**Back to ‘normal`? Building community resilience after COVID-19**

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While the challenge of the COVID-19 pandemic is far from over, many countries are resuming economic and social activities with the aim of returning to some semblance of normality. But what should the ‘new normal’ be? The pandemic has exposed how the *status quo* produces uneven vulnerability to the adverse effects COVID-19, with the most disadvantaged groups bearing the greatest health, social and economic burden. We argue that recovery from the pandemic offers an opportunity to develop policies to build community resilience to future pandemics and other large-scale health emergencies (1) and, by so doing, to move into a new era of health equality and social justice.

Globally, sections of the population with a higher prevalence of non-communicable diseases (NCDs) such as type-2 diabetes or hypertension have experienced substantially more individuals hospitalized or dying due to COVID-19 (2). These ‘pre-existing conditions’ are often framed as the result of individual lifestyle choices. Yet, unpacking this individual-centered narrative reveals several shortcomings. First, it risks creating a moral discourse (3) which renders patients individually responsible for negative health outcomes and can even be used to ‘explain away’ deaths from COVID-19. Secondly, viewing variation in risk at an individual level diverts attention from the deeper causes of susceptibility, especially how socio-economic inequalities shape the distribution of health risks in a population. In the U.S., for example, rates of diabetes are highest among Indigenous, Latinx, and Black people who are subject to economic and social discrimination (4). The roots of COVID-19 susceptibility lie deep in social structures characterized by persistent inequalities.

Research in the Developmental Origins of Health and Disease (DOHaD) field and in environmental epigenetics has revealed how adverse social and material conditions during early life affect later risk of NCDs, and how such risk is passed across generations through both inherited social conditions and non-genetic biological mechanisms (5). This perspective corresponds with insights from social epidemiology and the sociology of health that describe how societal structures and processes such as racism, socio-economic deprivation, or poor access to healthcare become embodied, shaping health and wellbeing throughout the life-course (6). Yet, while stressing the importance of early life experiences for later health, both life and social science approaches emphasize the ongoing plasticity of human bodies and the possibility of improving health outcomes across the population by improving social conditions (7).

A focus on community resilience recognizes that social justice is fundamental to promoting health in society. It centres the voices and experiences of those who are disadvantaged and assists vulnerable communities in building and maintaining structures and relations that support their health and well-being. This requires prioritizing systemic rather than individual change. The recovery phase from the pandemic offers opportunities for devising social and public health policies that channel resources to marginalized communities and support their self-determination. The Hawaiian State Commission on the Status of Women, for example, has proposed a post-pandemic economic recovery plan that advocates adopting universal basic income and single-payer healthcare, improving maternal and neonatal healthcare, addressing gender-based violence, and supporting Native, Black, and immigrant women in economic recovery (8). As the Commission argues: “Rather than rush to rebuild the status quo of inequality, we should encourage a deep structural transition that addresses the crises in healthcare, social, ecological and economic policies laid bare by the epidemic.” These recommendations are in line with both the Reproductive Justice and Black Lives Matter movements, which link systemic racism to the uneven distribution of health, wealth, and life chances.

Some of the most important factors which underlie community resilience may easily be overlooked if they are not immediately reflected in individual susceptibility to COVID-19. Attention needs to be paid to population groups *not* showing high morbidity and mortality rates in the current pandemic, but whose experiences and exposures during the pandemic nonetheless substantially affect population health longer-term. This is especially relevant to maternal and child health, which impact on pregnancy outcomes and child development (9). Disinvesting in the health of mothers and children, particularly of those living in disadvantaged communities, during the period of economic recession following the pandemic thus sows the seeds of later health inequality, which will undermine community resilience to a future health emergency. We therefore argue for the importance of community-led and state-supported initiatives for building community resilience which centre its most vulnerable members and allow individuals, families, and communities to support each other in times of crisis and beyond.

The rallying cry that “We’re all in this together” may encourage members of society to play their part in reducing the immediate impact of the pandemic but, at the same time, it hides the fact that some groups are affected much more than others. The ethical way forward must include significant systemic change that focuses on social, reproductive and health justice and redefines what socio-economic conditions we consider acceptable.

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