

What can the COVID-19 response tell us about public health interventions and inequalities? Three reflections from Newham

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2.5 years after the pandemic began, the darkest days of lockdown are in our ever-distant memory. The COVID-19 crisis has slid without joyous closure into the next crises of Ukraine and cost of living (with planetary health still struggling for planetary bandwidth).

Yet following a period of frenetic and all-consuming public health activity, surely there are vital lessons we need to take from the journey we've been on? No doubt the public inquiry when it reports one day will have plenty to say on pandemic readiness: from surveillance, to PPE, to global cooperation, vaccination and more.

As Director of Public Health of the London Borough of Newham in east London, it's clear to me though that there is important learning not just for future pandemics but for the chronic challenges of health inequalities that we try to address, day in, day out.

Three things stand out from our experience:

1. The vital importance of accessibility, relevance, trust (ART)

Why do some people take up health interventions and services while others don't? From testing to isolation to vaccination, the pandemic forced us to explore these questions with renewed focus.

In Newham we increasingly thought about ART: accessibility, relevance, trust as a reframing of the traditional [3Cs model](#) of vaccine hesitancy: convenience, complacency, confidence. We feel that this reframing provides a more relational understanding, as well as a broader and deeper

set of insights into the barriers people face.

Whereas the 3Cs frame implies a lack of rational decision making on the part of the people not doing the 'appropriate' or 'compliant' health-seeking behaviour, ACT provides a more nuanced understanding.

'Accessibility' rather than 'convenience' describes the experience of people who:

- are housebound, unable to access a clinic-based services
- have inflexible employment or caring requirements
- lack digital access, may not receive information or be able to make bookings online
- have limited English or cultural capital and struggle to navigate the system.

'Relevance' rather than 'complacency' describes the experience of people who face competing priorities where the importance of a particular intervention such as testing, isolating or vaccination is weighed up against other needs – such as concern over maintaining employment or losing wages.

'Trust' rather than 'confidence' describes what is required to accept certain messages, services and interventions. Most of us face asymmetry of expertise and information when we are offered health advice and medical intervention. While many of us have good reasons to trust this advice, the lived experiences of others may make them more fearful, influenced by damaging personal and/or collective histories and competing voices that they face championing alternative narratives. Low trust connects closely to stigma, being judged or perceiving that we will be negatively judged for an aspect of our self, our beliefs or behaviours.

These insights were central to our approach to ensuring take-up of COVID-19 measures. The more we've reflected since, the more we've come to think these questions are deeply relevant to all our services, and we intend to keep exploring them.

2. The community can mobilise very effectively

The pandemic showed how the state, with a willingness to trust the community and to take some risks, can achieve far more than acting on its own. Whether in our food security work, social welfare advice, testing or vaccination, the community came through in huge ways –

supported at times by a few sensible resources to catalyse mobilisation. This is true both in quantitative and qualitative terms. Undoubtedly the sheer scale of people reached far exceeded what we as a statutory system could have done on our own. Building capacity unlocked thousands of hours of volunteer time through community groups and faith organisations. But it also ensured that we reached many people we wouldn't have otherwise because the connections between them and statutory services are tenuous or non-existent.

This approach was also about listening. Our connections gave us an ear to the ground, hearing daily about the challenges residents were experiencing, enabling us to adapt and augment our response as we moved forward.

3. Getting serious on the wider determinants

While we have long had the wider determinants of health as core to our analysis and our macro vision, the pandemic made us go micro. Throughout the pandemic we saw how risk of infection and the worst outcomes were often linked to wider determinants. There were inequalities in who could work from home, travel by car, isolate at home, shop online, access health information, isolate from work when required, and navigate remote learning. Without trying to address these issues our communities remained exposed to ever more disproportionate risk.

Infection control in our community, therefore, meant trying to address issues like food security, labour rights, immigration advice, household overcrowding and digital access. If we are serious about tackling the wider determinants of health, these kinds of issues need to remain central to our approach.

Our long-term health challenges are immense. The direct and indirect impacts of the pandemic are now compounded by historically high inflation, which impacts the poorest the most. However, the pandemic gave us some tools and insights to reimagine how we tackle inequalities as a system: the NHS, councils, community and the full array of local partners, big and small.

In Newham, we have begun to work out what this might mean for us going forward and we want to join forces with others keen to go on this journey too.

Jason Strelitz ([@strelitz_jason](#)) is Director of Public Health for the London Borough of Newham.

<https://www.health.org.uk/news-and-comment/blogs/what-can-the-covid-19-response-tell-us-about-public-health-interventions>