

Written Brief

One-Page Summary and Recommendations

1. This brief focuses on the following question: *might some groups experience intensified risk and harm as a result of mobility tracking for public health?* Witnesses suggested before this Committee that mobility tracking helped public health's response to the pandemic. It helped to determine, for example, whether public health measures were working, and how to target scarce resources. We want, of course, to encourage innovations that improve public health. At the same time, we need to make sure that mobility tracking and disease surveillance do not undermine public health or community wellbeing, either by intensifying risks and harms for some communities, or, more generally, by diminishing public trust in our public institutions. Broader public awareness could help ensure that we are developing the most equitable, just, and trust-preserving forms of mobility tracking and disease surveillance for public health.
 - Recommendation 1: the Committee should recommend that the Public Health Agency of Canada (PHAC) amplify its public awareness and education work surrounding mobility tracking and disease surveillance initiatives in order to make them more transparent and more available to public deliberation.
2. While mobility tracking may have benefits, emphasis must be placed on how these benefits are distributed. When mobility tracking is used in directing government resources we may ask where these resources were directed, by whom, and with what effects for whom? For instance, was mobility tracking correlated with the intensification of punitive pandemic responses? Social scientific work has documented the use of punitive measures (e.g., policing; fines) as part of the pandemic response. We have reason to worry that these enforcement measures have fallen disproportionately on communities that have been historically targeted for increased policing.
 - Recommendation 2: the Committee should recommend that mobility tracking data (and data from other PHAC surveillance initiatives) be protected from access by police or other enforcement organizations. These data should be prevented from being used in criminal-law responses to communicable disease and other instances of criminal law proceedings. The Committee should remain sensitive to disease criminalization in drafting its report.
3. Beyond criminalization, epidemiological data about the point of origin of people experiencing communicable disease can be used in profoundly stigmatizing and discriminatory ways. We need to ensure, therefore, that public health tracking and surveillance initiatives do not aggravate extant social divisions (e.g. between people on the basis of race/ethnicity, or between provinces, or between urban and rural areas). A more community-engaged approach, with more diverse stakeholders, could help protect the data produced by mobility tracking and surveillance from becoming vectors of stigma and discrimination.
 - Recommendation 3: the Committee should recommend that PHAC develop robust forms of community-engagement surrounding mobility tracking and disease surveillance initiatives (e.g. independent, surveillance-focused Community Advisory Boards whose mandate would be, in part, to support input from diverse community members).

Introduction—*A Sociology With Public Health That Asks Critical Questions About Surveillance*

4. I am an Associate Professor with the Department of Sociology & Anthropology at Concordia University, in Montreal. I study the social dimensions of technology, with an empirical focus on communications and information technology in their everyday contexts. I have been studying public health surveillance from a sociological perspective since before 2003, when I started my doctoral studies. My dissertation examined the post-SARS transformation of Ontario's public health system, focusing on the development of the province's integrated public health information system, or *iPHIS*. Over the years since completing my doctoral work, I have continued to write about surveillance in public health and medical care contexts.¹
5. Sociologists have debated the most appropriate way for our discipline to approach public health. Should we work *in* the service of organized public health, and within epidemiological ways of understanding disease—should we, in other words, do sociology *in* public health? Or should we make the organizations, professions, cultures, technologies, discourses and practices of public health the objects of our critical reflection—should we do sociology *of* public health? Each sociological approach to public health has merits; and each has limitations. The former may be too accepting of problematic public health concepts that stigmatize—think of the infamy heaped upon so-called index cases (i.e. Patient Zero in the early years of the AIDS epidemic in the United States and Canada). The latter approach may be too far removed from the everyday practices of public health to be very impactful (i.e. to have a role in shaping policies that can guide public health practices). For these reasons, a number of sociologists who work in relation to public health (including myself) have found it necessary to articulate a third approach, a sociology *with* public health, which may be defined as a critical sociology that engages with public health actors while remaining committed to the specificity of social science theory and methodology.²
6. Applied to forms of public health surveillance, including mobility tracking for public health purposes, this means that **A)** I share public health professionals' evaluative concerns that touch on questions of efficacy, efficiency, utility, timeliness;³ and **B)** I prioritize critical sociological questions, which may not be centered in surveillance evaluation frameworks. I concentrate on

¹ French, Martin. 2009. *Picturing Public Health Surveillance: Tracing the Material Dimensions of Information in Ontario's Public Health System*. Kingston: Queen's University PhD Dissertation (available [here](#)); French, Martin. 2009. "Woven of War-Time Fabrics: The Globalization of Public Health Surveillance," *Surveillance & Society* 6(2): 101-115 (available [here](#)); French, Martin and Eric Mykhalovskiy. 2013. "Public Health Intelligence and the Detection of Potential Pandemics," *Sociology of Health & Illness* 35(2): 174-187 (available [here](#)); French, Martin. 2014. "Gaps in the Gaze: Informatic Practice and the Work of Public Health Surveillance," *Surveillance & Society* 12(2): 226-243 (available [here](#)); French, Martin and Torin Monahan. 2020. "Editorial—Dis-ease Surveillance: How Might Surveillance Studies Address COVID-19," *Surveillance & Society* 18(1): 1-11 (available [here](#)).

² Mykhalovskiy, Eric, Katherine Frohlich, Blake Poland, Erica Di Ruggiero, Melanie Rock and Leigha Comer. 2019. "Critical Social Science *with* Public Health: Agonism, critique and engagement," *Critical Public Health* 29(5): 522-533.

³ Public health scholars and professionals have developed a robust literature on the evaluation of public health surveillance systems. In 2004, Health Canada developed its own surveillance evaluation framework (see Health Canada. 2004. *Framework and Tools for Evaluating Health Surveillance Systems*. Ottawa: Health Canada). I imagine PHAC would have done an evaluation according to a framework like this prior to the establishment of the mobility tracking initiative before this Committee. However, as Groseclose and Buckeridge note, if an "evaluation is pursued in a reductionist manner (i.e., by assessing system attributes independent of one another), key insights into the surveillance system process and information may be missed." (see Groseclose, Samuel, and David Buckeridge. 2017. "Public Health Surveillance Systems: Recent Advances in Their Use and Evaluation," *Annual Review of Public Health* 38: 57-79 (available [here](#)).

how surveillance or its effects might be experienced in people's everyday lives. And I am interested in whether people might be advantaged or disadvantaged by surveillance.⁴ This leads me to pose critical, sociological questions about public health surveillance systems.⁵ In posing critical questions, I work to produce research that helps public health to better align public health surveillance with social justice and data justice goals.⁶

7. This brief is organized as follows. First I foreground questions of equity that mobility tracking for public health purposes might raise. Second, I put a spotlight on the potential of mobility tracking to intensify risks and harms of criminalization experienced by some communities. Third, I provide examples illustrating how epidemiological data about place has acted as a vector of stigma and discrimination. Fourth, I conclude by highlighting an approach to community-engagement that could mitigate potential risks and harms associated with surveillance and mobility tracking for public health.

A Focus on Equity Questions

8. Members of this Committee, and witnesses, have raised questions about privacy, consent, transparency and accountability in relation to the mobility tracking initiative developed by PHAC in collaboration with private-sector partners. While I am also concerned about these issues, I want to emphasize a set of adjacent issues that we can think about through the prism of equity.⁷

⁴ See, for instance, Lyon, David (ed). *Surveillance as Social Sorting: Privacy, Risk, and Digital Discrimination*. London: Routledge; Lyon, David. 2022. *Pandemic Surveillance*. Cambridge: Polity Press.

⁵ In asking critical questions about public health surveillance against a backdrop where political actors are leveraging vaccine hesitancy and misinformation to whip up anxiety and anti-public health protests, it has sadly become necessary to stress that, even though I may raise critical questions about public health, *I am not against public health. I am not against public health surveillance*. In fact, I participate nearly every week in the *FluWatchers* surveillance initiative, which is operated by the Public Health Agency of Canada. This is one of the surveillance systems that provides data for the *COVIDTrends* website mentioned by Minister Duclos in his remarks before this Committee (on the *FluWatchers* initiative, see: <https://health-infobase.canada.ca/covid-19/covidtrends/?HR=1&mapOpen=false>).

⁶ Simply put, *social justice* refers to an equitable distribution of justice in the world. From a bioethics and health policy perspective, Powers and Faden argue that social justice constitutes *the* moral foundation of public health. This is because, among other reasons, the institutions of public health have as an objective the wellbeing of the collectivity. Powers, Madison and Ruth Faden. 2006. *Social Justice: The Moral Foundations of Public Health and Health Policy*. Oxford: Oxford University Press. In recent work, we argue that, when it comes to the use of digital technologies for public health surveillance, we need to expand the social justice view of public health to include “data justice,” which considers “the implications that data-driven processes at the core of surveillance capitalism have for the pursuit of substantive social and economic justice claims”. See: French, Martin, Adrian Guta, Marilou Gagnon, Eric Mykhalovskiy, Stephen Roberts, Alexander McClelland, Su Goh, and Fenwick McKelvey. 2020. “Corporate Contact Tracing as a Pandemic Response,” *Critical Public Health*, 32(1): 48-55, [DOI](#); citing Dencik, L., Hintz, A., and Cable, J. 2016. “Towards data justice? The ambiguity of anti-surveillance resistance in political activism,” *Big Data & Society* 3 (2), [DOI](#); and Molldrem, S. and Smith, A. 2020. “Reassessing the ethics of molecular HIV surveillance in the era of cluster detection and response: Towards HIV data justice,” *American Journal of Bioethics*, 20:10, 10-23, [DOI](#).

⁷ There are different ways of defining equity in a public health contexts. *Health equity* has been defined as “the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically” (Pan-Canadian Public Health Network and the Public Health Agency of Canada. 2018. *Health Inequalities in Canada: A National Portrait*. Ottawa: PHAC, p. 14). PHAC has clearly foregrounded considerations of equity in its recent work (e.g. *From Risk to Resilience: An Equity Approach to COVID-19*), so there is good reason to believe that equity issues were front and centre in the development of PHAC's mobility tracking initiative. Nevertheless, we must also keep in mind that, while working towards equity is an important strategy in a broader social justice project, equity is not necessarily synonymous with social justice (see Smith 2015, who cautions against allowing

9. On the one hand, are there groups of the population who will not be able to reap whatever benefits may flow from mobility tracking because they do not own a mobile device or because they do not own the right kind of mobile device? The *COVID Trends* website, in a section discussing the limitations of mobility data, notes that the data do not “represent the entire population”.⁸ If it is the case that mobility tracking gives certain regions the ability to better control the pandemic what must be done to ensure that *all* regions benefit; how do we take insights from one region and apply the derivative benefits for all?
10. On the other hand, who may experience intensified risks or harms due to mobility tracking? In her remarks before this Committee on February 3, 2022, Dr. Tam mentioned that mobility tracking could be used to understand the efficacy of public health measures:

Mobility data at this kind of aggregated level can be used to see if provinces and territories, or local jurisdictions, when they enact public health measures to reduce contact rates, or to ask people to stay at home, for example, whether those are actually working...⁹

What would happen if these data were to show that people in a given neighbourhood were not, in fact, staying home? Is it possible that these data could lead to an intensification of policing and enforcement in that neighbourhood? Would such an intensification potentially interlock with extant over-policing of some communities? How would public health use that data? Could that data be shared with other institutions, such as the justice system? What could be the implications of sharing this information in the media? Could this data, or its sharing, be used in a way that violates Charter rights?

11. To better address the equity and data justice questions posed above, it seems important to resource PHAC well enough to support public deliberation of its surveillance and tracking initiatives. This is not just about transparency, although transparency is key; it is also about enabling public awareness and deliberation through education.

- **Recommendation 1:** the Committee should recommend that the Public Health Agency of Canada amplify its public awareness and education work surrounding mobility tracking and disease surveillance initiatives in order to make them more transparent and more available to public deliberation.

Potential of Mobility Tracking to Intensify Risks Experienced by Some Communities

12. Might some people experience intensified risks or harms as a result of PHAC’s mobility tracking? The equity issues mentioned above are equally important. However, I am going to focus on the issues and questions posed in paragraph 10, which, I believe, are more pressing over the near-term.

social justice concerns to be overshadowed by health equity concerns: Smith, Maxwell. 2015. “Health Equity in Public Health: Clarifying Our Commitment,” *Public Health Ethics* 8(2): 173-184. See also Henry et al., who, in an analysis of equity at Canadian Universities, critique the gap between what is promised by equity discourses, and what actually happens: Henry, Frances, Carl James, Peter Li, Audrey Kobayashi, Melinda Smith, Howard Ramos and Dua Enakshi. 2017. *The Equity Myth: Racialization and Indigeneity at Canadian Universities*. Vancouver: UBC Press.

⁸ *COVIDTrends* website, <https://health-infobase.canada.ca/covid-19/covidtrends/?HR=1&mapOpen=false>.

⁹ Dr. Tam, before the ETHI Committee on February 3, 2022 (available [here](#)).

13. Social scientists and civil liberties groups have monitored how health information has been used to police the pandemic.¹⁰ They have documented the use of punitive measures (e.g., policing; fines) as part of the pandemic response. Just concentrating on Quebec, where I live, there have been over \$24 million dollars in fines issued between the start of the pandemic and April 2021.¹¹ Such actions reveal the possibility and risk of enforcement activity falling disproportionately on communities that have been historically targeted for increased policing.
14. We do not have systematic, social-demographic data related to law enforcement's policing of COVID-19 measures in Canada. In other jurisdictions, however, we see troubling police responses.

The London Metropolitan Police, for example, released data indicating that Black and Asian people were more likely to be targeted and fined [under] COVID-19 emergency laws than white people. The New York City Police Department similarly released racially disaggregated data on COVID-related enforcement, and a New York Times analysis revealed that 81 percent of the NYPD's summonses related to physical distancing had gone to Black and Latinx people. An additional New York Times analysis revealed that 35 of 40 people arrested by the NYPD for alleged physical distancing failures were Black. A report that gathered public information about COVID-19 enforcement across the United States found that Black, Indigenous, and people of colour were 2.5 times more likely to be policed for alleged COVID-19 violations than white people. The same study found that Black people in particular were 4.5 times more likely to face COVID-19 enforcement actions than white people (references omitted, but available in the CCLA & PPMP report at the link below).¹²

Turning back to Canada, we have anecdotal evidence about similar concerning trends.

15. In Quebec, for instance, "grassroots organizations report that individuals experiencing homelessness have again [during the second wave] received tickets for being in public spaces after the province-wide curfew and have been harassed by police enforcing COVID orders when attempting to access safe injection sites".¹³ Additionally, enforcement activity increased in December 2020 after Premier Legault urged police to issue more fines to people not complying with COVID-19 rules. "Provincial and Montreal police seemed to answer this call, doubling the number of tickets issued from December 14-20," when compared with enforcement in the previous week. Following a court challenge by the Clinique Juridique Itinerante/Mobile Legal Clinic, the Quebec government amended some public health measures and stopped applying the

¹⁰ McClelland, Alexander and Alex Luscombe. 2020. *Policing the Pandemic: Tracking the Policing of COVID-19 Across Canada*, <https://www.policingthepandemic.ca/>.

¹¹ Canadian Civil Liberties Association (CCLA) & Policing the Pandemic Mapping Project (PPMP). 2021. *By the Numbers: The Second Wave of COVID-19 Law Enforcement in Canada*. Toronto: CCLA (available [here](#)).

¹² Ibid.

¹³ Ibid.

government's curfew order to those experiencing homelessness.¹⁴ Nevertheless, the effects of enforcement prior to, and after, this announcement remain to be investigated.

16. Did PHAC's mobility tracking initiative have a hand in Quebec's (and other province's) intensification of enforcement? Was mobility tracking data used to target enforcement resources in specific areas? Even if PHAC's mobility tracking data was not used in this way, there is the potential, without proper protections in place, that such data *could* be used for enforcement purposes.

Data about Place as a Vector of Stigma and Discrimination

17. Epidemiological data about the emplacement, or point of origin, of people experiencing communicable disease can be used in profoundly stigmatizing and discriminatory ways. This is especially the case during epidemics, as was shown for example in relation to a 1982 publication by the U.S. Centers for Disease Control and Prevention's *MMWR Weekly*, entitled "Opportunistic Infections and Kaposi's Sarcoma among Haitians in the United States". An editorial note accompanying this publication speculated about this occurrence of "severe opportunistic infections among 32 Haitians recently entering the United States".¹⁵ In the effort to identify risk factors the authors (perhaps inadvertently) communicated the idea that the patients' conditions were not acquired in the United States (e.g., that the patients could be responsible for 'importing' this communicable condition into the United States. This (and similar statements) helped to spawn the infamous '4H' discourse about who was at risk of developing AIDS and about who posed a risk to the health of the American population.
18. Viviane Namaste's book, *Savoir créoles: Leçons du sida pour l'histoire de Montréal*, shows how this kind of epidemiological data intersected with other policy decisions to stigmatize an entire community:

Aux États-Unis, pendant les premières années, le syndrome a été observé surtout chez les gais : le premier article scientifique qui constate ce phénomène raconte la présence de maladies opportunistes chez les jeunes gais qui, normalement, devraient être en santé. Peu de temps après, toujours aux États-Unis, on a observé des cas chez des personnes d'origine haïtienne récemment immigrées. La présentation clinique de certains toxicomanes et d'hémophiles vivant avec ce syndrome a appuyé l'hypothèse selon laquelle il y avait une transmission probable par le sang, même si on n'a pas pu déterminer si c'était un virus qui en était responsable. Dans un tel contexte générale, les autorités américaines de la Croix-Rouge ont décidé de déconseiller le don du sang chez les membres de ces groupes. Le Croix-Rouge canadienne lui a emboîté le pas. Au cœur de cette déclaration se trouve le concept de groupe à risque. Que ce soit les *homosexuels, les hémophiles, les Haïtiens.ne.s ou les héroïnomanes* [emphasis mine—the '4H' discourse mentioned above in paragraph 17], la logique de la Croix-Rouge visait à protéger le sang collectif en excluant des dons provenant de ces groupes. [...Mais le] traitement des personnes haïtiennes, n'est pas fait dans les mêmes termes que les autres

¹⁴ CCLA & PPMP, *By the Numbers: The Second Wave of COVID-19 Law Enforcement in Canada*.

¹⁵ Editor. 1982. "Opportunistic Infections and Kaposi's Sarcoma among Haitians in the United States," *MMWR* 31(26): 353-354, 360-361, (available [here](#)).

groupes identifiés. Pour les personnes militantes haïtiennes, cette différence de conduite par rapport aux groupes ethniques ou nationaux soulève la question du racisme.¹⁶

A key concern with data illustrating people's movements during epidemics and pandemics, as the above example illustrates, is in its potential to depict groups of people—in this case an entire nationality—as vectors of communicable disease, transporting infectious agents from Point A (e.g., the global south) to Point B (e.g., the global north).

19. More contemporarily, scientists in South Africa reported a new SARS-CoV-2 variant—B.1.1.529—to the World Health Organization in November 2021.¹⁷ Shortly thereafter, several countries including, the United States¹⁸ and Canada,¹⁹ blocked foreign nationals traveling from the Southern Africa region, including from South Africa, Eswatini, Lesotho, Botswana, Zimbabwe, Mozambique, and Namibia, from entering their countries.
20. These examples give us a sense of what is, and what has long been, at stake when it comes to collecting, using, and communicating about data to understand and prevent the movement of communicable disease. When such data intersect with stigmatizing and discriminatory ideas about who might be a “carrier,” a “superspreader,” “hyperinfectious,” and so on, extant social divisions may be intensified.²⁰ Indeed, we have seen a concerning rise in hate incidents since the start of the pandemic, exemplified by anti-Asian racism at the start of the pandemic and then mapping onto whichever communities have been comparatively more affected by COVID-19.²¹
21. To the extent that mobility data could depict one region or neighbourhood as more mobile, and therefore as more potentially infectious, this form of public health surveillance may aggravate inter-cultural and inter-regional divisions. It will be key to take steps to ensure that mobility data do not become a vector of stigma and discrimination.²²

¹⁶ Namaste, Viviane. 2019. *Savoir créoles: Leçons du sida pour l'histoire de Montréal*. Montréal : Mémoire D'encrier, pp. 108-111.

¹⁷ World Health Organization (WHO). 2021. “Classification of Omicron (B.1.1.529): SARS-CoV-2 Variant of Concern,” *News*. Geneva: WHO (available [here](#)).

¹⁸ United States, Centers for Disease Control and Prevention. 2021. *Science Brief: Omicron (B.1.1.529) Variant*. Atlanta: CDC (available [here](#)).

¹⁹ Canada, Public Health Agency of Canada. 2021. *Government of Canada introduces new measures to address COVID-19 Omicron variant of concern*. Ottawa: PHAC (available [here](#)).

²⁰ Mykhalovskiy, Eric and Martin French. 2020. “COVID-19, Public Health, and the Politics of Prevention,” *Sociology of Health & Illness*, 42(8): 4-15

²¹ See, for instance: British Columbia Office of the Human Rights Commissioner (BCOHR). 2022. *1 in 4 British Columbians Have Experienced or Witnessed Hate Incidents Since Start of Pandemic*. Vancouver: BCOHR (available [here](#)).

²² In addition to thinking about everyday discrimination on the street, mobility tracking implicates digital forms of discrimination. For an overview and critique of different forms of digital discrimination, see Benjamin, Ruha. 2019. *Race After Technology: Abolitionist Tools for the New Jim Code*. Cambridge: Polity Press.

- Recommendation 2: the Committee should recommend that mobility tracking data (and data from other PHAC surveillance initiatives) be protected from access by police or other enforcement organizations. These data should be prevented from being implicated in criminal-law responses to communicable disease and other instances of criminal law proceedings. The Committee should also remain sensitive to disease criminalization in drafting its report.

Community-Engagement—Necessary for Identifying and Mitigating Surveillance Risks

22. There are serious equity-related concerns, risks and potential harms associated mobility tracking for public health. These are perhaps more difficult to regulate in circumstances where the line between public-sector and private-sector tracking is blurred. Canada’s privacy legislation is currently bifurcated between a framework that focuses on public-sector actors (*The Privacy Act*) and one that focuses on private-sector actors (*The Personal Information Protection and Electronic Documents Act*, or PIPEDA). As the mobility tracking initiative before the Committee clearly implicates both private-sector and public-sector actors, it may highlight some of the limitations of these bifurcated privacy frameworks. Accordingly, the Committee may wish to make risk mitigation recommendations that can be put in place in the near term, without needing to wait for legislative overhaul. Below I point to one such measure: community engagement (in particular, the participatory praxis approach to community engagement).²³

23. *Private-sector mobility tracking: a process permitted by current privacy laws*—Google has published community mobility reports since early on in the COVID-19 pandemic. It emphasizes the privacy protections it has put in place to protect user data in the context of such uses.²⁴ Meanwhile, the Telus *Data for Good* initiative has provided data to different partners in order “to support health authorities and academic researchers in helping to reduce COVID-19 transmission without compromising the personal privacy of Canadians”.²⁵ Telus also emphasizes the privacy protections it has put in place to protect uses of these data (though, as has been noted before this Committee, the *Data for Good* initiative relies on an opt-out approach, potentially creating situations where users are not aware that they are contributing data).²⁶ Dr. Khan, before this Committee, noted that, when SARS-CoV-2 became detectable in Canada, BlueDot “analyzed deidentified GPS location data” that were “procured from third-party providers” who were “selected because they adhered to Canadian and other internationally-stringent privacy laws and regulations and had strong data privacy practices in place”.²⁷ The

²³ Community engagement may be defined as “the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. In general, the goals of community engagement are to build trust, enlist new resources and allies, create better communication, and improve overall health outcomes...” (references omitted): United States National Institutes of Health. 2011. *Principles of Community Engagement, Second Edition*. Bethesda: NIH, (available [here](#)).

²⁴ Fitzpatrick Jen and Karen DeSalvo. 2020. “Helping public health officials combat COVID-19,” *The Keyword*, <https://www.blog.google/technology/health/covid-19-community-mobility-reports>

²⁵ Telus. 2022. *Data for Good—Benefiting Canadians through data insights*, <https://www.telus.com/en/about/privacy/data-for-good>.

²⁶ Telus. 2022. *Technology is evolving and so are we*, <https://www.telus.com/en/about/privacy/data-analytics>.

²⁷ Dr. Khan, before the ETHI Committee on February 17, 2022 (available [here](#)).

privacy protections mentioned by these private-sector actors are important; however, de-identified, aggregate data can be, and have been, used to criminalize, stigmatize, and discriminate against classes of people (see paras 12-21 above).

24. *Government-initiated mobility tracking and the public ethos of public health*—for its part, public health organizations have long relied on “unofficial,” private-sector sources of data for surveillance purposes, including surveillance of private-sector news media, for instance. The Global Public Health Intelligence Network exemplified this kind of undertaking, operating with a view to learning about epidemics *before* they rose to the level of international concern.²⁸ We should situate PHAC’s current mobility tracking initiative against the backdrop of this longstanding effort to innovate the practices of public health surveillance in order to make it more proactive and less reactive. I think we want public policy to encourage, and not dissuade, such innovation. However, I think we also want to defend the *public* ethos and mission of PHAC, which is to “promote and protect the health of Canadians through leadership, partnership, innovation and action in public health”.²⁹ While corporate action in the public health sphere may have some advantages, we need to also be concerned about corporate influence in this sphere and notably whether it could spark the “potential erosion of an ethos of public health as a public good”.³⁰ Public-sector work in public health is nominally in the public domain and is therefore responsive to public and professional accountability. “Private-sector approaches stem from different sources of authority (e.g. economic, rather than sovereign, power) and are not subject to the same types of accountability measures”.³¹ If the equity-related risks described above are not well addressed by extant accountability measures, then it may be important for the Committee to make recommendations that help PHAC develop new accountability measures that can work across the public- and private-sector. Community-engagement may work in this regard.
25. Recently, we have advocated for a *participatory praxis* approach to community engagement as it concerns HIV surveillance:

This approach builds on the tradition of participatory action research [and...] derives its name from the characteristic attempt to fundamentally embed community voices into the everyday practices of decision- and policy-making.³²

²⁸ Weir, Lorna and Eric Mykhalovskiy. 2010. *Global Public Health Vigilance: Creating a World on Alert*. New York: Routledge-Cavendish.

²⁹ See: <https://www.canada.ca/en/public-health/corporate/mandate/about-agency.html>.

³⁰ Green, Judith. 2019. “Time to interrogate corporate interests in public health?” *Critical Public Health*, 29(3), 257-259, (available [here](#)), pp. 257-258.

³¹ French, Martin, Adrian Guta, Marilou Gagnon, Eric Mykhalovskiy, Stephen Roberts, Alexander McClelland, Su Goh, and Fenwick McKelvey. 2020. “Corporate Contact Tracing as a Pandemic Response,” *Critical Public Health*, 32(1): 48-55, [DOI](#).

³² Spieldenner, Andrew, Martin French, Venita Ray, Brian Minalga, Cristine Sardina, Robert Suttle, Marco Castro-Bojorquez, Octavia Lewis, and Laurel Sprague. 2022. “The Meaningful Involvement of People Living with HIV/AIDS (MIPA): The Participatory Praxis Approach to Community Engagement on HIV Surveillance,” *Journal of Community Engagement and Scholarship*, 14(2), [URL](#).

In this work, we emphasize the importance of valorizing and adequately resourcing expertise that stems from experience. Translated to the current example of mobility tracking, this might mean providing resources to community-based groups that could work with community members to facilitate their participation in community-engagement work concerning mobility tracking. It also means remunerating community-members for contributing their time expertise (especially community members who may be unwaged). Some approaches to community-engagement assume an equal capacity for participation across diverse publics. We cannot assume this when it comes to issues related to public health surveillance; accordingly, steps must be taken to enable participation by community-members coming from different social locations (e.g. those who may be undocumented, or unhoused).

26. Done well, community engagement could help to surface and address issues that emerge at the intersection of government-initiated and private-sector mobility tracking. It could help ensure that PHAC's mobility tracking and surveillance initiatives address community needs and concerns, demonstrate real care for participants' consent, and establish privacy protections that actually protect privacy. It could help build public trust and social solidarity through these initiatives by supporting measures that would make them equitable and just. In these ways, it might truly benefit the public's health.
27. Unfortunately, from what government representatives have stated to this Committee and in public, PHAC does not appear to have adopted a robust community-engaged approach for this mobility tracking initiative. While we might understand why PHAC, Telus, and BlueDot moved quickly and set some of these larger ethical questions to the side during the onset of the current pandemic, we should not retain the status quo as a model for community-engaged public health going forward. It is imperative that PHAC and its partners, instead, develop ethical approaches to using mobility data, especially when it might serve secondary or tertiary (e.g. punitive) purposes.

- Recommendation 3: the Committee should recommend that PHAC develop robust forms of community-engagement surrounding mobility tracking and disease surveillance initiatives (e.g. independent, surveillance-focused Community Advisory Boards whose mandate would be, in part, to support input from diverse community members).

Concluding Remarks

28. This brief is informed by the previous research that I have done, and not by empirical research focusing on the equity implications of this particular mobility tracking initiative. I ask Committee members to please keep this limitation in mind while considering my remarks.
29. Thanks to many colleagues, mentors, and public health professionals who have helped me to learn about surveillance in public health contexts. Thanks especially to colleagues who reviewed and commented on earlier versions of this brief. Special thanks to Dr. Viviane Namaste for her helpful comments on an earlier version - any omissions or errors are my own.