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Abstract

We are currently in the midst of a global pandemic with the spread of Coronavirus Disease 2019 (COVID-19). While we do not know how this situation will unfold or resolve, we do have insight into how it fits within existing patterns and relations, particularly those pertaining to sociocultural constructions of (in)security, vulnerability, and risk. We can see evidence of surveillance dynamics at play with how bodies and pathogens are being measured, tracked, predicted, and regulated. We can grasp how threat is being racialized, how and why institutions are flailing, and how social media might be fueling social divisions. There is, in other words, a lot that our scholarly community could add to the conversation. In this rapid-response editorial, we provide an introduction to the framing devices of disease surveillance and discuss how a surveillance studies orientation could help us think critically about the present crisis and its possible aftermath.

Introduction

There is nothing quite like a pandemic to provoke profound questions about one’s health and mortality, the anthropocentric conceit underlying the shared fiction of national borders, and humanity’s place in Planet Earth’s natural history. Amidst the fear and anxiety now being sparked by global reactions to Coronavirus Disease 2019 (COVID-19), it seems pertinent to reflect on how surveillance studies might address not only the specter of emerging infectious disease, but also the entangled web of social relations that this specter feeds off of and helps to catalyze.

In this editorial, we provide a brief overview of epidemics, pandemics, and outbreaks as social problems in order to situate our thinking about COVID-19. We next consider the concept of disease surveillance, sketching two different genealogies: one developed by public health professionals and scholars and the other articulated within surveillance studies and the critical social sciences in response to this public health approach. In recognition of the fact that scholars in our field may be called upon to speak to issues raised by COVID-19 and other communicable diseases, we then briefly discuss how a surveillance studies orientation can help us think critically about such crises and responses to them.

Epidemics, Pandemics, and Outbreaks

Popular culture has furnished us with countless representations of the apocalyptic fallout stemming from uncontrolled communicable disease. For example, in the 1995 Wolfgang Petersen film, Outbreak—an adaptation of Richard Preston’s The Hot Zone—Dustin Hoffman plays a US Army virologist given the harrowing task of tracking down the cause of a mysterious illness while his superiors attempt to suppress...
his findings. Merging disease-outbreak fiction with the zombie genre, Marc Foster’s filmic adaptation of Max Brooks’ *World War Z* features Brad Pitt in a similar race against time to develop a vaccine. Both films center on heroic protagonists and evoke images of “disease detectives” (Wald 2008) who are struggling against the odds to save humanity; neither film says much about conditions of stark inequality that threatened humanity in the first place. The larger social problems are instead sublimated through the figure of a deadly causal agent. As shallow as these representations are, they reflect commonplace and widespread beliefs, which are easily activated and reinforced by media coverage of public health events.

In the face of such representations, which under current conditions have the capacity to ignite fear and anxiety, how do we get to a deeper understanding of epidemics, pandemics, and outbreaks? Epidemics, the *Oxford English Dictionary* tells us, are widespread occurrences of infectious disease in a community at a particular time. Pandemics, inclusive of all the *demos*, suggest the prevalence of infectious disease on a large scale, something spread to whole countries or the whole world and usually signifying an epidemic that is beyond control. Outbreak connotes the temporality of these events, suggesting a “violent start of something unwelcome” (OED 1998: 1316). These terms may be said to make up part of a discourse or narrative that crystalizes webs of complex social relations into identifiable social problems (Wald 2008). They suggest an escalation of disease in populations and also “indicate the peculiar mobility of infectious agents, which transform the bodies of humans and other animals into vectors in order to move through space and across time” (French et al. 2018: 60). As epidemics, pandemics, and outbreaks become recognized as social problems, and as they subsume other social problems, critical analysts would want to attend to their cultural, symbolic, structural, and complex material dimensions. They would want, at a minimum, to keep track of how these terms contain and configure bodily vulnerability, stigmatization and marginalization, structural inequalities and violence, and disease construction and management (French et al. 2018).

**COVID-19**

With these dimensions in view, what can be said about COVID-19? First appearing as a cluster of pneumonia cases in December 2019 in Wuhan, Hubei, China, “with clinical presentations greatly resembling viral pneumonia,” COVID-19—a “novel coronavirus” (Huang et al. 2020: 497)—was identified in “samples of bronchoalveolar lavage fluid (BALF) from a patient from Wuhan by scientists of the National Institute of Viral Disease Control and Prevention (IVDC)” (Tan et al. 2020: 61).¹ COVID-19 is not the first coronavirus to make waves in the twenty-first century. Watching news media coverage, one could be forgiven for thinking that it is entirely new. However, it was preceded by MERS-CoV, the *Middle East Respiratory Syndrome*, cases of which were reported starting in 2012, and SARS-CoV, *Severe Acute Respiratory Syndrome*, which was first recognized in 2003.

Respiratory syndromes linked to coronavirus excite attention on the part of media and other organizational actors such as public health agencies because of a variety of factors, including their potential to spread rapidly through populations and become pandemic in scale, as well as their “severity” or their potential to produce life-threatening illness. Such viruses are assumed to come from an “animal reservoir,” a feature that is said to make them particularly dangerous to humans because they are unknown to the human immune system (US CDC 2020a). The World Health Organization (WHO) characterized COVID-19 as a pandemic on 11 March 2019 (WHO 2020a). Prior to this, on 30 January 2020, WHO Director General Dr. Tedros Adhanom Ghebreyesus declared “a public health emergency of international concern of the global outbreak of novel coronavirus” (WHO 2020b). Defined in the revised *International Health Regulations* (IHR) (2005)—a document that was itself propelled into its twenty-first century iteration by SARS—the declaration of an emergency triggers a range of obligations on state parties, including provisions related to

¹ It is noteworthy that in the paper published by Huang and colleagues in *The Lancet*, the authors indicate that the process for obtaining consent to perform this viral identification was circumvented. As they report, “Written informed consent was waived by the Ethics Commission of the designated hospital for emerging infectious diseases” (Huang et al. 2020: 498). As scholars of surveillance well know, states of exception go hand in hand with the deployment of extraordinary control measures and practices designed to intensify the gaze (e.g., Aas 2011; Abujidi 2010; Bigo 2006; French 2007; Lyon 2003; Monahan and Murakami Wood 2018; Topak 2017; Wilson and Weber 2008).
notification and information-sharing (WHO 2005). The declaration of an emergency also provides moral license to depart from business as usual, and indeed we have since seen many countries take drastic measures to contain the spread of COVID-19, including implementing travel bans and quarantines, as well as intensified surveillance in places like airports (e.g., Griffiths 2020).

These developments have been accompanied by an amplification in popular discourse—through broadcast and social media—of fear associated with pandemic disease, not to mention the rejuvenation of some of epidemiology’s most stigmatizing and problematic concepts (e.g., “super-spreader”). We have also seen the emergence of travel bans that target specific countries and nationalities, alongside augmented racial profiling of presumed human vectors (e.g., Egan and Gregorian 2020; Seddon 2020). (The racist dimensions of this crisis are discussed in further detail below.)

Clearly, the entire global economy has now been thrown into a tailspin as all sectors grapple with containing the virus while managing its associated dangers and uncertainties. Manufacturing, distribution, tourism, education, and healthcare, along with other vital components of the economy, are in shock mode as they confront shortages and take precautionary measures to mitigate risk. In the wake of national emergency declarations, panic buying and price gouging, especially of staple consumer goods, are amplifying these instabilities. The ripple effect through tightly coupled industries is generating a rapid decline in the value of stocks, pushing the global economy to the brink of another recession and thrusting vulnerable workers further into economic precarity. While various interventions are expected from governments and international bodies, of especial note are massive state allocations for the production of vaccines. For instance, the USA’s $8.3 billion emergency spending package designates roughly $3 billion for vaccine development, most of which will be directed toward the pharmaceutical industry (Hirsch and Breuninger 2020; Simmons-Duffin 2020). Even though the coronavirus may have petered out by the time the vaccines are approved for the market, advance purchase contracts will ensure that this articulation of “disaster capitalism” (Klein 2007) will fuel industry, perhaps ultimately to the detriment of other pressing health needs.

In the US context, the absence of universal health care means that economic inequalities are exacerbated by the COVID-19 threat, punishing many sick and/or worried individuals and their families with crippling healthcare costs should they seek diagnosis or treatment (Hoffower 2020). Even in Canada, where health care and public health systems are, comparatively speaking, robust and universally accessible, years of austerity budgeting by provinces (Evans and Fanelli 2018) have now led to questions about whether these systems have the resiliency and capacity to deal with the surge of critically ill patients that COVID-19 could produce. The situation, in sum, is primed to aggravate extant health inequities (Ruckert and Labonté 2014). Indeed, the economic and health harms of this crisis are being—and will continue to be—felt unequally.

**COVID-19 Surveillance: What is It?**

Amidst this crisis, one institutionalized response promises a modicum of certainty: surveillance. Daily counts of confirmed cases, along with a catalogue of the number of deaths related to COVID-19, work to provide authorities with a common ground for action. Yet, while providing a concrete accounting of

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2 New instantiations of “pharmaceutical nationalism” (Hayden 2015) are forming too, as can be seen with US attempts to lure German vaccine producer CureVac to the US so that US citizens could benefit first from any protections provided by eventual coronavirus vaccines (Carrel and Rinke 2020).

3 Andrew Lakoff (2015: 314) describes a similar situation with earlier vaccines for H1N1 in Europe, where once the vaccines were made available, they were deemed of little use, even after substantial state investment in them. As a result, “the governments of France, Germany, and England all sought to renegotiate their advance purchase agreements with vaccine manufacturers and to unload their excess doses on poor countries in the global south at bargain prices.”
prevalence and incidence, surveillance of COVID-19 also produces a range of uncertainties. These uncertainties start to come into view when we ask what, exactly, is surveillance of COVID-19?

Public health professionals and organizations typically have a specific domain of practice in mind when they use the term surveillance. Classically, they have tended to distinguish surveillance of disease from surveillance of individuals (e.g., Langmuir 1963; see also French 2009). The IHR defines surveillance as “the systematic ongoing collection, collation and analysis of data for public health purposes and the timely dissemination of public health information for assessment and public health response as necessary” (WHO 2005: 10). In this vein, WHO guidelines for the surveillance of COVID-19 outline the following objectives: “1) monitor trends in the disease where human-to-human transmission occurs; 2) rapidly detect new cases in countries where the virus is not circulating; 3) provide epidemiological information to conduct risk assessments at the national, regional and global levels; [and] 4) provide epidemiological information to guide preparedness and response measures” (WHO 2020c). The WHO guidelines also specify a set of “case definitions” of COVID-19, aiming to distinguish between “suspected cases,” “probable cases,” and “confirmed cases” (i.e., laboratory confirmed cases) (WHO 2020c). The organization provides recommendations for contact tracing (i.e., identifying people who have been in contact with someone identified as a case), laboratory testing, case-reporting to the WHO, data aggregation, and specimen collection (WHO 2020b).

Surveillance Studies Perspectives

Of course, from a surveillance studies perspective, this definition of disease surveillance and the WHO’s guidelines for surveillance of COVID-19 leave unnamed a wide swath of practices implicated in the surveillance of presumptive coronavirus cases. Between the categories of the suspected, the probable, and the confirmed lies a mess of complex social reality. Surveillance studies scholarship can bring this mess into view by attending to the differences between logics (or guidelines) and practices (e.g., French 2014; Magnet 2011; Smith 2015), and there is a need to look beyond WHO guidelines to see how the surveillance of COVID-19 is actually happening in practice.

Not mentioned in the WHO’s guidelines, for instance, is anything about how risk communication messages propagate through deeply surveillant media and social media networks. Also unnamed are countless instances of interpersonal surveillance of the kind embodied in side-long looks at—and evasion of—others who dare to sneeze, cough, or even walk too closely to others in shared spaces such as airports, mass transit, or cafes. And, in spite of all of the public health talk about monitoring one’s self for symptoms of illness, this action is not contemplated as a form of surveillance in public health discourse.

Nevertheless, the surveillant dynamics of these modes of monitoring for COVID-19 may be reflected in established surveillance studies concepts like “lateral surveillance” (Andrejevic 2005), “participatory surveillance” (Albrechtslund 2008), “social surveillance” (Marwick 2012), “self-vigilance” (Koskela 2000; 2003), “self-tracking” (Lupton and Smith 2018), and “exposure” (Ball 2009). These concepts name processes and practices that have to do with social order and subjectivity-formation in everyday life. Even if their surveillant dynamics are not explicitly acknowledged in public health discussions of surveillance, they are given structural weight in public health recommendations to avoid close contact and to act responsibly.5

Accordingly, to better capture the range of surveillant dynamics at work in our consideration of COVID-19, it seems analytically necessary to shift to a broader understanding of surveillance than what is typically given in public health discourse. This understanding could productively contemplate “any tracking and monitoring, whether systematic or not, of health-related information,” as well as any tracking and

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4 See Saulnier (2017) for a review of surveillance studies work on the surveilled subject.
5 The US CDC suggests that people can protect themselves from COVID-19 by practicing hand hygiene and avoiding close contact with people. Its website, entitled How to Protect Yourself, lists steps like “Clean your hands often” and “Put distance between yourself and other people if COVID-19 is spreading in your community” (US CDC 2020b).
monitoring that could be enrolled into the work of determining the health status of people and populations (French and Smith 2013: 383; see also, Armstrong 1995; Fisher and Monahan 2011).

Dis-ease Surveillance
A helpful text for locating the current public health response to COVID-19, and the specter of emerging infectious disease more generally, is Weir and Mykhalovskiy’s (2010) Global Public Health Vigilance. This book traces the twenty-first century reconfiguration of infectious disease surveillance at national, regional, and global levels. As Weir and Mykhalovskiy argue, the form of public health reasoning that emerges in the twenty-first century has as a key goal the containment of “public health emergencies prior to their spread across international boundaries” (Weir and Mykhalovskiy 2010: 3, emphasis ours). This effort to interrupt disease transmission before it crosses international boundaries reflects a broader set of time–space relations that are characteristic of contemporary thinking about pandemics. On the one hand, these relations involve a high degree of sensitivity to the spatial dimensions of health events, especially their potential to extend beyond local settings. On the other hand, they are beset by a deep anxiety about the timeliness of response, the outcome of which is an immense effort to detect, pre-empt or rapidly respond to health events to prevent them from having trans–local effects (French and Mykhalovskiy 2013: 175).

This effort to detect, pre-empt, and rapidly respond to health events like pandemics has effects that work to configure medical care and public health systems. We might consider, for example, what it means for publics to be constructed through the anticipatory measures sparked by pandemic anxiety (French and Mykhalovskiy 2013; Thomas 2014).

Pandemic anxiety creates dis-ease in several different registers, and these are worthy of scholarly attention. As noted above, it would be worthwhile to consider how COVID-19 is reconfiguring

1) cultural understandings of bodily vulnerability; 2) social processes of stigmatization and marginalization; 3) structural inequalities and forms of structural, everyday violence, which predispose people and communities to the harmful effects of communicable disease while also undercutting their capacity to respond to these effects; and 4) the role played by public health and other authorities in disease construction as well as the problems, unintended consequences and issues arising out of their efforts to detect, pre-empt and contain disease spread. (French et al. 2018: 67)

Surveillance studies scholarship might, in this sense, productively engage in the surveillance of dis-ease sparked by COVID-19.

What Can Surveillance Studies Say?
Following from recent trends in the field to problematize violent, racialized inflections of surveillance (e.g., Benjamin 2019; Browne 2015; Dubrofsky and Magnet 2015; Hall 2015), the global COVID-19 crisis is crying out for a critique of the categorization and demonization of racialized populations. In this case, politicians, fringe and mainstream media, and others have been quick to paint Chinese people as culpable for the origination and spread of the virus, as contagious embodiments of anxiety and risk unjustly visited upon “civilized” populations (Ellen 2020). As Marnie Ritchie (2020: 13) writes in this issue, the raced body is reduced “to an object of anxiety... a raced body is an unsettler of objects. The body becomes a moving target, a target because it can move. This body is accused of upending the capacity of those integrated into whiteness to feel settled in time and space.” Although Ritchie is not writing about the coronavirus, per se, one can easily detect the pattern in how racialized others are perceived as destabilizing and threatening to the white body politic. In these ways, a cultural script of racial dehumanization and white victimization animates extreme surveillance measures and is used to justify augmented intervention through surveillance,
containment, or attack (Monahan 2017). Particularly when there is a perceived existential threat, as with COVID-19, racial categories become incredibly slippery and capacious. Expansive understanding of racialized threat can be seen, for instance, with fearful whites physically assaultling “Asian-looking” individuals (Guy 2020; Yan et al. 2020) or with US President Trump calling COVID-19 a “foreign virus” (Liptak and Vazquez 2020), instituting travel bans for foreign nationals (but not US citizens) traveling from Europe (Egan and Gregorian 2020), and considering closing the US-Mexico border as a way to prevent the spread of the virus (Associated Press 2020). In these ways, the virus is conflated with racial threat and attached to deeper cultural narratives of racial contagion to the detriment of science-based public health interventions.6

What is especially fascinating about the COVID-19 crisis is how it has been able to short-circuit what were growing critiques of China’s surveillance state, its social credit system, and its internment (“reeducation”) camps for Uyghur Muslims and others (Matsakis 2019; Mitchell and Diamond 2018; Ramzy and Buckley 2019). The fact that the Chinese state has seemingly been able to arrest the spread of the virus by using some of the same heavy-handed techniques of surveillance-based control and containment has drawn praise from Western sources that might have previously denounced those tactics as abuses of human rights (Kuo 2020; Kupferschmidt and Cohen 2020). From a surveillance studies perspective, we might question the ways that this global health crisis is being used to normalize oppressive surveillance measures, perhaps making them seem more palatable or even necessary as insurance against unknown future contagions or threats.7 If surveillance is thought of as existing on a spectrum between care and control (Lyon 2001), then this case highlights how both care and control can look like oppression.

Given the technological nature of many of the proposed responses to this pandemic, surveillance figures prominently in these developments. For example, South Korea’s response, which is being presented as a model for “democratic” countries (Parodi et al. 2020), foregrounds fine-grained locational data and social network analysis to track and target individuals for containment and treatment, completely sideling any privacy concerns along the way:

This includes enforcing a law that grants the government wide authority to access data: CCTV footage, GPS tracking data from phones and cars, credit card transactions, immigration entry information, and other personal details of people confirmed to have an infectious disease. The authorities can then make some of this public, so anyone who may have been exposed can get themselves—or their friends and family members—tested. (Parodi et al. 2020)

In a different register, Google has been praised for its plans to develop a website to assist individuals with assessing their personal risk and need for testing or treatment (Bartz 2020). This “solution” will likely invite even further data-harvesting and -sharing. If this Google website follows current Centers for Disease Control and Prevention (CDC) guidelines, which emphasize international risk over “community spread,” it will algorithmically encode xenophobic mappings that align risk with foreign bodies or places. These are technological developments that hide their politics in plain sight, as fear and danger blind individuals and institutions to alternative answers that might protect privacy better and resist the normalization of racialized threat.

A surveillance studies orientation, in conversation with work that has theorized the mediated nature of pandemics (e.g., Levina 2015; Opitz 2017), could also direct attention to the algorithmic protocols shaping

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6 See also Silva (2016) for a broader discussion of the capaciousness of racialized threat in the US context.
7 Such an approach is not unique to the Chinese context, of course. In the early days of the COVID-19 outbreak, for instance, epidemiologists and public health experts contacted one of the authors asking for advice on how to use mobile phones to track affected individuals and their networks in order to expedite and make much more precise disease surveillance, as well as to quarantine exposed people. These aspirations, which are in keeping with Google-based tracking systems, could similarly function as a Trojan horse: encouraging people to accept intrusive surveillance in the name of public health and safety, regardless of where such applications and data might eventually creep.
audience exposure to social media content about the coronavirus, as well as to the polarizing effects of such social sorting. On one hand, there is the (now expected and commonplace) channeling of audiences into “filter bubbles” (Pariser 2011) where those who are inclined to view the threat through a racialized lens will be fed such content, whereas those who might see the threat as one of flagging public health systems will likewise find confirmation. On the other hand, amplification of such trends can lead to all-out panic as disinformation (e.g., conspiracy theories, science skepticism) fuels the kinds of fictional apocalyptic scenarios described in our introduction. This disinformation modality—of destructive inaccuracy masquerading as unassailable fact—is only aggravated by claims from leaders like President Trump, who has referred to the coronavirus crisis as a Democratic “hoax” (Global News 2020). As Mark Andrejevic (2013) has observed, the contemporary informational ecology is characterized by a form of populist postmodernism where trust in institutions is eroded, leaving no agreed upon mechanisms for adjudicating truth claims. In such a space, fear and xenophobia readily fill the vacuum left by institutional authority.  

Meanwhile, if people have lost faith in institutional authority, this will not protect them from the wrath of institutions if they are believed to have negligently contributed to the spread of COVID-19. Already, criminal charges are being pursued against the Christian sect contributing to the outbreak in South Korea (Seibt 2020), and authorities in Canada say they are not ruling out criminal law sanctions for “knowingly spreading COVID-19” (Bensadoun 2020). As we have seen with respect to HIV, a criminal justice response has been resurgent in the past decade (Mykhalovskiy 2011), suggesting the rise of an increasingly punitive approach to infectious disease (Hoppe 2018). In the case of HIV, this development has occurred without any evidence that a criminal justice response assists in HIV prevention (Mykhalovskiy 2015). In light of such developments, scholars should expect—and question the implications of—flows of health data into criminal justice systems (Spieldenner 2020).

Finally, the field of surveillance studies could further unpack the kinds of lateral and self-surveillance practices we described above. Particularly given the many media and public health directives to mitigate risk through personal hygiene practices and “social distancing,” it is obvious that the COVID-19 threat is being plugged into well-established neoliberal constructions of responsible subjects as those who manage risks on their own and do not (or cannot) rely on states or institutions to ensure safety:

This insecurity subject anticipates risks and minimizes them through consumption, regulates exposure to potentially threatening Others through systems of fortification, believes that economic inequalities are natural and social exclusion justified, voluntarily sacrifices privacy and civil liberties on the altar of national security, and fully supports punitive state policies, whether against immigrants, criminals, terrorists, or the poor. (Monahan 2010: 2)

Emphatically, personal hygiene practices and social distancing are important mechanisms for minimizing exposure to and spread of COVID-19. At the same time, the responsibilization move can also subtly (and not-so-subtly) redirect blame for the crisis and its (mis)management to individuals and their families (e.g., Gagnon and Guta 2012; Guta et al. 2016; McClelland et al. 2019), diverting attention from severely underfunded and understaffed public health and social services institutions, which are institutions that are

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8 As Alice Marwick and Rebecca Lewis (2017) relate, distrust in the media and increased radicalization (e.g., ethnonationalism) are two of the outcomes of online disinformation. Distrust in state institutions occurs as well. Caught in a downward spiral, reduced financial and political support for public institutions can lead to failures, which then can be used to justify future reductions. As a troubling articulation of this trend, the United States’ COVID-19 response has apparently been hampered by Trump administration funding cuts to the CDC and a longstanding unfilled position of “senior director for global health security and biothreats” (Borger 2020).
critical for minimizing the death toll as countries contend with affected individuals. The insecurity subject, especially in the US context, also harmonizes disturbingly well with conservative anti-government “prepper” communities, which hoard supplies and weapons in anticipation of societal and/or environmental collapse (Foster 2014). Not surprisingly, racism infuses many elements of this prepper contingent, thereby solidifying destructive cultural divisions and encouraging the close monitoring and exclusion of—if not outright violence against—minoritized others (Watts 2017).

Conclusion

As the coronavirus spreads throughout the world, there are many unknowns that make writing such an editorial difficult. We are writing in the middle of a crisis and without the benefit of hindsight. We are hyperaware of the fact that this is a terrifying event, that people are dying, that fear is permeating people’s lives. Yet, we, as surveillance studies scholars, are being called upon to speak to this crisis, and there are points we can raise and questions we can ask. In the words of anthropologist Kim Fortun (2001: 18), who was writing about the Bhopal chemical disaster, the situation is “too complex to fully understand, yet calls for a response.” While we do not know how this situation will unfold or resolve, we do have insight into how it fits within existing patterns and relations, particularly those pertaining to sociocultural constructions of (in)security, vulnerability, and risk. We can see evidence of surveillance dynamics at play with how bodies and pathogens are being measured, tracked, predicted, and regulated. We can grasp how threat is being racialized, how and why institutions are flailing, and how social media might be fueling social divisions. There is, in other words, a lot that our scholarly community could add to the conversation. Doing so could alter collective understandings of the processes we critique here and possibly inflect disease-surveillance policies or programs.

References


9 Symptomatic of this individualized orientation to governance, leaders have repeatedly emphasized that people should stay home if they are not feeling well. But what about those who do not have homes? Evidently, they have been an afterthought in pandemic planning. In Montreal, for example, homeless shelters “are scrambling to keep operations running as an expected volunteer shortage looms” (Olson 2020). As people are instructed to stay home to combat COVID-19, the concern is that “upper levels of government have been focused on schools, events, public transit and municipal buildings while neglecting one of the province’s most vulnerable populations” (Olson 2020).


