COVID-19 ASPHER Task Group –

Ethical and Professional Guidance for Public Health Academics and Professionals

How should we evaluate Country-level Rapid Reviews of Pandemic Impacts on Health Inequalities and Vulnerable population groups?

The release on 2nd June 2020 of the PHE Report on COVID-19 Health Disparities in the UK raises several issues for their public health system and population.

It raises questions about how ASPHER could promote country-level analyses across Europe with WHO(E) and the HSP Observatory.

It also asks questions about good practice for public health professionals who are supporting or conducting such rapid reviews.

The PHE Report we believe was the first to be published in the European Region and offers lessons for both technical analysis, research conduct and dissemination policies.[2]

ASPHER's COVID-19 Task Group has published its first Statement on Health Inequalities and Vulnerable Population on 1st June 2020. As the pan-European association of University Schools of Public Health ASPHER is actively encouraging all our Schools across Europe to stimulate action and engage with and constructively support Rapid Reviews of the impacts on health inequalities and vulnerable populations. ASPHER is promoting this guidance to Public Health professionals to enable them to choose best how and why to engage with such Rapid Reviews. There is concern that the impact of and reputation of public health professionals could be limited or damaged by participation in narrowly constructed and conducted rapid reviews. This guidance set out a range of parameters and criteria that public health professionals should consider when they decide how to engage with rapid reviews. Public health professionals should explore participation on an explicit and transparent basis and as a balance between a basis for long-term relationships with governments, along with relationships with disadvantaged and vulnerable populations.

ASPHER is broadly supportive of country-level Rapid Reviews of impacts on health inequalities and vulnerable population groups. We regard the choice of the term 'health disparities' is a definitive politically led decision. We see it as less preferable to the deeper concepts of 'health inequalities' and 'health inequities', as we believe it endorses a narrower conceptual understanding. Disparity terminology can lead to lesser attention to underlying structural determinants of health and of vulnerability in our societies and marginalise the pursuit of greater health equity in populations.

These Country-level Public Health Rapid Reviews should be done in each European Region by end of September 2020.

<u>Appendix 1</u> also offers a Professional Evaluation tool for engagement with Rapid Reviews and long-term research programmes.

<u>Appendix 2</u> shows a range of vulnerable or excluded groups or vulnerable settings that should each be considered, in addition to any other country specific excluded/vulnerable groups.

Eight Broad principles for conducting COVID-19 Public Health Rapid Reviews on health inequalities and vulnerable populations:

1. **Independently reporting** but funded and supported by each Governments There should be pre-agreed full Terms of Reference, independent academic participation, and all specific contributions acknowledged.

2. **Reflect the scope of Public Health**: To provide not just epidemiological analysis but also evidence-informed guidance on necessary interventions and effective public health programmes, addressing the social, economic, environmental, and political determinants of health.

3. **Strongly resourced:** with a wide range of public health expertise and additional capacity. This should include the capacity to undertake community engagement and foster participation in line with global good practices.[1]

4. **Longitudinally orientated:** so that the Rapid Review is a part of the long-term process to review the pandemic impacts and address underlying health inequalities and vulnerabilities. particular impacts, such as on mental health (including bereavement/grief reactions and PTSD), dependencies, domestic violence and adverse childhood experiences. We would recommend that longitudinal studies should be funded at least until 2030 to enable enduring health impacts to be assessed fully.

5. **Comprehensively scoped:** so that for each known or emerging health inequality, and each vulnerable group, and each vulnerable setting, the impacts are addressed fully. ***Appendix 2*.**

6. **Systematically conducted:** in line with multi-disciplinary public health models that embrace the full necessary range of quantitative and qualitative methodologies and innovative ways of understanding the pandemic, such as internet metrics. This should include expertise, apart from clinical epidemiology and statistics, from, for example, those in social and psychological sciences, health economics, public health ethics and communication experts.

7. **A three-way Epidemic Focus** for comprehensive and systematic investigation and research.

The three causations that ASPHER would advocate should be fully explored in any Pandemic Rapid Review (and necessary subsequent reviews) are:

- **Impacts of COVID-19 illness itself, leaving long-term consequences for many people who survive it, and/or direct impacts on their families or their carers.**
- **Pandemic Disruption and delay of usual health and social care, and effects on public health prevention programmes.**
- **Extra wider determinants of health arising from social distancing and short-long-term economic pandemic impacts**

Each of these gives us three forms of **epidemic focus** for investigation and research that must be followed up closely over the next five to ten years. These must include impacts that are harder to study such as mental health and psychological wellbeing. It needs active probing with tailored investigational methods to elicit adverse effects that require special expertise and resources. Vulnerable groups such as children, elderly, ethnic minorities, migrants, unemployed, homeless,

disabled and those with pre-existing mental health problems should be actively sought out and their experiences documented and collated.

The wide-ranging and connected determinants of the differential impacts on vulnerable groups is still being debated and clarified.[3-14] Public health researchers and leaders will need to embrace complexity and wider concepts to allow for and expand upon the multiple risks and cumulative impacts of excluded or vulnerable populations.[15-17]

Given these three broad epidemic foci we would advise that public health professionals should contest strongly any country-level Rapid Review that proposes a narrow focus that would potentially not reveal, or could conceal, the true extent of the pandemic impacts on any excluded or disadvantaged groups. Public health professionals should be mindful of the ethical standards for maintaining trust with communities and of using all available mechanisms to understand and incorporate their perspectives.[18-24]

8. **Evaluative Research:** Much evaluative research is needed of the many initiatives and tools that have been generated during the pandemic, by a variety of volunteer and community leaders, professional groups, statutory agencies and by third sector organisations. All research and evaluation should be conducted, albeit with strongly based scientific methods, with close engagement and support of affected communities. Models of investigation should recognise community and peer led initiatives and support their reports of their activities' outcomes.

Appendix 1. Professional Evaluation tool for engagement with Rapid Reviews and long-term research programmes:

(Example of Accountability Framework for rapid reviews for public health leaders to consider before/during/after participation in country-level reviews. *Includes ethical issues for public health participants.*

Criteria	Assessment notes for proposed Rapid Review	Strengths	Weaknesses
Timing and timescales	Compiling early investigations and strategic reporting during a pandemic is a central function for rapid reviews. This is to inform how to adapt and strengthen responses for vulnerable groups, particularly during the inter-wave period (summer 2020 in Europe) and before a potential second wave and the seasonal respiratory virus season. All initial reviews should also be stepping-stones in a commitment to systematic and comprehensive long-term research and investigation.		
Context and ownership	Any national 'country-level' rapid review should be of a good standard across WHO Europe region. This should be informed by national surveillance and population data systems plus have wider ownership by communities of interest who represent or work closely with vulnerable groups. Likely short-term limitations should be acknowledged, e.g. where due to timescales or data constraints. In-country Schools of Public Health should all be invited to identify their potential contributions.		
Scope and clarity of due process	The scope of the review should enable a level of initial commentary on all recognised vulnerable groups and settings. The full terms of reference and procedural mechanism for scrutiny and governance should be published earlier.		
Resources and wider expertise	The rapid reviews should commit funding and dedicated personnel to allow full attention to the agreed tasks.		
Public health leadership	There should be full ownership by and engagement with local public health directors and schools of public health, as well as by national public health leaders. The dilemmas already faced by local public health leaders, or anticipated, should be recognised.		
Transparency and independence	While there are national groups of experts advising each government, this can be construed as being too close to government, or amenable to political interference, or being cosy group of the usual suspects. Clear steps should be taken to ensure the independence to report findings without interference, or		

Comprehensive modern Public Health Methodologies	The range of expertise and applied skills anticipated should be documented and checked for comprehensiveness.		
Wider engagement and active participation by vulnerable communities in review processes	There should be strong participation and input from communities/vulnerable groups affected (e.g. asylum seekers, ethnic minorities) Consider good practice and guidance – need to identify and list key sources including other WHO regions USA/CDC examples Professional public health ethical standards of 'maintaining public trust'		
Analysis and interpretation	A procedural approach should be adopted for highlighting areas of uncertainty or disagreement on methods applied or interpretation of results		
Communications and knowledge translation	The spokespersons and dissemination process should be agreed early on.		
Recommendations for long term action and research	The Rapid Review process should be agreed as a milestone in a longer-term process from 2020 until 2025-2030		
Recommendations for early action and urgent interventions	The Rapid Review process should be agreed to be to provide public health advice on the most urgent intervention and programmes, to highlight successful case studies, and to widen participation by vulnerable populations.		
Further local research needed – schools of PH	Each school of public health is an asset that could assist in local and regional activities to investigate. All available public health expertise and capacity should be invited to contribute initially to the Rapid Review and to identify how they may further contribute in the periods after that.		
In-country Case Studies signposted	Each Rapid Review should offer an opportunity to highlight local or national initiatives that have been successful in counteracting vulnerabilities, or where lack of success offers key lessons learned.		

Appendix 2. Lists of vulnerable populations and settings to be considered in any country-level review of pandemic impacts. *(minimum considerations as some countries may have additional vulnerable or excluded groups)*

<u>Vulnerable adults with prior conditions</u>

- ***People with long term conditions and chronic diseases such as COPD, diabetes and circulatory disorders***
- ***People with disabilities***
- ***Older and frail people***

<u>Excluded groups</u>

- ***Black and Ethnic minority communities***
- ***Migrant people***
- ***Asylum seeking and refugee people***
- ***Homeless or housing exclusion (including new homeless)***
- ***Gypsies, Roma and Travellers***
- ***Rural isolation***

<u>Workplace and occupational vulnerability</u>

- ***Health and social and care workers***
- ***People in other high-risk occupations***
- ***People in Sex work***
- ***Unemployed People including those who have lost employment or source of income as a result of the pandemic***

Unemployed people including those who have lost employment or their source of income because of the pandemic
Deprived communities and those communities who suffer additional economic disadvantage from the pandemic.

People with Mental illness, particularly those affected deeply by social distancing or loss of care during the pandemic

People who use Drugs/substances

Gender differences

Modern slavery victims

All other people affected by exclusion or stigmatising conditions

<u>Children and families</u>

Those affected by domestic violence issues

Children with underlying severe health problems

Young Carers

Vulnerable settings

People living in known deprived areas or communities or newly arising ones

Cared for the elderly (including those in care homes and supported in their own homes)

Cared for younger adults

Cared for children and adolescents

Prisons and offender accommodation

Long term healthcare facilities, including some mental health facilities

Immigrant and asylum seeker formal and informal facilities (including detention centres)

Migrant worker or seasonal worker group accommodation

Homeless shelters and emergency centres

International student group accommodation

Modern slavery households with captive victims

Cuckoo' residences in illicit drug distribution networks (UK County Lines)

Military encampments

Other at-risk group accommodation

Reference list:

1. Inter-Agency Standing Committee (IASC). COVID-19: *How to include marginalized and vulnerable people in risk communication and community engagement.* WHO 2020 https://interagencystandingcommittee.org
2. Public Health England. *COVID-19: review of disparities in risks and outcomes*. 2020, PHE. https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes
3. Douglas M, Katikireddi SV, Taulbut M, McKee M, McCartney G. *Mitigating the Wider Health Effects of covid-19 Pandemic Response.* BMJ 2020;369:m1557 doi: https://doi.org/10.1136/bmj.m1557
4. European Centre for Disease Prevention and Control. Risk Assessment on COVID-19, on 23rd April 2020. https://www.ecdc.europa.eu/en/current-risk-assessment-novel-coronavirus-situation
5. British Society of Rehabilitation Medicine. *Rehabilitation in the wake of Covid-19 - A phoenix from the ashes.* BSRM 2020
6. Boddington NL, Charlett A, Elgohari S, Walker JL, McDonald HI, Byers C, et al. *COVID-19 in Great Britain: epidemiological and clinical characteristics of the first few hundred (FF100) cases: a descriptive case series and case control analysis.* 2020. WHO. *https://www.who.int/bulletin/online_first/20-265603.pdf*
7. World Health Organization Collaborating Centre on Investment for Health and Wellbeing Public Health Wales. *How are we doing in Wales? (How deprivation, age and gender make a difference to the impacts of Coronavirus)* Public Health Wales 2020. https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/how-are-you-doing/weekly-hayd-reports/how-are-we-doing-by-demographics-report/
8. World Health Organization Collaborating Centre on Investment for Health and Wellbeing Public Health Wales. *How are we doing in Wales? (Focus on Ethnicity)* Public Health Wales 2020. https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/staying-well-at-home/weekly-hayd-reports/how-are-we-doing-in-wales-a-focus-on-ethnicity/
9. A statement from the Academy of Medical Royal Colleges (7th April UK). *Patients and the public must continue to seek medical help for serious conditions during this COVID-19 pandemic.* https://www.aomrc.org.uk/wp-content/uploads/2020/04/200407_patient_public_seek_medical_help_statement.pdf
10. Triggle N. Coronavirus: *What is the hidden health cost? (ref Parallel epidemic)* BBC News 29th April 2020. https://www.bbc.co.uk/news/health-52461034
11. Sinha I, Bennett D, Taylor-Robinson DC. *Children are being sidelined by covid-19 -They must not be left behind in its aftermath.* BMJ 2020; 369:m2061 doi: https://doi.org/10.1136/bmj.m2061
12. Public Health Wales. *Adverse Childhood Experiences in child refugee and asylum seeking populations.* PHW 2020.
13. Yao H, Chen JH, Xu YF. *Patients with mental health disorders in the COVID-19 epidemic*. Lancet 2020:7(4);e21 doi: https://doi.org/10.1016/S2215-0366(20)30090-0
14. Fiorillo A, Gorwood P. The consequences of the COVID-19 pandemic on mental health and implications for clinical practice. European Psychiatry 2020;63(1):e32,1-2 DOI: https://doi.org/10.1192/j.eurpsy.2020.35
15. Editorial. Syndemics - Health in context. Lancet 2017;389:881

16. Wakeman SE, Green TC, Rich JD. From Documenting Death to Comprehensive Care: Applying Lessons from the HIV/AIDS Epidemic to Addiction ('Parallel Epidemics with a need for parallel responses') Am J Med. 2014; 127(6): 465–466. doi: https://doi.org/10.1016/j.amjmed.2013.12.018
17. Whitehead M, Barr B, Taylor-Robinson D. Covid-19. *We are not "all in it together"- less privileged in society are suffering the brunt of the damage*. May 22, 2020. BMJ Opinion https://blogs.bmj.com/bmj/2020/05/22/covid-19-we-are-not-all-in-it-together-less-privileged-in-society-are-suffering-the-brunt-of-the-damage/
18. European Public Health Alliance (and partners). *Joint Statement - Vulnerable Groups should be protected during the COVID-19 Pandemic, 14th April 2020*. EPHA. https://epha.org/joint-statement-vulnerable-groups-should-be-protected-during-the-covid-19-pandemic/
19. World Health Organisation. *Health in All Policies (HiAP): Framework for Country Action*. WHO 2014. https://www.who.int/healthpromotion/frameworkforcountryaction/en/
20. Paakkari L, Okan O. COVID-19: *Health literacy is an underestimated problem*. Lancet 2020:5;e249-50 doi: https://doi.org/10.1016/S2468-2667(20)30086-4
21. WHO (ER), EC, EOHSP. *COVID-19 Health Systems Response Monitor: Cross- Country Analysis 21st May 2020. How are countries supporting the mental health and wellbeing of their health workforce?* https://analysis.covid19healthsystem.org/index.php/2020/05/21/how-are-countries-supporting-the-mental-health-and-wellbeing-of-their-health-workforce/
22. European Public Health Alliance. *New network aims to tackle Roma health inequalities highlighted by COVID-19. 4th June 2020*. EPHA. https://epha.org/new-network-aims-to-tackle-roma-health-inequalities-highlighted-by-covid-19/
23. Faculty of Public Health (UK). *Good Public Health Practice framework - Short Guide*. FPH London 2016. https://www.fph.org.uk/media/1305/short-guide_good-public-health-practice_april-2016.pdf
24. WHO Europe, ASPHER *WHO-ASPHER Competency Framework for the Public Health Workforce in the European Region (2020).*http://www.euro.who.int/en/health-topics/Health-systems/public-health-services/publications/2020/who-aspher-competency-framework-for-the-public-health-workforce-in-the-european-region-2020