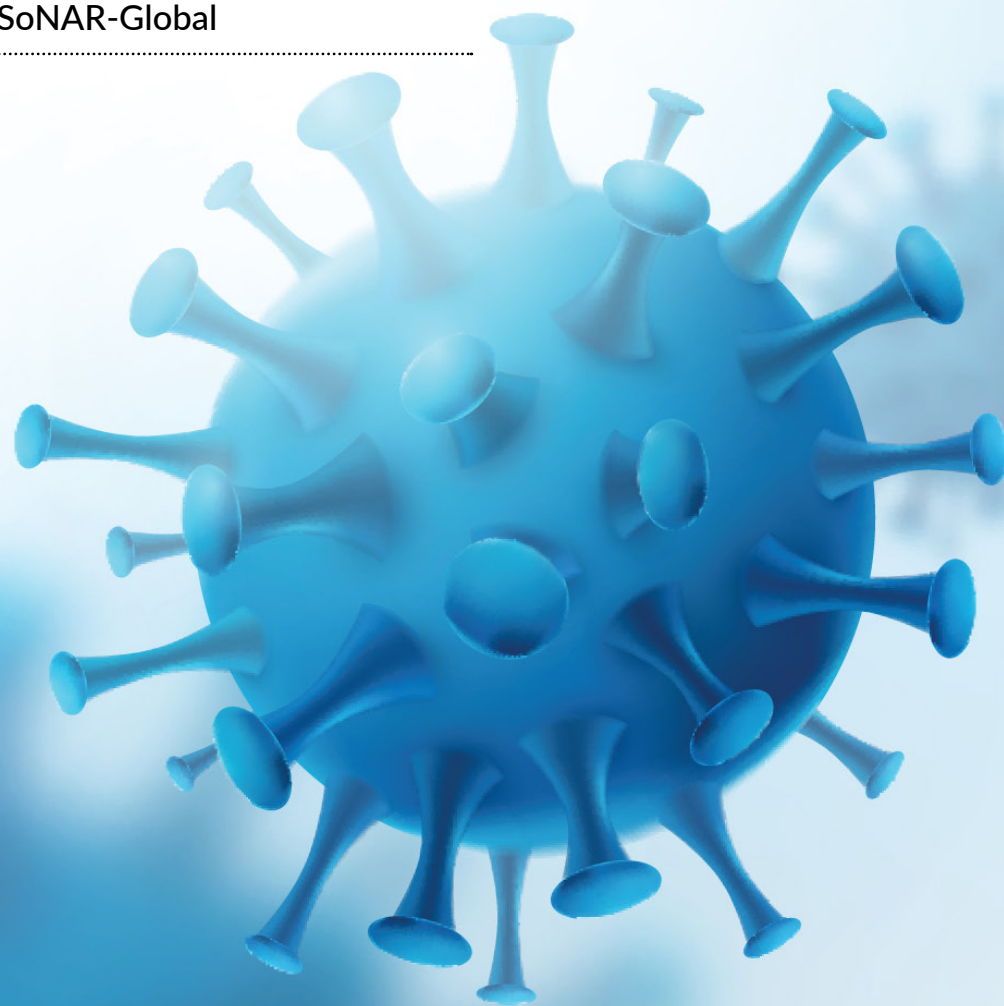


Evaluating and acting on health and social vulnerabilities during the COVID-19 pandemic

Tamara Giles-Vernick and Benedetta Lana
Institut Pasteur, SoNAR-Global



SoNAR-Global, a global consortium led by social scientists specialising in emerging infectious diseases (EID) and antimicrobial resistance (AMR), has actively contributed to the COVID-19 pandemic response in multiple countries. Created in 2019 and funded by the European Commission, SoNAR-Global is comprised of 15 partner institutions located in Europe (France, the Netherlands, Italy, Germany, Austria, Slovenia and Malta) and eastern Europe (Ukraine), as well as in Africa (Senegal and Uganda), South Asia (Bangladesh), Southeast Asia (Thailand), and the United Kingdom.

Over the course of 2021 and 2022, the SoNAR-Global project implemented the COVID-19 vulnerability assessments (C-VA) in six countries to identify and describe new and existing health and social vulnerabilities resulting from the COVID-19 pandemic (Napier, 2020). This tool, adapted from one developed by our partners David Napier and Anna Volkmann at University College London, had already been piloted and applied in

other multi-site contexts (Napier *et al.*, 2017), for instance, for diabetes (see: www.citieschangingdiabetes.com).

Findings of the six C-VA investigations were shared with key stakeholders and actors in country sites, translated into concrete policy recommendations, and in some cases, into new policies designed to promote resilience among those groups most affected by the pandemic.

An earlier version of this vulnerability assessment was piloted at the very beginning of the pandemic in Uganda (Kaawa-Mafigiri *et al.*, 2022). Still, the tool was subsequently adapted and implemented as a standardised C-VA tool in Germany, France, Italy, Malta, Slovenia and Bangladesh.¹ Specifically, shared objectives across these countries identify local factors that reduced or augmented health vulnerabilities; develop local case definitions (or local profiles) of vulnerability and resilience; provide policy recommendations based on local insights; and suggest locally

meaningful actions and interventions (if applicable, via stakeholder/ community involvement).

The C-VA protocol encompasses a demographic data questionnaire, a semi-structured interview guide covering aspects of health, wellbeing and risk relating to COVID-19, and a field summary template to summarise the assessment and include some ethnographic observations. The country teams translated C-VA materials into local languages and dialects relevant to local participant populations,² and assessments were then carried out. All teams conducted thematic analyses following interview transcription and reported their findings to the European Commission (see: <https://www.sonar-global.eu/vulnerability-assessment/va-reports>).

The demographic profiles of participants included in each country site are included in Table 1.

Table 1 Overview of key demographic data

	Total Number Participants	Gender			Age Range	Region	
		Female	Male	Non-binary		Urban	Rural
Bangladesh	60	24	36	-	18 - >65	47 (Dhaka)	13 (Faridpur and Narayanganj)
France	156	92	60	4	21 - 95	112 (Paris)	44 (Communauté d'agglomération Territoires Vendomais)
Germany	83	45	36	2	19 - 86	54 (Munich)	29 (Surrounding Area)
Italy	190	99	87	4	18 - 91	101 (Rome)	89 (Province of Lazio)
Malta	110	59	50	1	20 - 89	Not applicable	
Slovenia	214	131	81	2	18 - 91	109 (Ljubljana)	105 (Murska Sobota)
	813	Total Number of Participants					

1 Institutional partners in these countries were the Ludwig Maximilian University of Munich, Institut Pasteur, CENSIS, University of Malta, University of Ljubljana, and James P. Grant School of Public Health at BRAC University, respectively.

2 Bangla, English, French, German, I Adobe stock © zaie talian, Maltese, Persian, Slovenian, Spanish, Turkish, Wolof, various local dialects.

We assumed from the beginning that some vulnerabilities would be firmly anchored in country-specific, local contexts, whereas others would be cross-cutting and more universally expressed and experienced. Global, cross-cutting findings are summarised here, although each country team has developed more specific contextual analyses.

Unsurprisingly, the studies confirmed that pre-existing vulnerabilities (e.g. vulnerabilities linked to poverty, chronic illness, social isolation, and so on) were exacerbated in the pandemic across all research sites. Poor nutrition, poor living conditions and inaccessibility of formal health care—for those with COVID-19 as well as for other illnesses—were particularly problematic in Bangladesh during the pandemic. Bangladeshi participants avoided crowded formal health facilities, preferring local care providers and home treatments. European participants, particularly those with chronic illnesses, also encountered serious problems obtaining formal care; access to and affordability of care posed challenges for certain populations. These difficulties frequently resulted from pandemic control measures (mobility restrictions, closures) and very high demand for certain services such as mental health care, though in some cases, they were a consequence of individuals contracting COVID-19 and being both unwell and socially isolated. Loss of income and financial instability due to pandemic mitigation measures

affected many participants in all the study sites, though experiences were very diverse within countries. Those who had been living through financial hardship before the pandemic were largely pushed into even worse circumstances. Yet many participants across sites who belonged to the 'new poor', having previously not faced this level of threat to their livelihoods. In Bangladesh, salary reductions, job losses and lack of assistance pushed lower-middle income groups into deep financial insecurity.

Data across our European sites confirm that young and older people were more adversely affected by pandemic restrictions and by fears of contracting the virus—especially those living alone—than those in middle age. Students³ especially experienced serious social isolation, often losing a sense of purpose in their studies. There are likely to be significant, lasting effects on this cohort, which could, in turn, also generate further health and economic vulnerabilities.

The stigmatisation of certain groups took on new forms during the pandemic, according to study participants across the board. In European countries, participants described COVID-related stigmatisation and discrimination (e.g. for having contracted the disease or caring for those who were ill, being legally labelled as vulnerable, or, in some circles, being pro- or anti-vaccine, respectively). In addition, there was notable and increased violence

against traditionally marginalised groups, especially during acute phases of the pandemic.

Community engagement (Osborne *et al.*, 2021a and 2021b) and translation of research findings into policy recommendations and changes were framed by our partners at NIVEL; these actions played out differently in different sites. Many teams held dialogues with key stakeholders in pandemic response or, as in the case of the French team, created an advisory committee of diverse local stakeholders to take up C-VA findings as they came to light during the tool implementation. In all country sites, however, C-VA findings have resulted in new kinds of dialogues between institutional, associational and research actors and in concrete contributions to policies.

The Bangladesh team, for instance, engaged in multiple stakeholder dialogues and focus group discussions with wide-ranging participants, from day labourers, sex workers and garment workers to religious leaders and schoolteachers. The team presented their C-VA findings, and these dialogues resulted in multiple concrete recommendations. Such recommendations included using social media and local tea stalls, mobilising informal health workers and improving health communications and education.

The Italy team held dialogues with diverse national stakeholders involved in pandemic response to present C-VA findings. The team has worked with these stakeholders to develop several new policies, including those promoting telemedicine, investment in mental health prevention, initiatives for promoting healthy lifestyles at work and school, the study and monitoring of health determinants at municipal levels and redressing the digital divide throughout the country.

The C-VA research-action tool demonstrates the value of integrating

social sciences into a pandemic response. It produced useful evidence and insight into the dynamics of health and social vulnerabilities and facilitated dialogues with actors on the ground to develop new measures to enhance resilience. Through the new European Commission-created ISIDORE research infrastructure, the SoNAR-Global consortium can provide users with training, protocol development and implementation of such tools for preparedness and response to the COVID-19 and other epidemics.

References

- Kaawa-Mafigiri, D., Kato, F., Kyamulabi, A., Giles-Vernick, T., Kutalek, R., Napier, D. and Walakira, E.J. (2022) *Communicative Health Promotion for Refugee Children in Uganda, Global Health Communication for Immigrants and Refugees: Cases, Theories, and Strategies*. New York: Routledge.
- Napier, A.D., Nolan, J.J., Bagger, M., Hesseldal, L. and Volkmann, A.M. (2017) 'Study protocol for the Cities Changing Diabetes programme: a global mixed-methods approach', *BMJ Open*, 7(11), e015240. doi: 10.1136/bmjopen-2016-015240.
- Napier, A.D. (2020) 'Rethinking vulnerability through Covid-19', *Anthropology Today*, 36(3), pp. 1–2. doi: 10.1111/1467-8322.12571.
- Osborne, J., Paget, J., Napier, D., Giles-Vernick, T., Kutalek, R., Rodyna, R., Ahmed, S.M. and Dückers, M. (2021a) 'Addressing vulnerabilities in communities facing infectious disease threats: A need for social science-driven assessments', *Journal of Global Health*, 11, 03003. doi: 10.7189/jogh.11.03003.
- Osborne, J., Paget, J., Giles-Vernick, T., Kutalek, R., Napier, D., Baliatsas, C. and Dückers, M. (2021b) 'Community engagement and vulnerability in infectious diseases: A systematic review and qualitative analysis of the literature', *Social Science & Medicine*, 284, 114246. doi: 10.1016/j.socscimed.2021.114246.

PROJECT SUMMARY

The rise of emerging infectious diseases (EIDs) and antimicrobial resistance (AMR) in the last 20 years has increased the need for improved prevention and response. The EU-funded SoNAR-Global project will establish a sustainable international social science network to attract the active participation of social sciences and advance complementarity and synergy in the governance of prevention and response to EIDs and AMR. The project is driven by social scientists specialising in EIDs and AMR and aims to become an integral part of emergency response. SoNAR-Global will develop an open-access platform, adapt, test and assess vulnerability assessment tools and engagement models, and create and assess curricula for training social scientists and non-social sciences actors interested in working with them.

PROJECT PARTNERS

SoNAR-Global is led by the Institut Pasteur in France. For a complete list of our project partners, please see: <https://www.sonar-global.eu/consortia-directory>

PROJECT LEAD PROFILE

Tamara Giles-Vernick currently conducts research at the interstices of medical anthropology and ethnohistory (historical research using anthropological tools), investigating infectious disease transmission and global health interventions in Africa. She leads multidisciplinary research examining the changing nature and contexts of human contact with great apes and monkeys in equatorial Africa and the health consequences of that contact. She also conducts anthropological research on hepatitis B and vaccination, the historical emergence of HIV in central Africa; malnutrition; infantile diarrhoea in the Central African Republic; historical epidemiology of malaria in West Africa; hepatitis C transmission in hospital and dental settings in Egypt; comparative history of pandemic influenza; a history of global health in Africa; and the history of epidemiological surveillance.

PROJECT CONTACTS

Tamara Giles-Vernick, Project Coordinator
Institut Pasteur, 25-28 rue du Docteur Roux,
75724 Paris Cedex 15

+33 1 40 61 32 42
tamara.giles-vernick@pasteur.fr
www.pasteur.fr/en

FUNDING

This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No. 825671.

