

VIRTUAL

FAST-TRACK CITIES 2020

September 9-10, 2020

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IN PARTNERSHIP WITH:



Montreal and COVID-19

Montréal, Québec, Canada

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Land acknowledgement

- Montréal is located on stolen, unceded Indigenous lands. The Kanien'kehá:ka Nation is recognized as the custodians of the lands and waters from which we are presenting today.
- Tiohtià:ke/Montréal is historically known as a gathering place for many First Nations. Today, it is home to a diverse population of Indigenous and other peoples.
- Canada, like other colonial nations, is built on the continued genocide of Indigenous peoples. Viral epidemics are facilitated by colonial domination and, as such, affect Indigenous and racialized communities with particularly devastating results.

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COVID-19 data

Trends and inequalities in
Montréal

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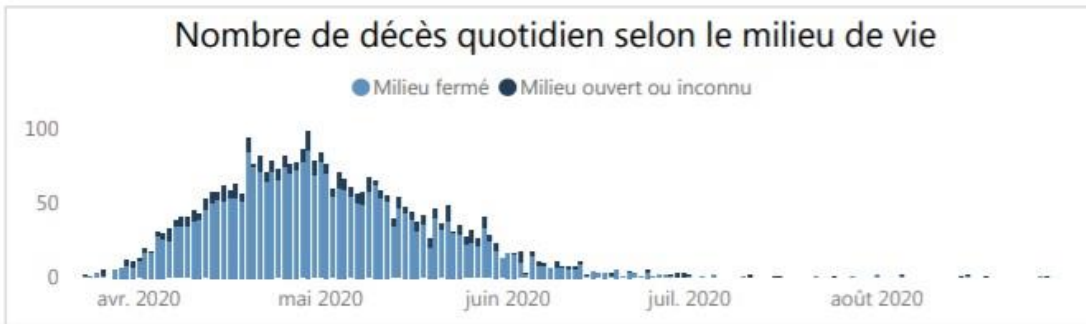
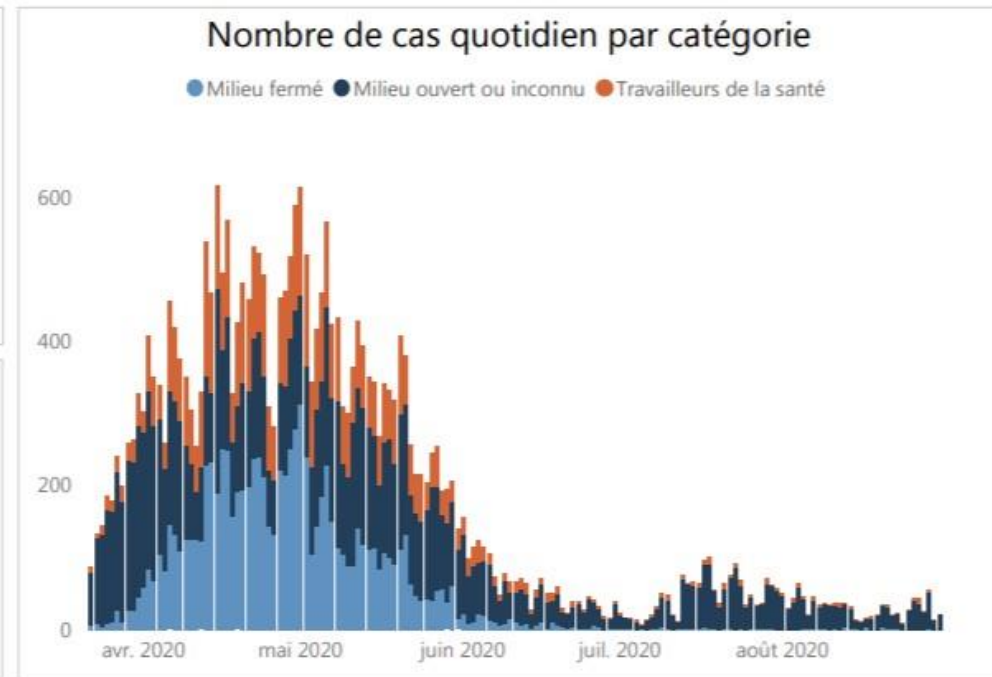
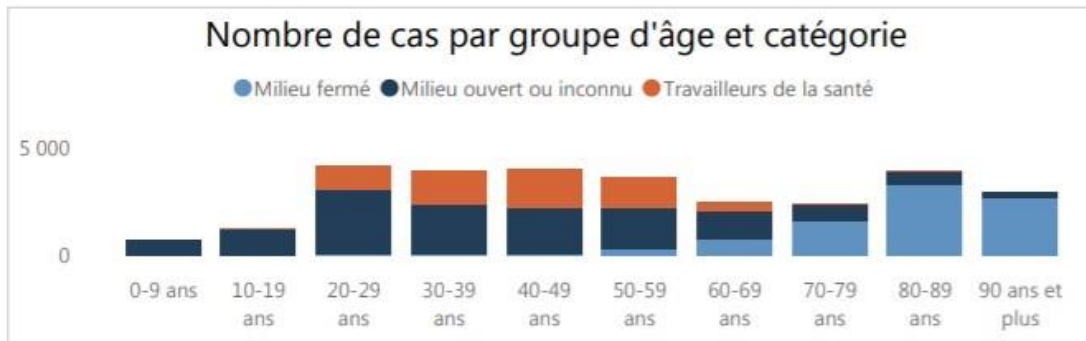


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Situation COVID-19 sur l'Île de Montréal, le 1er septembre 2020 : Ensemble de l'Île de Montréal

Nombre de cas	Nombre de cas - Travailleurs de la santé	Nombre de décès	Nombre de décès en milieux fermés
29 863	6 405	3 471	3 037
Taux de cas par 100 000 habitants	Pourcentage du total des cas	Taux de mortalité par 100 000 habitants	Pourcentage du total des décès
1 445,7	21 %	168,0	87 %



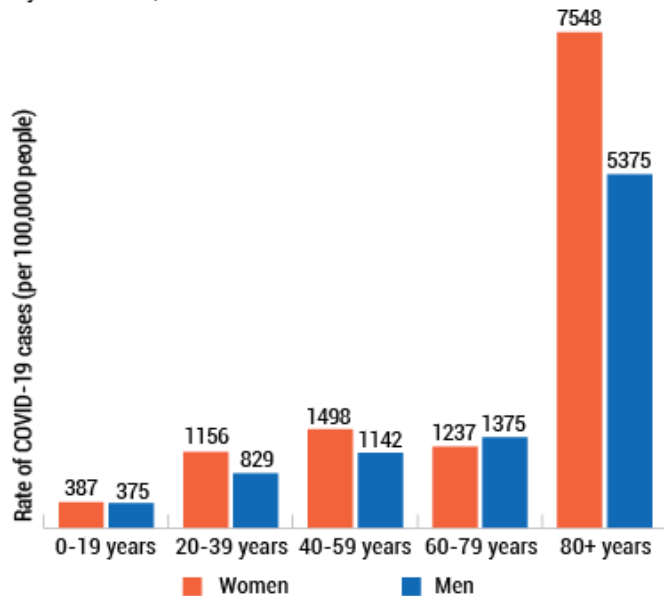
Source : TSP, MSSS (MAJ du 31 août 2020 17h15). Traitement et analyse : DRSP. Rapports individualisés uniquement pour les arrondissements de Montréal et les villes liées ayant +100 cas.

Note 1 : Les milieux fermés incluent les CHSLD, ressources intermédiaires, résidences privées pour aînés, centres de réadaptation, centres hospitaliers, prison et hébergement communautaire.

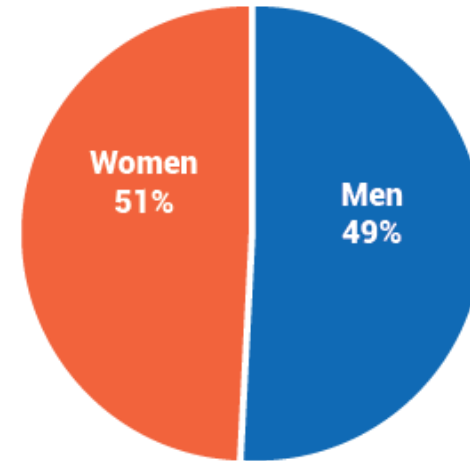
Note 2 : Les travailleurs de la santé sont classés dans une catégorie distincte, indépendamment du type de milieu de vie.

Inequality during the pandemic : more women contracted COVID-19, men had a more severe form of the disease

Rate of COVID-19 cases (per 100,000 people) by age group and gender by June 14th, 2020



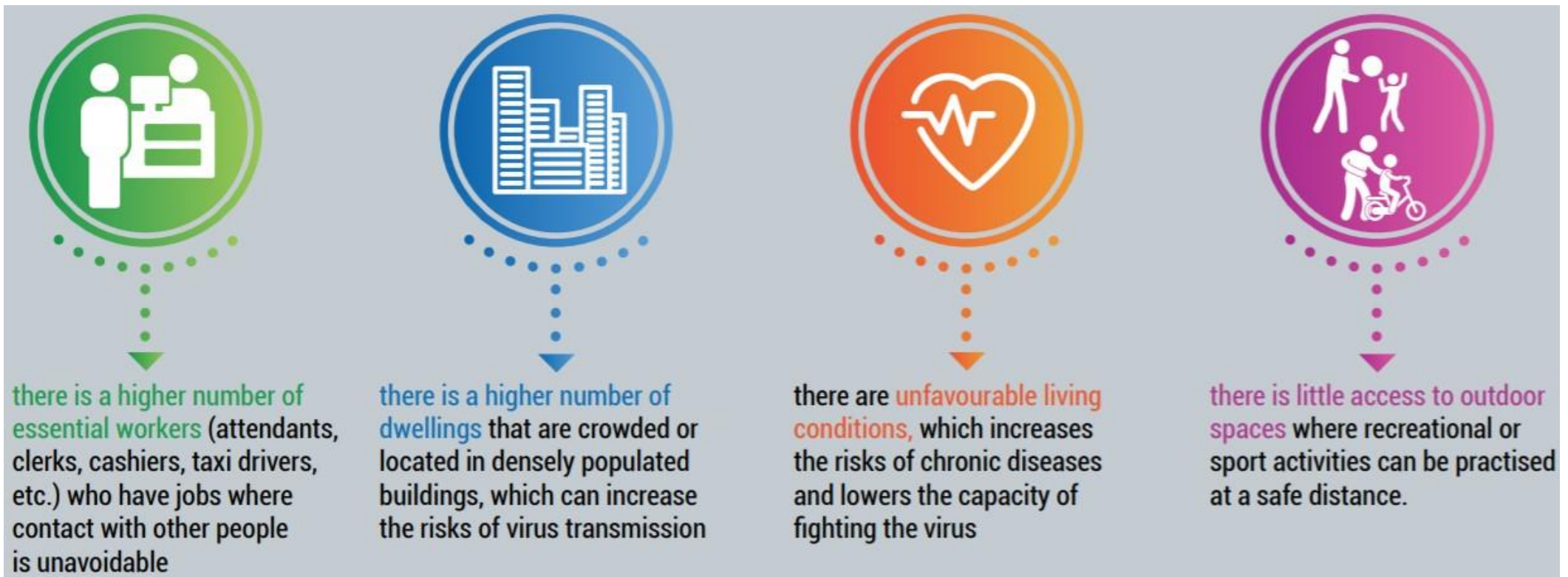
Distribution of COVID-19 hospitalizations by gender



Inequalities during the pandemic: COVID-19 hitting harder in the most disadvantaged neighbourhoods



Some reasons why COVID-19 hit harder in the most disadvantaged neighbourhoods



Inequalities during the pandemic: Racialized populations

- At this time in Québec, it is impossible to establish the exact number of confirmed cases of COVID-19 by ethnocultural group. This information is not asked when public health contacts individuals who have tested positive.
- Other types of data and surveys shed light on the distribution of confirmed COVID-19 cases and the socioeconomic effects of the pandemic in neighbourhoods with high proportions of racialized groups.
- The lack of racial data is a major problem that has been noted for years in HIV data, as well as in data around police interventions.

Higher rates of COVID-19 in areas where the proportion of visible minorities is greater

- Rate of COVID-19 is about 1.6 times higher in parts of the Island where the proportion of people identified as visible minorities is highest (1,145 cases for 100,000 inhabitants), compared with areas where this proportion is lowest (713 for 100,000 inhabitants)
- This disparity follows a gradient.

Visible minority proportion in the neighborhood ¹	Rate of COVID-19 cases per 100,000 inhabitants
Less than 17.4%	713
17.4% - 24.7%	693
24.8% - 37.4%	946
37.5% - 46.8%	1 128
46.9% and more	1 145
<i>Total</i>	<i>951</i>

¹ Term used to define the following groups: South Asian, Chinese, Black, Filipino, Latin-American, Arab, Southeast Asian, West Asian, Korean and Japanese (data from 2016)

² Excludes cases in closed settings (eg, long-term care facilities, etc.)

Racialized communities are more vulnerable to the negative socioeconomic effects of the pandemic / pandemic response



28% of non-Caucasian Montrealers report major financial losses (versus 18% among Caucasians).



14% of non-Caucasian Montrealers say that the pandemic has had an impact on their ability to pay their rent (versus 5% among Caucasians).



49% of non-Caucasian Montrealers indicate that the pandemic has led to someone in their household losing their job (versus 31% among Caucasians).

Impacts on marginalized communities

- Repressive measures – 1500\$ tickets given by police to anyone deemed to not respect distancing measures – obvious targeting of marginalized communities
- Issues with access to drug supplies – closed borders, price fluctuations, usual income streams non-available, increased contamination with other substances, increased surveillance
- Difficulty accessing washrooms and water for homeless people
- Increased social isolation for PLWH, LGBTQ2S+ youth and elderly, etc
- Difficulties with housing stability, access to food, etc
- Lack of access to government aid for sex workers, undocumented migrants, people with criminalized sources of income

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HIV and related services

COVID-related disruptions in access and utilization

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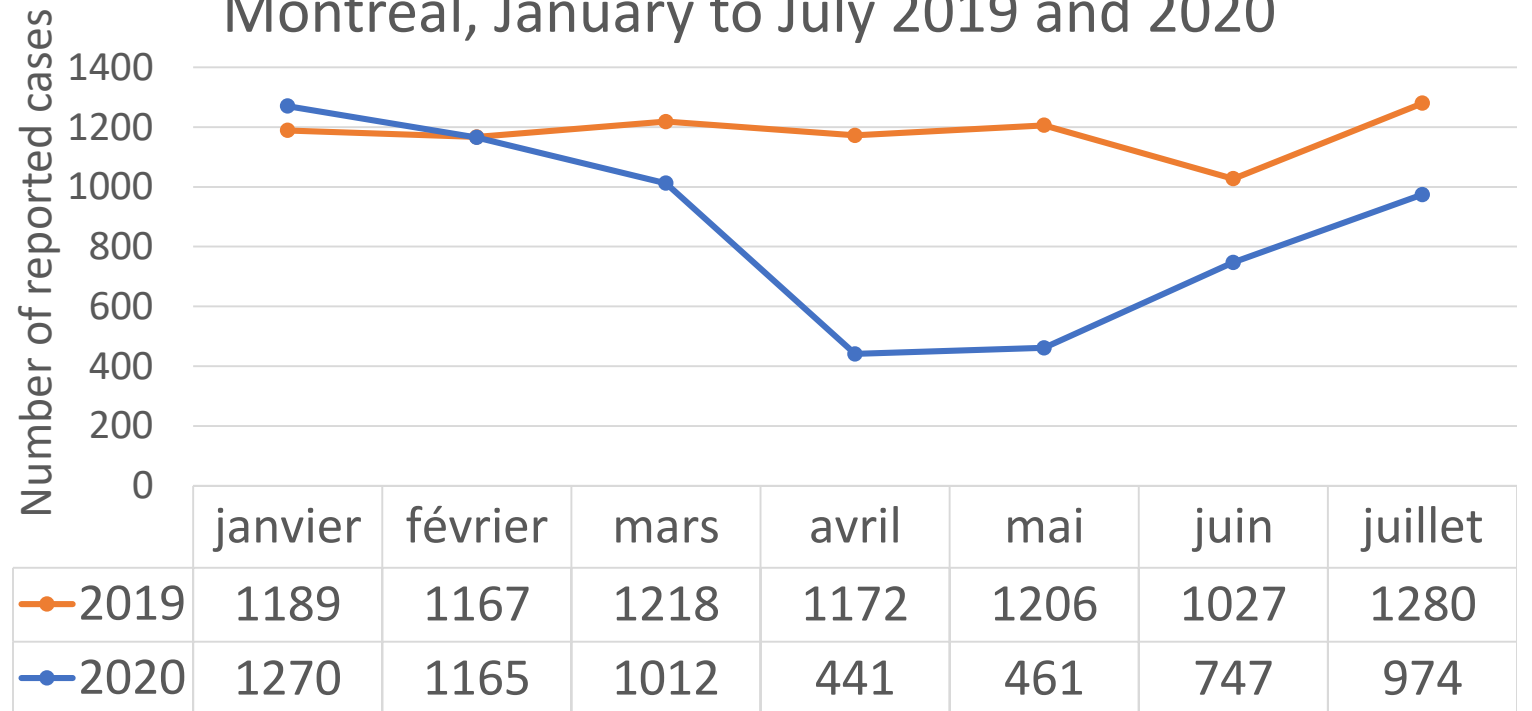
Community-based organizations

- 3 out of 4 supervised consumption sites were forced to close for several weeks because of lack of PPE and training
- Difficulty establishing protocols for HIV-specific housing resources – public health tends to care more about prevention of HIV than supporting PLWH
- Near-total stoppage of all community-based or easily accessible STI testing
- Most service organizations remained open with modified services

STI testing and treatment services

- In the first months of the pandemic :
 - Reduced access to services
 - Reduced demand for services
 - Reduced STI incidence?
- Gradual return to normal thereafter

Number of reported bacterial STIs
Montréal, January to July 2019 and 2020



Tuberculosis screening and treatment services

- No measurable drop in the number of new diagnoses
- Initial adverse impact on DOT (followed by service adaptation and general improvement of DOT services, such as tele-DOT)
- Anecdotal but meaningful adverse impact on supervised treatment for homeless people (ex. early termination of treatment for a young women who could not be admitted in any adequate facility due to restrictions imposed by COVID protocols)

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Policy and program
innovations

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Policies

- Temporary authorizations for expanded telemedicine services, including HIV treatment and PrEP follow ups every 6 months instead of 3 and the ability to initiate methadone or suboxone
- Temporary authorizations for pharmacists to renew and transfer certain prescriptions, as well as adjust some dosages
- Official recognition of community-based organizations as essential services
- “universal” income-replacement benefit – 2000\$ a month from March to September

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Lessons learned

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- Criminalization/penalization/repression DO NOT WORK. They are not useful public health interventions, as demonstrated in the fight against HIV. What can public health officials do to avoid public health orders being turned into mandates for police interventions?
- Testing can and should be “demedicalized” to remain accessible if medical resources are mobilized elsewhere
- We need to seriously address how we communicate information and how to respond to conspiracy theories, stigmatizing information, etc.

- Community-based organizations are indispensable in a sanitary crisis
- Communities affected by HIV have developed reflexes around testing, public health advice, living with viral risks and can therefore be trusted to make the best decisions for their own situation
- Community-based organizations are able to quickly adapt services, produce useful documentation, create new programs and reach their communities if given the necessary support and resources