandemic has, as stated in the UN’s Sustainable Development Goals COVID-19 report (1) highlighted the plight of the least privileged globally (3) and in Canada (2,4) even further.

As many of the chapters in this book highlight, northerners often face barriers to achieving health equity through inequities in the various dimensions of health, including the northern Indigenous determinants of health/ socioecological determinants of health, and in northern health care systems. These barriers are further emphasized during health emergencies, such as those presented by a pandemic.

While we acknowledge that a whole book could be written about the ways in which COVID-19 has impacted health and health care in northern and remote Canada, we wanted to briefly recognize the impacts of some of the highly intertwined determinants of health in this book. These include some of the proximal determinants that have long-lasting implications, such as food security, housing, and income or socio-economic status; the intermediate determinants, such as health care and educational systems; community infrastructure and capacities; environmental stewardship or connections to the land; and cultural and linguistic continuity, kinship, and social ties; and the distal determinants within which all other determinants are constructed (5), including national, institutional, political, legal, and cultural factors (6) and, for Indigenous peoples, colonization, colonialism, “racism, social exclusion [and] ... repression of self-determination” (5 p22).

Proximal Determinants

Income and Food Security

As discussed by Schiff and Schembri in this volume ([chapter 2](#)), food insecurity is a well-known issue experienced by northern and remote communities in Canada. For many Indigenous peoples and communities, these issues have been exacerbated by lockdown measures and the closure of businesses, followed by layoffs and furloughs, to curb the spread of COVID-19. These measures and the overall impact of the pandemic on the food supply has amplified concerns about already fragile food supply systems and chains, employment, and incomes ([7](#)).

Housing

Food security is linked to housing and several other determinants, including “education, adequate employment and ... overall health and well-being” ([8](#) para3). COVID-19 has compounded the issue of housing insecurity for many. For people who live in overcrowded housing or are homeless, conventional and sound physical distancing measures implemented during pandemics, like staying at home, are not an option ([8–10](#)): “The ability to isolate or social distance hinges on access to stable and adequate housing” ([9](#) para5). Historically, housing and homelessness have been well-known challenges in rural, northern, and remote communities ([11](#)), particularly northern fly-in, First Nations reserves, and Inuit communities ([9](#)). But while the “unique needs of homeless populations during pandemics has been a major component of the Canadian federal response to the COVID-19 crisis” northern, rural, and remote communities “have received little to no funding to aid in their care of homeless people during the pandemic” ([11](#) para1).

With COVID-19 and the need to isolate in already crowded homes, challenges in areas like mental health and violence against women and children have increased globally ([3](#)) and in Canada ([12](#)). In rural and remote communities where access to health care and social service options ([13](#)), mental health supports, and emergency shelters is very limited, the situation for women – particularly pregnant women – and children may be significantly aggravated ([3](#)).

Intermediate Determinants

Health Care Systems

The shortages of health care professionals and well-functioning health care systems have intensified across Canada during COVID-19, nowhere more acutely than in northern and remote communities ([14–16](#)). The southern health care

systems, where northern residents are sent for anything that cannot be dealt with in a northern health centre or small northern hospital, have faced unprecedented challenges during COVID-19. Planned tests and elective surgery have been cancelled and postponed because of fears of further spread of the disease and of overextending the capacity of the health care system as victims of COVID-19 filled hospitals across the country (17). For northern residents living in fly-in communities, the cancellation of and reduction in flights because of COVID-19 turned to questions of life and death as no flights meant no medical evacuations – whether for having cancer treatment, giving birth, or treating a complicated fracture (18). Strongly urged to do so by Indigenous politicians and organizations alike, the federal government did rise to the occasion and provided the funding needed to enable some airlines to continue operating (19). Leaving a northern community to access medical care in the south has, however, become an even more arduous, and for many, a more frightening experience, than it was already (20) because of the fear of bringing COVID-19 back home and the need to stay in isolation hubs for 14 days before being able to board a homebound flight (19). The fear of spread prompted an increase in the use of the internet in both health care and educational systems everywhere (14,21–23) and made telemedicine and virtual medical appointments essential.

Telemedicine

Canada was fortunate to have an existing telemedicine infrastructure, which was significantly expanded early in the pandemic (21). The expansion has, unfortunately, not benefited many northern and remote communities. COVID-19 has drawn further attention to the stark disparities in access to high-speed internet between northern, rural, and remote communities and their southern counterparts (14,22). Many northern and remote communities were already hugely underserved before the pandemic hit, and COVID-19 challenged the federal government to follow through on promises to bring high-speed internet to northern, rural, and remote communities (21). These promises were not realized for many northern communities, and fear of them never being realized moving forward has been expressed (23). The disparity in connectivity between northern and southern communities has instead been exacerbated during COVID-19; consequently, disparity in access to health care has also been exacerbated. The opportunity that existed before COVID-19 to make an appointment with a physician or specialist from a southern hospital has, for some northerners, been impossible during the pandemic. Taking into consideration the health and safety of the individuals, families, and communities in their care, while also considering their own health and safety, many providers have chosen to conduct their appointments online (4,12). This change has meant that people who live in a northern and or remote community with no

or limited connectivity or no or limited access to a computer or phone simply won't see a care provider until their concern has intensified and may require hospitalization (4,23).

Women's and Maternal Health

Pregnancy and postpartum checkups with midwives or physicians have, for many women, changed to being virtual appointments. This change has led to increasing uncertainty, anxiety, and depression among pregnant and postpartum women (24). Anxiety and depression have been three to four times higher than usual since the advent of COVID-19 (25). Women who live in northern communities have probably felt the isolation more deeply than other women in Canada; many northern communities are characterized by no or few health care facilities, no or extremely limited space to isolate individuals if infected, and little or no access to the protective personal equipment available in other communities (26–28). For women in Indigenous fly-in communities, this has intensified the stress associated with being evacuated to give birth in urban hubs (29), where COVID-19 infection rates are higher than in the birthing women's home communities, resulting in concern for babies' health and for bringing home infection (25,30).

For many Indigenous peoples and communities, the birth of a child is normally a time for family and community gatherings and celebration (29) and holds particular significance for the Elders of the family, as they come to give the baby the name with which the child “enters ... the tribe” (31 para2). Such traditions have been difficult to honour with the prohibitions against larger gatherings and with COVID-19-related morbidity and mortality statistics very high among older people. As a result, older people, for their own health and safety, have been encouraged to self-isolate if living independently or been forced into isolation if living in long-term-care facilities (32). Indigenous communities' fear of losing traditional and cultural knowledge and Knowledge Keepers has, during COVID-19 been more present than ever, as older people in northern, rural, remote, and Indigenous communities typically “are forced to leave their communities” to access health and long-term care “when they grow older” (33 para13). The tradition in many Indigenous communities of keeping Elders in the community, rather than encouraging a move to a long-term-care facility outside the community, may have been lifesaving for Indigenous Elders during COVID-19 (34).

Mental Health, Addiction, and Suicide

It is not surprising that mental health issues and addiction during COVID-19 have increased globally (35) and in Canada (36,37). Similarly, while people everywhere may be physiologically impacted by COVID-19, some may be

particularly affected, such as pregnant and postpartum women; children and young people; seniors and their families, especially seniors living in long-term-care facilities; people who are precariously employed or unemployed; people who are precariously housed or homeless; and people living in communities that are underserved in relation to health care, social services, and education (e.g., northern and remote communities) (38). The population groups and communities that have least access to care are unfortunately also among the population groups and communities in Canada that generally see the highest rates of suicide and suicide attempts (39). And although Mara Grunau, the executive director of the Centre for Suicide Prevention in Alberta, posits that suicide attempts and suicide rates generally go down at the beginning of a crisis, she also notes that “the cumulative effect spikes after 12 to 18 months” (37 para20). That means that the real or long-lasting impact of COVID-19 on mental health has yet to be seen, just like the real or long-lasting impacts of COVID-19 on education (40).

Education and the Overall Health of Youth and Children

COVID-19 has underscored the inequity in access to education and the tools necessary for access, particularly for northern and Indigenous communities, where connectivity is a challenge and far from all students have computers (22,41,42). Moreover, as schools and day cares have closed in an attempt to maintain health and safety, some children have been without a safe place, access to food from breakfast and lunch programs, and other supports (2), increasing the risks to their health and of food insecurity rather than lowering them.

Distal Determinants

In addition to highlighting the plight of the least privileged in nations and societies, and the ways in which histories, current politics, and policies perpetuate inequities and disparities, COVID-19 has also brought to light the strength and resilience of Indigenous communities despite these communities (particularly northern Indigenous communities) living with many inequities in relation to dimensions and determinants of health. Indigenous communities had, on average, only 25 percent of the infection rates of Canada, and the death toll has been even smaller (43). Indigenous communities initially had successfully limited the spread of the infection by, among other things, “articulating and enforcing rules on who can enter their communities, often implementing far stricter measures than those enacted by local municipalities, such as closures and checkpoints” (44 para12). In addition, many Indigenous communities used traditional means to maintain and improve health and immune responses and to overcome the anxiety and depression that followed in the wake of COVID-19

(14,45). In response to the challenges imposed by COVID-19, many northern Indigenous communities found strength in returning to and or increasing focus on more traditional land-based food systems and developed “new ways to exercise their food self-determination to meet the changing needs of their communities” (14,46 para14). Not only Indigenous peoples and communities but also people living in northern Canadian communities generally returned to or started growing their own gardens/vegetables and making food from scratch (47).

Throughout 2020, COVID-19 exacerbated existing disparities in the dimensions of health, including the northern Indigenous determinants of health/socioecological determinants of health, and in northern health care systems. However, COVID-19 has also demonstrated that it is possible for local, provincial and territorial, and federal governments to act decisively and quickly to implement needed supports and make changes in systems affecting population health and well-being (whether or not the support has been enough for the northern and remote areas of Canada notwithstanding), with the federal government, in the 2020 throne speech, offering further support to the populations most severely impacted (48).

We are hopeful that the increasing focus on disparities between northern and southern communities in Canada and how disparities among and between populations impact the health and well-being of us all, will have a positive impact on addressing inequities in dimensions and determinants of health and well-being moving forward, of people living in Canada generally and in northern Canada specifically. Research to document the outcomes of this increased focus, however, is essential. At the time we wrote this preface, little research centring on COVID-19 in a northern context has been published (49). An increased focus on the effects of pandemics such as COVID-19 on northern communities and regions in Canada is needed as a tool for advocacy and for crucial changes in health and health care disparities.

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