The CoVivre Program: Community Development and Empowerment to Address the Inequalities Exacerbated by the COVID-19 Pandemic in the Greater Montreal Area, Canada

Joy Schinazi¹, Tara Santavicca¹, Cindy Ngov¹, Anabelle Vanier-Clément¹, Aissata Touré¹, Emmanuelle Bolduc¹, and Cécile Rousseau¹,²

Abstract
The COVID-19 pandemic had devastating effects around the world, yet it was not experienced equally by all. The emergence of the virus has been linked with the intensification of discrimination and inequities, as well as other systemic issues already present in society prior to the pandemic. The CoVivre Program was created with the mission to facilitate and accelerate initiatives aimed at reducing socioeconomic and health disparities caused by the COVID-19 pandemic in the Greater Montreal Area. CoVivre aims to inform, protect, and support communities, with an emphasis on communities experiencing marginalization, such as ethnic and religious minorities,

¹Research Institute of the McGill University Health Centre, Montreal, Quebec, Canada
²McGill University, Montreal, Quebec, Canada

Corresponding Author:
Joy Schinazi, CoVivre Program, Research Institute of the McGill University Health Centre, 7085 Hutchison Street, Montréal, Quebec, Canada H3N 1Y9.
Email: joyschin@gmail.com
refugees, asylum seekers, and precarious workers. This mission is guided by the latest research and CoVivre’s values of community empowerment, partnership, democratic communications, and cultural competency, among others. This article describes the process of planning and implementing the program and its components: Communications, Outreach and Awareness Raising, and Psychosocial Support and Mental Health, with a description of one project per component. It also aims to identify obstacles and facilitators of the program, to reflect on their relation with local and global ecosystems and their relationship to community action, and to examine community mobilization as expressing both resilience and resistance to top-down impositions.

**Keywords**

community, COVID-19, inequalities, program, empowerment, minorities

**Introduction**

**Context**

Shortly after the World Health Organization declared COVID-19 as a global pandemic on March 11, 2020, population preventive measures were implemented worldwide (Cucinotta & Vanelli, 2020; Onyeaka et al., 2021). The first wave of the COVID-19 pandemic had devastating effects around the world, yet the pandemic was experienced equally by all (Onyeaka et al., 2021). Within the United States and Canada, certain groups were more affected, either in terms of their risk of exposure to the virus (workplace or living environment), or in terms of their means of implementing measures aimed to prevent infection (understanding of guidelines, socioeconomic means to implement them) (Cleveland et al., 2020; Frounfelker et al., 2021; Kantamneni, 2020). In addition, the emergence of the virus has also been associated with the intensification of discrimination and inequities as well as other systemic issues already present in society prior to the pandemic (Cleveland et al., 2020; Miconi et al., 2020; Perry et al., 2021). This was observed in Montreal, Quebec, Canada, where significant differences in morbidity, mortality, and indirect effects of the COVID-19 pandemic were found among ethnocultural communities compared with the general population (Depri et al., 2020). If programs to control the pandemic were led by governments and public health institutions, efforts to mitigate these inequities and the collateral effects of the pandemic on marginalized communities were
often left to community and nongovernmental organizations (Cleveland et al., 2020). To reflect on the lessons learned from these community initiatives which played an essential role but were often poorly documented, this article describes one of these initiatives, the CoVivre Program in Montreal, Quebec, Canada, its implementation, and the facilitators and obstacles that were encountered.

**Conceptual and Theoretical Framework**

The program is based on three theoretical pillars: first, an ecosystemic approach that informs an intersectional reading of social determinants of health, to capture not only the local dynamics of marginalization but also the community strengths. Second, the concept of empowerment is key to represent a process which is centered around community and individual agency, intervention being conceptualized as a support to those. Third, when individual and group resources are overwhelmed, as it was often the case during the pandemic, a mental health lens is useful to understand and cope with the individual and collective distress.

**Ecosystemic Approach, Social Determinants of Health, and Intersectionality.** The role of Public Health is to ensure the health and safety of the population, and in doing so it can cover vast ground, beyond individual and personal factors. Bronfenbrenner’s ecosystemic model describes an environment as consisting of several socio-ecological levels beyond that of individual characteristics, shedding light on the complexities and depth of interaction between individuals, groups and communities, institutions, and their environment (Bronfenbrenner, 1979).

Social determinants of health are factors outside the individual that have an important impact on their health and socio-emotional development. Social determinants of health include socioeconomic status, education, healthcare access, and the built environment, and are an integral aspect in monitoring, understanding, and addressing public health problems and reducing health inequities (Penman-Aguilar et al., 2016; Williams et al., 2008). To have effective interventions with local communities, a collaborative ecosystemic approach is imperative to address these determinants and the implications that the disparities among these determinants can have on a person’s health and development. Addressing the pandemic through this angle would also prevent a top-down approach or majority discourse that has allowed for the most vulnerable to fall through the cracks of the health care system.
Further, intersectionality draws attention to the ways that these multiple social determinants of health, intersect to reflect interlocking systems of privilege and oppression. Integrating intersectionality as a theoretical framework for Public Health work can facilitate the elaboration of programs that account for different social identities and needs that are not exclusive (Bowleg, 2012). Bowleg (2012) notes that intersectionality can inform the development of well-targeted interventions and prompts public health scholars to conceptualize health disparities in ways that mirror the experiences of the populations who experience disproportionate adverse health risks and outcomes. In short, while it is not a new idea to claim that human beings are complex entities and that their attitudes, behaviors and subsequent health outcomes are the result of a multitude of factors at different levels of their ecosystem, applying this approach in interventions to address the emerging pandemic presents its own set of challenges and requires particular attention.

**Empowerment.** Empowerment in health promotion has become a common public health approach, as it presents gaining the strength and confidence to act upon one’s life or situation. However, this approach must be carefully used to ensure communities are not exploited and that they retain a strong voice within institutional relationships (Labonte, 1994). To elaborate on this, Labonte (1994) explains that the term “to empower” can either be defined as giving power to others, or it can be defined as gaining power. In the former definition, which uses empower as a transitive verb, the entity bestowing the power is still controlling the power, while the intransitive definition has no object (Labonte, 1994). Intransitive empowerment (i.e., ensuring power can be taken as opposed to giving power that is controlled) is a key value in decolonizing Public Health initiatives and ensuring communities take the lead role. The empowerment holosphere presents a way health professionals can integrate empowerment into their work on these multiple levels, including personal care, group development, community organization, coalition advocacy, and political action; providing resources and support to have power with these communities as opposed to directing what should be done is an integral aspect of how Public Health community work can bring about meaningful change (Labonte, 1994).

**Mental Health Support.** Furthermore, mental health also becomes a priority area, given the impact the aforementioned factors, and their interplay, can have on an individual’s mental well-being. Public health and government measures put in place to mitigate the spread of the COVID-19 virus have also had serious impacts on mental health and well-being of children and adults
worldwide (Xiong et al., 2020; Yue et al., 2020). Symptoms of anxiety, depression, post-traumatic stress disorder, psychological distress, and stress have increased since the onset of the COVID-19 pandemic (Xiong et al., 2020). Significant declines in mental health were particularly observed among marginalized communities who were more severely impacted by these measures supporting immediate preventive and early intervention efforts (Cleveland et al., 2020; Galea et al., 2020; Miconi et al., 2020). Culturally adapted interventions have proven to be effective in mitigating the negative psychosocial effects during the COVID-19 pandemic, Ebola, and SARS, suggesting these are viable initiatives to be considered and integrated into public health emergency responses (Yue et al., 2020).

**CoVivre’s Role and Approach**

Although targeted interventions for specific groups and interventions focused on the social determinants of health, are both Public Health priorities recognized by the World Health Organization (WHO), the Canadian Public Health Agency, and the provincial and regional health authorities (Blas et al., 2011; Public Health Agency of Canada [PHAC], 2016), the urgency of the pandemic made it hard for institutions to adapt their interventions to the needs of different groups, favoring one-size-fits-all generic approaches to communicating and implementing public health measures, including vaccination. Within this context, it became clear to many stakeholders that the impact of the pandemic and communities’ means to adapt to it was not equality distributed in the population, and that to reduce and mitigate inequalities related to the social determinants of health whose conditions were exacerbated by COVID-19, tailored measures for groups who were being disproportionately affected were needed.

Community organizations play a key role during periods of crisis, facilitating access and adaptation of services to different communities according to their specific needs (Cleveland et al., 2020). As such, the CoVivre Program positioned itself as a facilitator and accelerator of local initiatives that focused on addressing systemic factors that were making certain groups more vulnerable to COVID-19 and to public health measures aimed at controlling the virus spread. As such, the program’s mission was to facilitate and accelerate initiatives aimed at reducing socioeconomic and health disparities caused by the pandemic. Three Canadian researchers founded CoVivre (Co-Living) with the aim to inform, protect, and support communities in the Greater Montreal Area which were identified as the most negatively affected by the pandemic, including communities who experience discrimination or exclusion, such as ethnic and religious minorities, refugees and asylum seekers,
and precarious workers. What started as a 1-year crisis intervention project in the Greater Montreal Area quickly expanded into an innovative practice with opportunities to have an impact where most needed.

It is worth noting that the CoVivre Program had a number of limitations in terms of its scope, which were related to the choices made in terms of priority and feasibility. For instance, it specifically did not target older adults or Indigenous communities because it did not have enough expertise and partnerships with these communities and their representatives to be able to rapidly launch the initiatives in a crisis context, while respecting the communities’ rhythm and empowerment. A choice was then made to focus on the communities and groups which the program founders already had partnerships and an established trust.

Objectives

The objectives of this article are to (a) present the planning and implementation phases of the CoVivre Program, drawing on the latest available research on the COVID-19 pandemic, with public health approaches grounded in addressing social determinants of health, the reduction of health disparities, and community-based interventions, (b) describe each program component and its objectives followed by the presentation of one project per program component (the full list of CoVivre’s Phase 1 projects can be found in Supplemental Appendix 1), and (c) discuss the challenges, facilitators, and lessons learned from this experience. We hope that this article will shed light on the challenges and resilience faced by communities in the context of community mobilization during a crisis and the issues around the adoption of top-down impositions made by institutions and political authorities.

CoVivre operates from the principle that community development is integral to individual development, in as much as an individual’s thriving is contingent upon the conditions they live in. By alleviating the burden on vulnerable communities, CoVivre hopes can provide a better opportunity for its members to experience the COVID-19 crisis as a potential catalyst of personal change and development, as it has been observed with some groups (Frounfelder et al., 2021).

Methods

Program Creation

The CoVivre Program was created during the second wave of the COVID-19 pandemic in Montreal, Quebec, Canada. CoVivre is a not-for-profit program funded by a local private philanthropic organization, with the Research
Institute of the McGill University Health Centre acting as fiduciary. Funders expected a quick deployment of activities and funds were mostly allocated to human resources and then assigned to specific projects.

The early planning stages in July and August 2020 consisted of outlining a stakeholder map to identify key partners and those with whom the team could collaborate quickly and implement specific projects in a short timeframe given the urgency of the needs during the pandemic. They also served to set the program’s structure, mission, core values and objectives.

Although CoVivre was never set up to be a research program, the team developed a series of forms documenting each initiative CoVivre was involved in during the year as way to document the program and guide the preparation of its final report. These forms were intended for internal use and have not gone through any research ethics board processes. A total of 20 forms were created, one for each project or initiative that was deployed. Each form contained a description of the project, the process of its implementation with partners, as well as the challenges and facilitating factors that affected the implementation of the initiative, and recommendations and lessons learned. In addition, partners who had received funding for projects from CoVivre also completed a similar form detailing their perspectives on the implementation of each project. A survey was also conducted for most partners involved in the vaccination projects. Finally, CoVivre conducted interviews with its academic and private partners involved in all three components.

**Results**

**Program Deployment**

Evolving discussions with key partners and stakeholders over the summer of 2020 consisted of first, defining what needs were being met and what needs remained with regard to their adaptation to the crisis (that CoVivre could address), and second, to validate CoVivre’s program objectives and components with its partners. These consultations were mostly informal and focused primarily on what these actors had done since March 2020, what needs were still unaddressed, as well as on observations made in their neighborhood or sector of intervention. The previous relationships that the program founders had with key partners and stakeholders which enabled collaboration and a certain level of trust, as well as the flexibility and ability of the team to mobilize more community action were keys facilitator in this process, and essentially what made the program interventions possible at such a quick rate.
CoVivre’s program structure was then created and consisted of an Executive Committee composed of CoVivre’s three program founders as well as the Program Coordinator. The program team included the Coordinator, and a Communications and Knowledge Transfer Advisor, a Health Liaison Officer, and two Project Officers. Over the course of the year, CoVivre hired three project managers for specific initiatives related to precarious workers and vaccination. In addition, CoVivre’s initiatives were implemented through partnerships with different stakeholders from grassroots community groups and representatives, public institutions (Public Health and Health, Social and Educational Services), and academia, which were represented by an advisory committee that met with CoVivre’s team periodically over the year. Ad hoc partners from different sectors also collaborated in specific projects.

At the core of CoVivre’s mission was the single intention to provide conditions for vulnerable communities who were carrying the brunt of the pandemic to navigate the crisis in the most humane and dignified way possible. More specifically, CoVivre’s mission was guided by a set of values, which are at the core of every project (see Table 1). The CoVivre team, was highly diverse, but the team was also aware that their life experiences may not reflect the realities of all of the communities, and that sometimes when they did, this may also bring in a particular gaze on reality. As such, CoVivre’s core values aimed to identify and reduce biases and blind spots, as much as possible by paying attention to the communities heterogeneity and to the necessarily non neutral stance of the intervention in a consistent manner. These values are considered to be best practices in community development (Ramsbottom et al., 2018; Sobelson et al., 2015) but can oftentimes be neglected due to time, financial or institutional constraints, or power dynamics. However, given the unique position of CoVivre as a privately funded, independent stakeholder, the team was able to uphold the constant attention to these values throughout every program initiative. Table 1 details the core values set out by the CoVivre Program.

It is worth noting that one of CoVivre’s main assets was its autonomy. Organizational autonomy within the public sector has shown to increase efficiency and result in better performance, of which are two critical outcomes in the time of a crisis (Wynen & Verhoest, 2016). The team was able to function and quickly adapt to demands from the communities as well as the ever-changing landscape of public health directives, while still maintaining close contact with the executive and advisory committees, and with the program funders, who did not impose a rigid agenda on the program. This was accomplished through the flexibility, adaptability, and highly supportive nature of the team, despite working remotely for the most part. Focusing on the tasks at hand while letting go of patriarchal approaches and trusting the process
Table 1. CoVivre Program Core Values.

| Value                                | Description                                                                                                                                                                                                 |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Empowerment                          | Allow for and promote the maximization of the potential of individuals through community development and actions focused on the social determinants of health.                                                                 |
| Partnership                          | Develop and implement all projects in close partnership with key stakeholders (community organizations, grassroots organizations, religious leaders, etc.)                                                   |
| Democratic and adapted communications | Favor the use of a nonprescriptive, nonpaternalistic collaborative and transparent communication style in all formal and informal communications. In addition, information tools developed for the population should take into account literacy levels and be culturally adapted. |
| Cultural competency and safety       | Build a team that is culturally competent, that is, able to develop initiatives that are suitable for different cultural communities and that instills a sense of cultural safety for all stakeholders, by considering issues of colonialism, systematic racism and discrimination, and the complex power relations they ensue. |
| Transparency                         | Ensure transparency at every step of project development, implementation, and evaluation.                                                                                                                                 |
| Recognition                          | Recognize, acknowledge, and integrate the expertise of field stakeholders and differentials in power dynamics between community groups and institutions, as well as CoVivre's own biases.                                           |
| Adaptability                         | Develop and demonstrate a capacity to be flexible and adapt projects, priorities, strategies, and orientations with the changing landscape of the pandemic and its impact on different communities.                       |
| Science-driven                       | Integrate the latest science in terms of best practices and data in all aspects of project planning, implementation, and evaluation. This includes community development practices, survey data about how different groups are being affected by the pandemic, and the new emergent data on the virus and the best ways to protect the population. |

Note. CoVivre set out to place these eight values informed by the best practices in community development at the core of every project it undertook with the aim to reduce biases and blind spots in a consistent manner.

and those involved in it was at the core of the team dynamic between the executive committee, its funders, and partners. Figure 1 details the structure of the CoVivre Program.
With the core mission to Inform, Protect, and Support vulnerable communities in the Greater Montreal Area, the CoVivre program deployed and collaborated on over 20 projects with a multitude of partners over the span of its first phase (July 2020 to August 2021). These projects were grouped under three main components: Communications, Outreach and Awareness Raising, and Psychosocial Support and Mental Health (Figure 2 describes the layout of the program components). CoVivre is an intervention program, with a purpose to maximize the capacity of communities in their response to their COVID-19 crisis. Figure 3 details the specific program objectives that CoVivre has identified as intermediates to achieve the broader goals of mitigating the consequences of the pandemic on marginalized communities.

The information about each project collected using the forms described in the Methods section, and the input provided by the partners through the forms, interviews, and survey point to the largely positive impact that CoVivre had in all its collaborations. More specifically, the feedback received consistently reiterated the guiding principles that CoVivre set out from the get-go, which proved to be important facilitators of the entire process, and which helped address the constraints and demands of the provincial government and the health care network it manages, and the more specific needs of local community organizations.
The next section describes in more detail each of CoVivre’s components and with an example of a project or initiative per component. It is worth noting that not all projects involved the allocation of funds to partners. Some projects were more focused on the CoVivre team providing support, facilitation, and moderation for different initiatives such as the implementation of pop-up vaccination clinics, brokering meetings between religious groups and Public Health, and the adaptation of informational tools for different audiences, among others. Supplemental Appendix 1 contains a description of all projects that were deployed over the first phase of the program.
Program Components and Featured Projects

Component 1: Communications. Communications are considered a nonpharmacological health intervention, in as much as they ensure the understanding and adoption of health and safety behaviors in the population (Tworek et al., 2020). Effective and democratic communications during a public health crisis such as the COVID-19 pandemic are key elements in maintaining democracy and civic engagement at a time when institutions require great collaboration and trust from its citizens (Tworek et al., 2020). While official public health and government authorities in Quebec tended to take a global top-down communications approach in the implementation of public health directives, a communication gap remained for communities that were more isolated from the mainstream of Quebec’s civic society, such as ethnic and language minorities, or people with low literacy or socioeconomic levels, who are less likely to consume traditional media (Cleveland et al., 2020).

With this in mind, CoVivre set out to put democratic communications at the forefront of every initiative both formally and informally. CoVivre’s communications projects included several initiatives and collaborations, with the overarching goals of (a) increasing access to information through the creation, adaptation, translation, and dissemination of information tools, (b) raising awareness about the reality and needs of different communities, (c) promoting a communications approach that is democratic, inclusive, adapted, nonjudgmental and nonpaternalistic, and (d) reducing misinformation around COVID-19 and vaccines and preventing the scapegoating of specific groups.

Featured Project: “The Worst Game” Ad Campaign. In the spring of 2021, CoVivre deployed a social media ad campaign targeting youth aged 15 to 25, with the goal of mitigating the impact of disinformation and conspiracy theories related to COVID-19 to prevent the legitimization of discrimination against certain groups and to promote health guidelines that limit the spread of the virus. This unique campaign took a global approach, inviting young people to develop a critical mind and a more nuanced discourse, while addressing their emotional struggles regarding the restrictive nature of public health directives, which in Montreal included extended lockdowns, curfews, and school closures.

Young people are heavy consumers of social media, not only for socializing but also for keeping up with the news and current events (Abi-Jaoude et al., 2020). As such, they are susceptible to misinformation and conspiracy theories that circulate in these networks (Islam et al., 2021). Adherence to conspiracy theories related to the COVID-19 pandemic is associated with psychological distress and anxiety symptoms (De Coninck et al., 2021).
Given this context, the ad campaign intended to mitigate conspiracy theories and misinformation by providing emotional support to youth by validating feelings and uncertainties, while at the same time encouraging them to adopt and maintain public health measures.

The campaign was conducted with a local ad agency specializing in online marketing, as well as several academic experts in communications and youth radicalization from Sherbrooke University in Canada. The campaign strategy was developed around the symbolism of board games: What we have been experiencing since March 2020 is The Worst Game—We play it against our will, the rules change often, it lasts too long, and many want to quit. But, to win, we must play as a team and finish the round.

Twelve messages were developed around three tension points (mental health, public health measures, and misinformation) and four board games (Jenga, Monopoly, Uno, Cards Against Humanity), which would link to a landing page with links to resources related to the three tension points. The posts ran on three social networks (Facebook, Instagram, and Snapchat) between April 9 and May 28, 2021. The campaign was a great success, with over 11.5 million impressions and over 300,000 engagements. Figures 4–6 highlight three of the 12 ads from the campaign, which were presented in GIF format across the different social media platforms.

Component 2: Outreach and Awareness Raising. Outreach work and awareness raising are the cornerstone of all traditional models of community

Figure 4. Ad Campaign: Mental Health Component Using Jenga Imagery in Reference to the Challenges of Online Classes: (A) “My Anxiety: My Teacher Asking Me to Turn on My Camera.” (B) “It’s Tough. Don’t Give Up.” (C) “Let’s Finish This Round?”
Note. Spring 2021 social media ad campaign targeting youth with the goal of mitigating the impact of disinformation and conspiracy theories related to COVID-19, developed around three tension points (mental health, public health measures, and misinformation).
development, as they lay the ground for identifying and prioritizing the expressed needs of specific groups (Decorby-Watson et al., 2018). Capacity building is defined by the WHO as “the development of knowledge, skills, commitment, structures, systems, and leadership to enable effective health promotion” (Decorby-Watson et al., 2018, p. 2). Concretely, capacity building may, for example, take the form of training materials and sessions,
consultations, or mentoring and may translate into increased knowledge, skills, and self-efficacy, as well as changes in practices, policies, and behavior (Decorby-Watson et al., 2018). It is an especially important component of health at the community level, as many roots of the complex determinants of health rely on community structures. As such, the objective of CoVivre’s second component was to collaborate with different communities in capacity building projects to support local initiatives.

Between the summer of 2020 and the fall of 2021, several local philanthropic organizations came together in an unprecedented effort to support community action during the COVID-19 pandemic (Baril et al., 2022). These organizations financed local action plans in 26 neighborhoods in the Greater Montreal Area, managed by local “brigades” led by local community agents, and supported by CoVivre and the Canadian Red Cross. Rooted in each neighborhood, these brigades carried various prevention and awareness activities on the ground (through door-to-door or at strategic places in neighborhoods, etc.), such as the distribution of masks and hand sanitizer, information about sanitary measures or vaccination, as well as support to pop-up vaccination clinics’ preparation and deployment.

CoVivre played a key role in the development of several projects pertaining to these action plans, which aimed at directly equipping groups in key sectors strongly affected by the pandemic. With the collaboration of several experts and in partnership with reference organizations, CoVivre examined the issues affecting precarious workers, the challenges faced by the vaccination awareness teams from the brigades, and the issues affecting local community organizations supporting immigrant individuals and families. Thus, the “Protect” component is divided into four subcomponents, namely:

Realities of precarious workers, needs in the school environment, vaccine hesitancy and support for the vaccination campaign, and cultural mediation in Public Health.

**Realities of Precarious Workers.** Precarious work, often defined as work which is insecure, poorly paid, and unprotected, imposes unique precarious situations on workers, particularly on racial and ethnic minority workers, including migrant workers, a category which is concentrated in high-risk occupations (Côté et al., 2021). The COVID-19 pandemic created new health risks for precarious workers and exacerbated the preexisting health risks of precarious employment, which already encompassed negative mental health implications, employment insecurity, income inadequacy, and a lack of rights and protections (McNamara et al., 2021). In fact, occupational risk of exposure to COVID-19 was greater among some typically precarious categories of workers, including low-income and low-skilled workers.
(McNamara et al., 2021). The pandemic has therefore also exacerbated health inequalities, especially considering intersectional issues relating to race, migration status, and gender (Côté et al., 2021). It has highlighted the immediate need to advocate for their rights to safety and the increased uncertainty surrounding employment issues. A partnership was established between a local philanthropic organization, CoVivre and the Immigrant Workers Centre (IWC), which supports vulnerable workers through various initiatives such as the preparation of individual and collective requests for occupational health and safety, awareness, training and referral and accompaniment of these workers.

**Needs in the School Environment.** As COVID-19 and associated rising social tensions have instilled a unique reality within schools, CoVivre has created and supported various tools for students, school teams, and communities surrounding them. These include a pedagogical guide and videos on leading respectful discussions around racism in the classroom, a back-to-school guide for teachers addressing mental health issues related to the pandemic, and vignettes on dealing with tensions arising from the vaccination and public health discourse. In addition, CoVivre collaborated with several partners to adapt and translate letters from the Public Health department that were sent to parents in case of positive or suspected cases in classrooms.

**Vaccine Hesitancy and Support for the Vaccination Campaign.** Starting in January 2021, CoVivre took on a central role in training the community agents about COVID-19 vaccines, vaccine hesitancy and the motivational interviewing approach to vaccine hesitancy (Gabarda & Butterworth, 2021; Rousseau et al., 2021). This training and support was offered through three webinars and the distribution of a vaccine hesitancy guide and vaccine information sheets in English and French, translated into eight other languages, as well as through regular meetings with the brigades, according to their needs, and at times through working as a facilitator with local health institutions (e.g., in the context of pop-up clinics).

**Cultural Mediation in Public Health.** Cultural mediation is a cross-cutting competency essential to CoVivre’s actions and interventions. By promoting dialogue aimed at an integrated community mediation approach, CoVivre reflects on the complexity of the relationship between health, social, and political phenomena, and on principles that should underlie decision-making processes in times of a pandemic. Concretely, this took the form of a cultural mediation guide aimed at public health workers, as well as the application of its concepts at the crossroad of CoVivre’s privileged relationship with many community leaders and its collaboration with public health institutions.
Featured Project: Support to Community Leaders to Facilitate Vaccine Access and to Address Vaccine Hesitancy. Beginning in January of 2021, CoVivre took a community-based approach to vaccination and vaccine hesitancy among minority communities in the Greater Montreal Area. The premise of this intervention has been the recognition that community and religious leaders have firsthand access to their communities’ preoccupations and needs, that they generally feel a responsibility to protect their communities who trust them in return. Consequently, these leaders have the necessary legitimacy to mobilize their communities and convey important messages to them in a meaningful and adapted manner, on topics such as infection-control measures, health, and vaccination. Considering that health and education institutions rarely have this level of connectedness and trust with minority groups, working with various types of leaders appeared as a fruitful approach to take.

Using its preexisting contacts in different communities, CoVivre developed partnerships with community and religious leaders to accompany them in co-constructing and implementing several initiatives adapted to communities’ preoccupations and needs with regard to vaccination. These tailor-made initiatives were meant both to inform communities about COVID-19 vaccines in an adapted manner and through trusted channels, and to facilitate community-adapted access to vaccines, with the greater aim of encouraging vaccine uptake. More precisely, CoVivre’s initiatives included: the assessment of communities’ concerns and needs in relation to COVID-19 vaccines, the co-construction and facilitation of initiatives according to community needs, liaisons between community leaders and health authorities to bring forward the communities’ concerns and needs in relation to COVID-19 vaccination, and the creation, adaptation and dissemination of material on vaccination intended for leaders and their communities (written material, informative meetings, webinars) to increase their understanding of and trust in the vaccine.

An example of a tailored initiative facilitated by the CoVivre Program was the pop-up vaccination clinic in a mosque in the Parc-Extension neighborhood. Parc-Extension is a multi-ethnic low-income neighborhood in Montreal with a high proportion of recently arrived immigrants, especially from South Asia. The initiative attracted many local Muslims but also other residents with other religious or nonreligious identities. Congregants of the mosque reported that being vaccinated at their mosque had made a significant difference for them in the sense of both bringing the vaccination close to them but also receiving it in a space that they trusted. The mosque’s Imam expressed feeling proud of participating, as a Muslim leader and Quebec citizen, to the mass vaccination campaign by helping protect his congregants but also local residents regardless of their religious identity, and of contributing in some
ways to the neighborhood cohesion, as non-Muslims were invited to enter the mosque to receive their shot.

One of the principles that guided CoVivre’s support to community and religious leaders in relation to COVID-19 vaccination, was the recognition that communities are heterogeneous and that they have their own needs and expertise. It is to be noted that while some community or religious leaders jumped on the occasion to mobilize their communities around vaccination, others were not particularly interested, and some felt that they were being instrumentalized to play a role that didn’t belong to them. Still, as symbols of trust and protection, many community and religious leaders were key partners in encouraging their communities’ vaccination against COVID-19. This partnership could be maintained in the future and put forward again to foster community mobilization around other public health initiatives, to enhance communities’ trust in health institutions, and to enhance communities’ general well-being.

**Component 3: Psychosocial Support and Mental Health.** CoVivre oriented its Psychosocial and Mental Health component to ensure that it was complementary to programs and services that were already being offered in the communities, as well as the needs expressed by these communities and their capacity to sustain services. This was done in an effort to quickly mobilize teams who were equipped to tailor interventions to their community and to respond to needs in a culturally appropriate way. Following several consultations, several community organizations that were already in contact with marginalized populations were identified. CoVivre then partnered with several organizations to expand or enhance their service offer in response to the impacts of COVID-19.

The program prioritized three main areas of intervention, namely, (a) individual or group support by experts in psychosocial intervention, (b) training or information workshops to support the work of community workers or to better equip marginalized communities, and (c) raising awareness around COVID-19, particularly in relation to vaccination. Five collaboration agreements were developed with six organizations offering services to different marginalized communities in the Greater area.

**Featured Project: Supporting the Creation of the Mauve Clinic.** The COVID-19 pandemic has had adverse effects on the mental health of migrant and racialized LGBTQI+ individuals. Specifically, social distancing measures impacted the psychological well-being of migrant and racialized LGBTQI+ individuals. The consequences include anxiety and depression related to isolation and disruption of social networks (which are often structurally different from household family units), increased wait times to access health care
related to medical gender transition or immigration-related procedures, and an increase in suicide risk (Drabble & Eliason, 2021; PHAC, 2020).

The Mauve Clinic, the very first point of service and outreach program for LGBTQI+ migrants living in Quebec, was established to mitigate the direct and indirect impacts of COVID-19 and to reduce structural barriers to accessing care and social services. The Mauve Clinic aims to provide medical, sexual, and psychological health care to LGBTQI+ migrants as well as to inform and educate them on issues related to COVID-19 through a liaison program. The Mauve Clinic advocates for anti-oppressive, cross-cultural, intersectional, trans-affirmative, and trauma-informed approaches. It equally advocates for harm reduction and informed consent and emphasizes user empowerment. The Mauve Clinic’s services and outreach activities are offered in four languages (French, English, Arabic, and Spanish) and represent an innovative model of integrated care by addressing a critical need.

Under the partnership, CoVivre supported the implementation of the Mauve Clinic team by financing two peer navigators for their psychosocial support and communication/advocacy components, as well as a liaison program coordinator. A total 273 individual interventions were carried out by the peer navigators in collaboration with social workers to offer support pertaining to different issues such as mental and physical health, language barriers, employability, and psychological distress. Group discussion workshops on the topic of self-care and on the topic of COVID-19 vaccination were also carried out and a self-care tool promoting psychological well-being was created. Furthermore, two outreach activities were organized in collaboration with a community group, through which care packs containing personal protective equipment, STBBI prevention materials, COVID-19 informational resources developed in-house and from other partners, and gift cards to promote food security.

**Discussion**

Communities, organizations, and leaders showed unprecedented resilience, mobilization, and capacity to respond. For example, strategies including digitization of work and services had to be quickly implemented to adapt to the fracture that physical distancing imposed on community services. This systematically cut off a portion of individuals who were not tapped into the digital world or lacked digital literacy, requiring door-to-door efforts or phone calls for them to be reached (Baril et al., 2022). It also became clear from the feedback received from partners that their already limited resources were stretched thin over the first year of the pandemic, which began to take a toll on the staff as the pandemic persisted into its second year. This point
reiterates the need to always integrate a psychosocial support component to front line workers in all public health approaches and the need to recognize community workers and community leaders as essential frontline workers who need to be included at every stage of program development and implementation.

The already present resistance to top-down impositions from large institutions also became apparent during this time and was a contributing factor on the stress levels of community organizations. This issue is particularly evident in the case of a health care system that is public and centralized at the provincial level, where public health, health and social services are managed and financed by the same government body. In fact, the COVID-19 pandemic made clear that issues of governance between public institutions, philanthropy, and community groups needed to be addressed. In turn, the crisis also provided the opportunity to start a dialogue and to develop new models based on the experiences of CoVivre and other collaborative community-based initiatives that were deployed during the crisis (Baril et al., 2022).

Interestingly, it was observed that handing over the power to communities could elicit strong discussions, with partners sometimes feeling they would like to have even more, and others preferring a more passive role: respecting the rhythm and capacity of each community partner, and being self-critical in a continuous way were key factors in overcoming successfully these exchanges. CoVivre’s role as a facilitator, accelerator, and moderator of local initiatives made it possible to implement institutional initiatives in an adapted way that was collaborative and attuned to the needs of different communities and their local ecosystem.

Toward the end of its first year of implementation, it became clear to the CoVivre team that it was necessary to take the time to not only recognize the outstanding work done and ensure the sustainability of the new practices developed but also to amplify the voices of the communities and to advocate for the needs of the community organization networks in Quebec, Canada. In this vein, CoVivre submitted a proposal to its funders and received additional financial support to hold a large-scale community forum in September 2022, whose goals were to highlight and transfer knowledge of the innovative community action practices, discuss the lessons learned from the COVID-19 crisis and provide a safe space for the amplification of advocacy voices from these groups.

In the fall of 2021, CoVivre also received funding for an additional 6 months to properly support the phasing out of its work with the communities and to engage in knowledge translation activities, including the community forum. But as fate will have it, team members had to quickly adapt and change course to support communities and schools with regard to the
vaccination of youth aged 5 to 11 years, which began in the beginning of the school year, and the tensions that this provoked in certain communities. CoVivre also re-oriented itself to provide further support to communities in the aftermath of the Omicron wave, which hit Montreal extremely hard.

Discussions held during the forum with several partners strongly supported CoVivre’s initiatives and its approach as a valuable means to the advancement of public health initiatives founded in collaborative work with community members and other relevant stakeholders. The CoVivre team succeeded in putting into practice the program’s theoretical approaches (ecosystemic approach, social determinants of health, empowerment, intersectionality, mental health support) which are evident and often discussed in policy, but not easily applied in many instances because of financial, time, or institutional constraints, as well lack of expertise in listening to, moderating, and mediating several stakeholders, and their needs and interests.

By placing its core values at the forefront of all initiatives, and by being a small, agile, flexible, and independent team, the CoVivre team was able to ensure the application of these principles in the selection of projects and throughout implementation. For example, CoVivre’s partnership with Médecins du Monde (described in Supplemental Appendix 1), an organization whose work focuses on highly marginalized populations, such as sex workers, people experiencing homelessness, refugees and migrants with precarious status, provided mental health counseling support and continuing education to its workers, who were engaged in the community to help stop the spread of COVID-19. This project illustrates an approach to infection control that takes into account not only the social determinants of health, but also the intersectionality of high risk populations, and the needs of the front line workers who support them. This approach can only be implemented when local community stakeholders who already have the contact with these populations, are mobilized and supported.

In addition, these humanistic values seem not only to have facilitated communication with partners but also demonstrated an appreciation for their tireless work, which served to further solidify partnerships. Given the success of these partnerships and the mutual desire to continue them, the CoVivre team is currently evaluating the possibility of adapting the program beyond the COVID-19 crisis, to continue serving as a facilitator and accelerator of local public health and community initiatives. The program’s success is indicative of the need for an intermediate body to help connect and adapt government and institutional programs that exist at the provincial and regional (city) level and policies to the realities and needs of local communities, especially the most marginalized ones.
The appreciation that partners demonstrated for the CoVivre Program is also an indication that humanistic values can be applied not only in interpersonal relationships but also in inter-group relations. In turn, public health programs with a humanistic approach and values should be further studied to determine how they can be better integrated in public health practice and how public health theoretical frameworks can incorporate such values in ways that are applicable at the community level and for the most vulnerable social groups.

**Conclusion**

The psychological and socioeconomic impacts of the pandemic will be felt for years to come, and the impact on more vulnerable communities such as minorities and precarious workers are not yet fully understood. CoVivre was created with the goal to address this issue by acting as an intermediate and independent stakeholder in a setting where preexisting power dynamics became intensified and the diversity of voices from local communities needed to be heard more than ever. CoVivre allowed for the creation of initiatives to address the needs of groups that had been largely forgotten in the crisis context (e.g., financial support for precarious workers) and for the adaptation of initiatives that were designed with the majority general population in mind to specific groups and their needs, culture and communication style and language.

CoVivre’s focus on the social determinants of health, such as people’s living and working conditions, allowed for a more global and sustainable approach to addressing the impact of the pandemic on different communities. Hopefully, this systemic approach helped lighten the load on communities and that our actions provided an opportunity for mobilization, solidarity, and empowerment of those who were the most vulnerable going into this crisis and who carried its brunt throughout.

The COVID-19 pandemic made it clear that democracy and equality can be fragile and need to be valued and reinforced during times of crisis. This starts with the recognition that some suffered the pandemic and its consequences disproportionately, and perhaps unnecessarily, because of their background of life conditions. Crises will come and go, and empowering communities to adapt is key for a sustainable future. Ultimately, programs like CoVivre should work to enable communities to participate as much as possible in civil society during periods of crisis and use these periods for transformation and evolution in community action and advocacy. We strongly believe that the CoVivre model could continue to be used to support communities’ recoveries once COVID-19 becomes endemic, and beyond.
Acknowledgments
The authors would like to acknowledge CoVivre co-founders Dr. Alexandra de Pokomandy and Dr. Sarah Gallagher, as well as CoVivre’s advisory committee, and all its academic and ad hoc partners for turning the CoVivre concept into reality. In addition, the authors acknowledge Professor Laurence Monnais, Key Collaborator for CoVivre, historian, and expert in vaccination, for her valuable contribution to CoVivre’s vaccination initiatives, as well as Catherine Montmagny Grenier and Claire Guenat, Project Managers, for their work on the precarious workers and vaccination webinars projects, respectively. Finally, the authors acknowledge Yasmine Abdessettar, Junior Assistant at CoVivre, for her contribution to the organization of the paper and the appendix.

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

Funding
The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The CoVivre program would like to acknowledge its funding by the Trottier Family Foundation.

ORCID iDs
Joy Schinazi https://orcid.org/0000-0001-7647-8631
Tara Santavicca https://orcid.org/0000-0003-4425-1277

Supplemental Material
Supplemental material for this article is available online.

References
Abi-Jaoude, E., Naylor, K. T., & Pignatiello, A. (2020). Smartphones, social media use and youth mental health. *Canadian Medical Association Journal, 192*(6), E136–E141. https://doi.org/10.1503/cmaj.190434
Baril, G., Arnaud, J., Normandin, J. M., Bernet, M., Dumouchel, L., Pilon, C., St-Amand, R. M., & Therrien, M. C. (2022). Implementing a collaborative governance based on community engagement for resilient public health crisis management: A study of community action plans to address COVID-19. Cité-ID LivingLab.
Blas, E., Sommerfeld, J., & Kurup, A. S. (2011). *Social determinants approaches to public health: From concept to practice*. World Health Organization. https://apps.who.int/iris/handle/10665/44492
Bowleg, L. (2012). The problem with the phrase women and minorities: Intersectionality—An important theoretical framework for public health. *American
Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Cleveland, J., Hanley, J., Jaimes, A., & Wolofsky, T. (2020). Impacts of the covid-19 crisis on Montreal’s “cultural communities”. L’Institut universitaire SHERPA. https://sherpa-recherche.com/wp-content/uploads/impact_covid19_communautes_culturelles.pdf

Côté, D., Durant, S., MacEachen, E., Majowicz, S., Meyer, S., Huynh, A. T., Laberge, M., & Dubé, J. (2021). A rapid scoping review of covid-19 and vulnerable workers: Intersecting occupational and public health issues. *American Journal of Industrial Medicine, 64*, 551–566. https://doi.org/10.1002/ajim.23256

Cucinotta, D., & Vanelli, M. (2020). WHO declares COVID-19 a pandemic. Acta biomedica: Atenei Parmensis, 91(1), 157–160. https://doi.org/10.23750/abm.v91i1.9397

De Coninck, D., Frissen, T., Matthijs, K., d’Haenens, L., Lits, G., Champagne-Poirier, O., Carignan, M.-E., David, M. D., Pignard-Cheynel, N., Salerno, S., & Généreux, M. (2021). Beliefs in conspiracy theories and misinformation about COVID-19: Comparative perspectives on the role of anxiety, depression and exposure to and trust in information sources. *Frontiers in Psychology, 12*, Article 646394. https://doi.org/10.3389/fpsyg.2021.646394

Decorby-Watson, K., Mensah, G., Bergeron, K., Abdi, S., Rempel, B., & Manson, H. (2018). Effectiveness of capacity building interventions relevant to public health practice: A systematic review. *BMC Public Health, 18*(1), Article 684. https://doi.org/10.1186/s12889-018-5591-6

Depri, D. K., Benoit, M., & Adrien, A. (2020). Improving the response to the COVID-19 pandemic for immigrant and racialized populations in Montreal: Consultation with field stakeholders (final report). Direction régionale de santé publique du CIUSSS du Centre-Sud-de-l’Île-de-Montréal. https://santemontreal.qc.ca/fileadmin/fichiers/professionnels/DRSP/Directeur/Rapports/RapportReponsePandemiqueCommunautesImmigrantesRacisees.pdf

Drabble, L. A., & Eliason, M. J. (2021). Introduction to special issue: Impacts of the COVID-19 pandemic on LGBTQ+ health and well-being. *Journal of Homosexuality, 68*(4), 545–559. https://doi.org/10.1080/00918369.2020.1868182

Frounfelker, R. L., Santavicca, T., Li, Z., Miconi, D., Venkatesh, V., & Rousseau, C. (2021). COVID-19 experiences and social distancing: Insights from the theory of planned behavior. *American Journal of Health Promotion, 35*(8), 1095–1104. https://doi.org/10.1177/08901171211020997

Gabarda, A., & Butterworth, S. W. (2021). Using best practices to address COVID-19 vaccine hesitancy: The case for the motivational interviewing approach. *Health Promotion Practice, 22*(5), 611–615. https://doi.org/10.1177/15248399211016463

Galea, S., Merchant, R. M., & Lurie, N. (2020). The mental health consequences of COVID-19 and physical distancing. *JAMA Internal Medicine, 180*(6), 817–818. https://doi.org/10.1001/jamanetworkmed.2020.1562

Islam, M. S., Kamal, A.-H. M., Kabir, A., Southern, D. L., Khan, S. H., Hasan, S. M. M., Sarkar, T., Sharmin, S., Das, S., Roy, T., Harun, M. G. D., Chuhtai,
Schinazi et al.

A. A., Homaira, N., & Seale, H. (2021). COVID-19 vaccine rumors and conspiracy theories: The need for cognitive inoculation against misinformation to improve vaccine adherence. *PLOS ONE, 16*(5), Article e0251605. https://doi.org/10.1371/journal.pone.0251605

Kantamneni, N. (2020). The impact of the COVID-19 pandemic on marginalized populations in the United States: A research agenda. *Journal of Vocational Behavior, 119*, Article 103439. https://doi.org/10.1016/j.jvb.2020.103439

Labonte, R. (1994). Health promotion and empowerment: Reflections on professional practice. *Health Education Quarterly, 21*(2), 253–268. https://doi.org/10.1177/109019819402100209

McNamara, C. L., McKee, M., & Stuckler, D. (2021). Precarious employment and health in the context of covid-19: A rapid scoping umbrella review. *European Journal of Public Health, 31*(Suppl. 4), iv40–iv49. https://doi.org/10.1093/eurpub/ckab159

Miconi, D., Li, Z. Y., Frounfelker, R. L., Santavicca, T., Cénat, J. M., Venkatesh, V., & Rousseau, C. (2020). Ethno-cultural disparities in mental health during the COVID-19 pandemic: A cross-sectional study on the impact of exposure to the virus and COVID-19-related discrimination and stigma on mental health across ethno-cultural groups in Quebec (Canada). *BJPsych Open, 7*(1), e14. https://doi.org/10.1192/bjo.2020.146

Onyeaka, H., Anumudu, C. K., Al-Sharify, Z. T., Egele-Godswill, E., & Mbaegbu, P. (2021). COVID-19 pandemic: A review of the global lockdown and its far-reaching effects. *Science Progress, 104*(2), 003685042110198. https://doi.org/10.1177/00368504211019854

Penman-Aguilar, A., Talih, M., Huang, D., Moonesinghe, R., Bouye, K., & Beckles, G. (2016). Measurement of health disparities, health inequalities, and social determinants of health to support the advancement of health equity. *Journal of Public Health Management and Practice, 22*(Suppl. 1), S33–S42. https://doi.org/10.1097/phh.0000000000000373

Perry, B. L., Aronson, B., & Pescosolido, B. A. (2021). Pandemic precarity: COVID-19 is exposing and exacerbating inequalities in the American heartland. *Proceedings of the National Academy of Sciences of the United States of America, 118*(8), Article e2020685118. https://doi.org/10.1073/pnas.2020685118

Public Health Agency of Canada. (2016). *Social determinants of health*. https://cbpp-pcpe.phac-aspc.gc.ca/public-health-topics/social-determinants-of-health/

Public Health Agency of Canada. (2020). *Vulnerabilities related to COVID-19 among LGBTQ2+ Canadians*. https://www150.statcan.gc.ca/n1/pub/45-28-0001/2020001/article/00075-eng.htm

Ramsbottom, A., O’Brien, E., Ciotti, L., & Takacs, J. (2018). Enablers and barriers to community engagement in public health emergency preparedness: A literature review. *Journal of Community Health, 43*(2), 412–420. https://doi.org/10.1007/s10900-017-0415-7

Rousseau, C., Monnais, L., Tousignant, N., Gagneur, A., Gosselin, V., Santavicca, T., Ngov, C., Guenat, C., Schinazi, J. & Bolduc, E. (2021). Understanding vaccine hesitancy and supporting vaccine decision-making: Practical guide for pro-
fessionals in contact with the public in the context of COVID-19 in Quebec. CoVivre. ISBN 978-2-9820209-1-7.

Sobelson, R. K., Wigington, C. J., Harp, V., & Bronson, B. (2015). A whole community approach to emergency management: Strategies and best practices of seven community programs. *Journal of Emergency Management, 13*(4), 349–357. https://doi.org/10.5055/jem.2015.0247

Tworek, H., Beacock, I., & Ojo, E. (2020). *Democratic health communications during covid-19: A RAPID response*. Centre for the Study of Democratic Institutions, The University of British Columbia. https://democracy2017.sites.olt.ubc.ca/files/2020/09/Democratic-Health-Communication-during-Covid_FINAL.pdf

Williams, D. R., Costa, M. V., Odunlami, A. O., & Mohammed, S. A. (2008). Moving upstream. *Journal of Public Health Management and Practice, 14*(6), S8–S17. https://doi.org/10.1097/01.phh.0000338382.36695.42

Wynen, J., & Verhoest, K. (2016). Internal performance-based steering in public sector organizations: Examining the effect of organizational autonomy and external result control. *Public Performance & Management Review, 39*(3), 535–559. https://doi.org/10.1080/15309576.2015.1137769

Xiong, J., Lipsitz, O., Nasri, F., Lui, L., Gill, H., Phan, L., Chen-Li, D., Iacobucci, M., Ho, R., Majeed, A., & McIntyre, R. S. (2020). Impact of COVID-19 pandemic on mental health in the general population: A systematic review. *Journal of Affective Disorders, 277*, 55–64. https://doi.org/10.1016/j.jad.2020.08.001

Yue, J.-L., Yan, W., Sun, Y.-K., Yuan, K., Su, S.-Z., Han, Y., Ravindran, A. V., Kosten, T., Everall, I., Davey, C. G., Bullmore, E., Kawakami, N., Barbui, C., Thornicroft, G., Lund, C., Lin, X., Liu, L., Shi, L., Shi, J., . . . Lu, L. (2020). Mental health services for infectious disease outbreaks including COVID-19: A rapid systematic review. *Psychological Medicine, 50*(15), 2498–2513. https://doi.org/10.1017/s0033291720003888

**Author Biographies**

Joy Schinazi is CoVivre Coordinator (Phase 2), Communication and Transfer of Knowledge component. She holds a Master’s degree in Developmental Psychology from McGill University and a Master’s degree in Public Health (MPH) in Family and Community Health from Harvard University. Her experience includes more than 15 years within the Public Health network in Québec, working in the implementation and evaluation of preventive programs aimed at reducing health disparities.

Tara Santavicca is Program Officer for CoVivre. She has a Master’s degree in Public Health from McGill University. She also holds a Bachelor’s degree in Kinesiology and is an accredited member of the Québec Kinesiology Federation. She has worked on
the education and awareness of physical activity across the lifespan, in the context of health and illness.

**Cindy Ngov** is Program Officer for CoVivre. She holds a Master’s degree in Public Health from McGill University and a Bachelor’s degree in Microbiology and Immunology. She is very interested in the issue of social inequalities and the link between basic research and practical interventions around all aspects of physical and psychosocial well-being.

**Anabelle Vanier-Clément** is CoVivre Coordinator (Phase 2), Support for Religious and Community Leaders component. She holds a double Master’s degree in International Relations from Sciences-Po Paris and the London School of Economics, as well as training in mediation from the Canadian Institute for Conflict Resolution. She has professional experiences in Montreal and abroad in journalism, human rights, and coordination of youth projects in a multicultural context.

**Aïssata Touré** is the Health Liaison Officer for CoVivre. She holds a Bachelor’s degree in Business Administration with a specialization in Marketing from HEC Montréal and is currently completing her studies in Psychology at the Université de Montréal. She has worked for more than 6 years for a charitable organization dedicated to research, education, and support for people affected by cancer.

**Emmanuelle Bolduc** was the Coordinator of CoVivre for Phase 1. She holds a Master’s degree in Social and Transcultural Psychiatry from McGill University and an MBA. in International Development and Humanitarian Management from Laval University. She has more than 10 years of experience in program management and research-analysis, mainly in youth mental health and in community and partnership mobilization in a multicultural context, both internationally and in Quebec. Emmanuelle has been on maternity leave as of August 2021.

**Cécile Rousseau** is the founder of the CoVivre program. She is a child psychiatrist at the Montreal Children’s Hospital, and a researcher specializing in youth mental health care for immigrant and refugee children, and in the phenomenon of radicalization leading to violence. She is also a Professor in the Department of Psychiatry at McGill University.