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International Health

International Horizon Scanning and Learning to Inform Wales' COVID-19 Public Health Response and Recovery

Report 36, 16/12/2021

Canolfan Gydwethredol Sefydliad
Iechyd y Byd ar Fuddsoddi
ar gyfer Iechyd a Llesiant



World Health Organization
Collaborating Centre on Investment
for Health and Well-being

Overview


The International Horizon Scanning and Learning work stream was initiated as part of the COVID-19 public health response, to support response and recovery measures and planning in Wales.


The learning and intelligence is summarised in regular reports to inform decision-making. These may vary in focus and scope, depending on the evolving COVID-19 situation and public health/policy needs. The reports focus on COVID-19 international evidence, experience, measures, transition and recovery approaches. Evidence is provided to help understand and explore solutions for addressing the on-going and emerging health, well-being, social and economic impacts (potential harms and benefits) of COVID-19.

This work is aligned with and feeds into the Welsh Government Office for Science and into Public Health Wales Gold Command. It is part of a wider Public Health Wales' systematic approach to intelligence gathering to inform comprehensive, coherent, inclusive and evidence-informed policy action, which supports the Well-being of Future Generations (Wales) Act and the Prosperity for All national strategy towards a healthier, more equal, resilient, prosperous and globally responsible Wales.

Disclaimer: The reports provide high-level summary of emerging evidence from country experience and epidemiology; research papers (peer-reviewed/not); and key organisations' guidance/reports, including sources of information to allow further exploration. The reports do not provide detailed or in-depth data/evidence analysis. Due to the novelty of COVID-19 virus and the dynamic epidemiological situation, studies, data and evidence can be conflicting, inconclusive or out-of-date very quickly depending on country/other context.

In focus this week

 **The impact of COVID-19 on ethnic minority groups**

 **COVID-19 scientific advice to governments**

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At a glance: summary of international learning on COVID-19

“The COVID-19 pandemic has brought social and racial injustice and inequity to the forefront of public health. It has highlighted that health equity is still not a reality as COVID-19 has unequally affected many racial and ethnic minority groups...”
(Centers for Disease Control and Prevention)¹

The impact of COVID-19 on ethnic minority groups

- ✚ The COVID-19 pandemic has exacerbated existing inequalities both within and between countries.
- ✚ The structural inequalities in society that generate differential health outcomes need to be addressed for COVID-19 and beyond.
- ✚ Differences in vaccine uptake by ethnic group have been explored as part of the pandemic response but there is more to do to address these differences and increase uptake.
- ✚ Language as a barrier to access health services has long been identified as an issue: all public health messages must be accessible to the population.
- ✚ Access to online health services may increase health inequalities if not managed carefully.

More information is summarised on pp. 4-13

COVID-19 scientific advice to governments

From the survey we conducted we found:

- ✚ In all countries that responded COVID-19 responsibilities still lie with the government.
- ✚ All countries that responded had established scientific advisory groups to help governments make evidence based decisions.
- ✚ The frequency of meetings was the primary method of flexing the support needed with more or less frequent meetings depending on the stage of the pandemic.
- ✚ Only one country had disbanded the scientific advice to government. However, this may subsequently have been reinstated due to the rise in cases from the Omicron variant.

More information is summarised on pp. 14-16

¹ <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html>

The impact of COVID-19 on ethnic minority groups

Overview: Disparities in COVID-19 outcomes

International evidence suggests that there are **ethnic disparities in COVID-19 outcomes in levels of infections, hospitalisations and deaths, however data is still sparse and ethnic minorities are still underrepresented in research.**² People from ethnic minority groups appear to be of greater risk for severe (health) outcomes related to a COVID-19 infection.³ This has been explained by **inequalities in the social determinants of health** including general health status, education, economic stability, the wealth gap, access to quality healthcare and many other factors that **affect health risks and outcomes.**⁴ Figure 1 shows data from the United States of America (US) and the disproportionate risk of COVID-19 infection, hospitalisation and deaths by ethnicity.

Figure 1: Risk for COVID-19 infection, hospitalisation and death by ethnicity⁵

Rate ratios compared to White, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases ¹	1.6x	0.6x	1.0x	1.6x
Hospitalization ²	3.3x	0.8x	2.6x	2.5x
Death ³	2.2x	0.9x	1.9x	2.1x

- A systematic review⁶ evaluated ethnic disparities in severe acute infection rates and COVID-19 outcomes suggesting that **African-American/ Black and Hispanic populations experience higher rates of COVID-19 infection** compared with non-Hispanic White populations. The review also showed that **African-American/ Black populations have a higher risk for hospitalization and disproportionately account for COVID-19 deaths** due to SARS-CoV-2
- Similar conclusions were drawn from a systematic review and meta-analysis conducted to explore the relationship between ethnicity and clinical outcomes in COVID-19. **Individuals of Black and Asian ethnicity were identified as being at increased risk of COVID-19 infection when compared to White individuals;** this same report found that **Asians may be at higher risk of intensive therapy unit admission and death**⁷
- An observational cohort study conducted in England showed that some **minority ethnic populations have excess risks of testing positive for COVID-19 and of adverse COVID-19 outcomes** (this held true after accounting for differences in sociodemographic, clinical, and household characteristics)⁸

² [Targeting COVID-19 Vaccine Hesitancy in Minority Populations in the US: Implications for Herd Immunity - PubMed \(nih.gov\)](#)

³ [COVID-19 Racial and Ethnic Disparities \(cdc.gov\)](#)

⁴ [Risk of Severe Illness or Death from COVID-19 | CDC](#)

⁵ [Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity | CDC](#)

⁶ [Racial and Ethnic Disparities in COVID-19-Related Infections, Hospitalizations, and Deaths \(nih.gov\)](#)

⁷ [Ethnicity and clinical outcomes in COVID-19: A systematic review and meta-analysis \(nih.gov\)](#)

⁸ [Ethnic differences in SARS-CoV-2 infection and COVID-19-related hospitalisation, intensive care unit admission, and death in 17 million adults in England: an observational cohort study using the OpenSAFELY platform \(nih.gov\)](#)

COVID-19 vaccine uptake

Discrimination including racism shape social and economic factors that put people at increased risk of severe COVID-19 illness and **deter people from seeking or receiving timely testing, vaccination, and treatment** for health concerns, including COVID-19.⁹

A systematic review examined perceptions of vaccinations amongst older adults from minority ethnic backgrounds and revealed that **factors influencing vaccination uptake involve healthcare provider and system, patient-related, and governance-level factors.**¹⁰ **Differential uptake in vaccines** between population groups is likely **exacerbated by existing health inequalities.**¹¹ Therefore, an understanding of the causes of and ways to address the differential uptake are key areas of interest. Multiple factors have been identified that facilitate vaccination uptake (figure 2):¹²

Figure 2: Facilitators for vaccination uptake¹³

(i) Healthcare provider & healthcare systems related	Recommendation from a trusted healthcare professional (HCP)	Recommendation from a physician with a long-term relationship; efforts made to “persuade” vaccination uptake Physician displays empathy, patience; cultural competence e.g. assessing English literacy; providing sufficient information
	Vaccination reminders	Offers at clinic; reminders from physicians; pamphlets; media
	Knowledge of vaccinations and mechanism of action	Awareness vaccination prevents illness, can reduce severity and duration of illness; understanding of how vaccination supports immunity
		Knowledge vaccine can reduce severity and duration of illness
Understanding of how vaccination supports immunity Awareness of potential long-term benefits		
(ii) Patient-related	Supportive community	Encouragement from friends, family, social community, cultural leaders
	Fear of developing disease	Concerns about severe influenza illness; concerns about SARS
		Concern cost of disease treatment will outweigh vaccination cost
Recognition of age as risk-factor	Perception of age and own health status as vulnerable – requiring vaccine	
(iii) Policy and operational level	Vaccination setting	Varied preference of vaccination setting; range from traditional medical settings to community facilities; clear information about where to access vaccination

Language barriers were found to **impact the likelihood for both participation in vaccine trials and vaccine uptake**, with a subsequent lack of the former impacting the latter. In the UK, ethnic minority populations were found to be less likely to participate in vaccine trials, with language barriers and a feeling of lack of support if problems arose being partial reasoning:¹⁴

- In the UK and US, **lower levels of vaccine uptake by ethnic minority populations were partially attributed to language barriers, alongside compounding issues such as digital literacy,**¹⁵

A further study identified that:¹⁶

- Language barriers were found to negatively impact the convenience of getting vaccinated, reducing overall intention to vaccinate
- A lack of face-to-face appointments and **language barriers made it more difficult to build the trusting relationships required to improve vaccine uptake**

⁹ [COVID-19 Racial and Ethnic Disparities \(cdc.gov\)](https://www.cdc.gov)

¹⁰ [Vaccination uptake amongst older adults from minority ethnic backgrounds: A systematic review - PubMed \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov/)

¹¹ [Covid-19 vaccine hesitancy among ethnic minority groups](https://pubmed.ncbi.nlm.nih.gov/)

¹² [Vaccination uptake amongst older adults from minority ethnic backgrounds: A systematic review - PubMed \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov/)

¹³ [Vaccination uptake amongst older adults from minority ethnic backgrounds: A systematic review - PubMed \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov/)

¹⁴ [The views of ethnic minority and vulnerable communities towards participation in COVID-19 vaccine trials](https://pubmed.ncbi.nlm.nih.gov/)

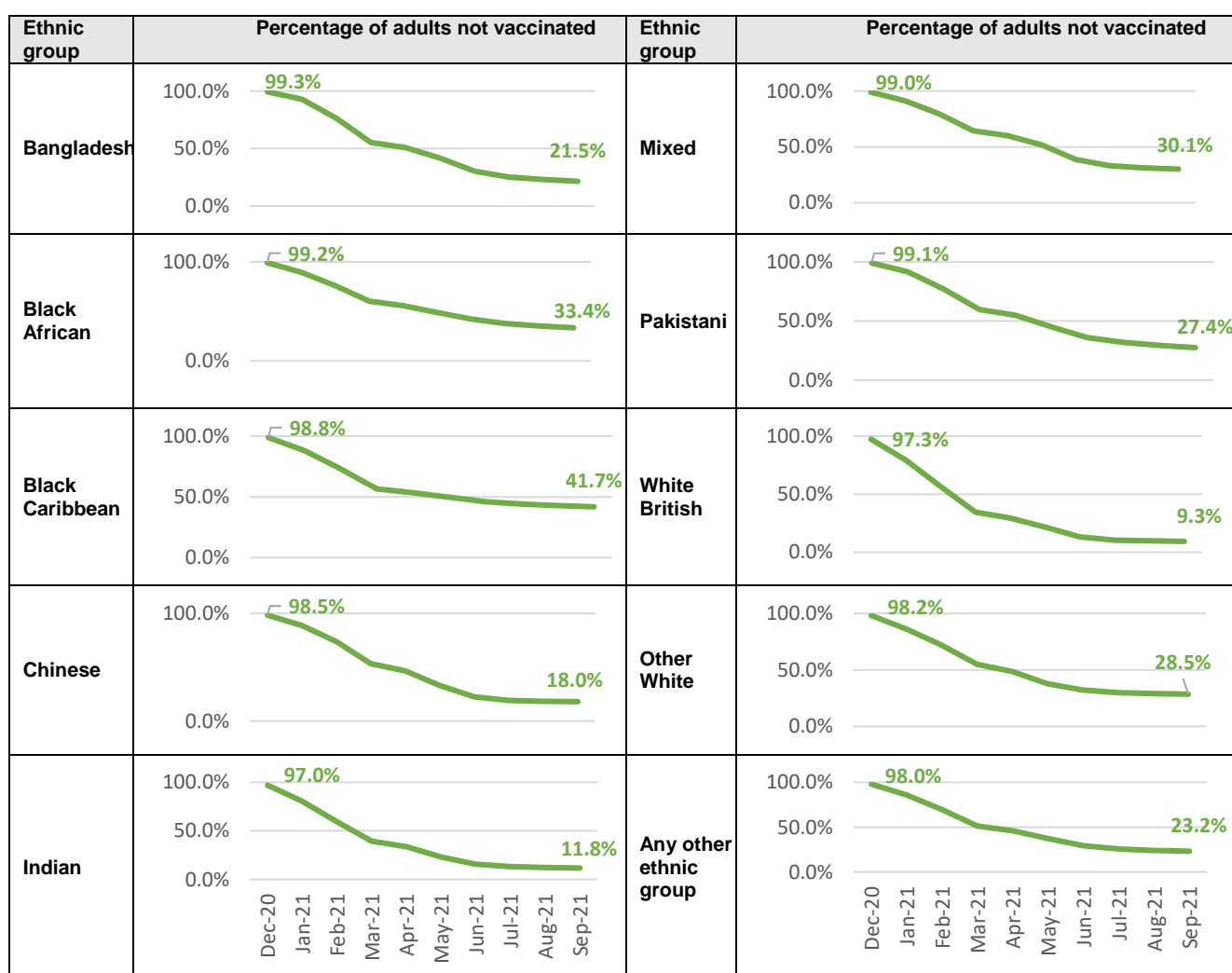
¹⁵ [What must be done to tackle vaccine hesitancy and barriers to COVID-19 vaccination in migrants?](https://pubmed.ncbi.nlm.nih.gov/)

¹⁶ [Changing the Narrative: Structural Barriers and Racial and Ethnic Inequities in COVID-19 Vaccination](https://pubmed.ncbi.nlm.nih.gov/)

Various evidence sources suggest that trusted members of the community, **religious leaders can play a vital role in promoting vaccine uptake amongst their followers** and thus help to combat vaccine hesitancy.¹⁷¹⁸¹⁹ **It is therefore crucial to appreciate the role that religious leaders can play in assisting with public health messaging** and the need for there to be a harmony between science and religion in promoting vaccine uptake²⁰

Figure 3 shows COVID-19 vaccination uptake by ethnic group for England. It shows that for adults, the ethnic group that has the highest percentage of unvaccinated adults is **Black Caribbean** where **41.7% were not vaccinated by September 2021**.

Figure 3: Percentage of adults who have NOT been vaccinated, by ethnic group, in England, December 2020 – September 2021 [data extracted on 31/11/2021]²¹



Language

The COVID-19 pandemic brought about unprecedented change to the world and particularly to healthcare and its delivery. The changes necessitated by the introduction of Non-Pharmaceutical Interventions (particularly social distancing) have brought to the fore a range of issues relating to the access of public health and healthcare related information for both the

¹⁷ [Multisectoral Approach on COVID-19 vaccination: a proposed solution on vaccine hesitancy | Journal of Public Health | Oxford Academic \(oup.com\)](#)

¹⁸ [Pope Francis suggests people have moral obligation to take coronavirus vaccine | National Catholic Reporter \(ncronline.org\)](#)

¹⁹ [fdab128.pdf \(nih.gov\)](#)

²⁰ [fdab128.pdf \(nih.gov\)](#)

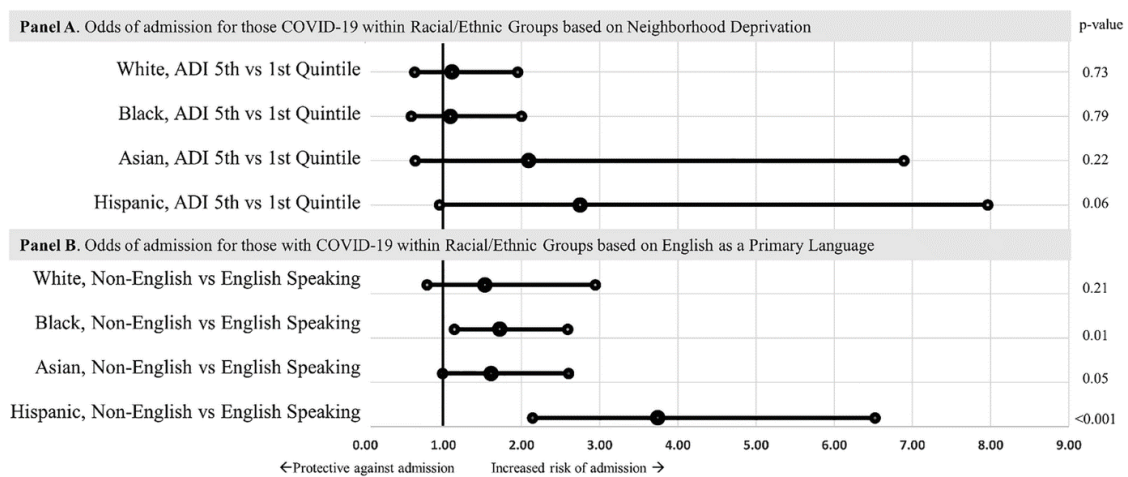
²¹ [CHIME - COVID-19 Health Inequalities \(phe.gov.uk\)](#)

patient (in the form of service delivery) and official bodies (in the form of collecting data and research participation).²²²³

Language barriers have been highlighted as a leading cause of inequalities in outcomes related to COVID-19 and are a known barrier to individuals accessing sufficient healthcare related information.²⁴ Studies from the US have highlighted:

- **English language proficiency is the most significant predictor of incidence and mortality** when measured at a county level²⁵
- **Non-English language is a stronger predictor for severe COVID-19 outcomes** than ethnicity²⁶
- The media remains a more convenient form of attaining COVID-19 related information in comparison to official sources such as the WHO or national public health organisations potentially leading to disparities due to language proficiency issues²⁷
- Language barriers present significant explanation for disparities observed within ethnic groups (figure 4)

Figure 4: Forest plots of multiple logistic regression models using each ethnicity as a baseline to compare Area Deprivation Index and primary language stratified by ethnicity²⁸



One explanation offered by the authors of this study for the difference in odds of admission relates to the **accessibility of information relevant for self-protection** and to prevent the spread of COVID-19. Other studies have also highlighted this:

- Migrant population in **Denmark²⁹ and Japan³⁰** highlighted an inability to access sufficient healthcare and public health material related to COVID-19 in a known language
- In the **US and Canada**, recently resettled refugees were found to be more vulnerable to COVID-19 at the beginning of the pandemic partially due to an **inability to access public health information in a known language**, and other language barrier related issues³¹

²² <https://pubmed.ncbi.nlm.nih.gov/33093038/>

²³ <https://pubmed.ncbi.nlm.nih.gov/32991604/>

²⁴ [Health Literacy: A Prescription to End Confusion](#)

²⁵ [Association of Social and Demographic Factors With COVID-19 Incidence and Death Rates in the US](#)

²⁶ [A model of disparities: risk factors associated with COVID-19 infection](#)

²⁷ [Racial and Ethnic Disparities in Hospital Admissions from COVID-19: Determining the Impact of Neighborhood Deprivation and Primary Language](#)

²⁸ [Racial and Ethnic Disparities in Hospital Admissions from COVID-19: Determining the Impact of Neighborhood Deprivation and Primary Language](#)

²⁹ ["I Just Want Some Clear Answers": Challenges and Tactics Adopted by Migrants in Denmark When Accessing Health Risk Information about COVID-19](#)

³⁰ [COVID-19: challenges faced by Nepalese migrants living in Japan](#)

³¹ [Potential Impact of COVID-19 on Recently Resettled Refugee Populations in the United States and Canada: Perspectives of Refugee Healthcare Providers](#)

- Another potential explanation relates to the likelihood of ethnic minority populations to seek testing for COVID-19. For example, studies in both the **US³²** and **Canada³³** both found that **non-English speakers were less likely to be tested for COVID-19** than English speakers

Finally, the **social conditions that drive some COVID-19 comorbidities** (specifically diabetes and hypertension) **include language barriers**,³⁴ for example:

- **Individuals with limited English proficiency have been found to be more vulnerable to social isolation**,³⁵ with isolation and lack of stimulation leading to poorer patient outcomes^{36,37}
- In particular, elderly Asian-Americans have been highlighted as especially vulnerable to mental health issues due to COVID-19 related isolation with **peer-to-peer support being presented as a potential way of addressing these problems**³⁸

Telehealth

Changes such as the delivering of healthcare services via electronic methods (telehealth/telemedicine) have brought about significant opportunities for health services globally. However, the delivery of such services has not been without difficulties. While the uptake of telehealth was well received for certain populations, **it also exacerbated existing health inequalities between populations due to access issues** (including language barriers).³⁹

- The rescheduling of appointments due to a combination of language barrier and equipment, proved a resource intensive problem for geriatric services in **Australia⁴⁰**
- Evidence from the **UK** found that telehealth amplified health inequalities experienced by migrant populations largely due to **digital literacy issues**, which were further compounded by language barriers⁴¹
- In the **US**, the move to increased telehealth was found to cause access issues for Latin American populations – particularly those with limited English proficiency⁴²
- A global study found that a **mixture of digital literacy issues and language barriers were a widespread problem found when implementing telehealth services**⁴³

Even for those organisations who were able to manage the switch to (or increase use of) telehealth relatively well, organisations still found language barriers created a problem which was resource intensive to fix –this is expected to remain an issue to address beyond the pandemic.⁴⁴

Throughout the course of the COVID-19 pandemic, **language barriers have presented an issue which has impacted a number of interlinked issues**, resulting in worse health outcomes for those individuals unable to communicate sufficiently in official languages. Language barriers have impacted the following areas in particular:

- Inability to communicate in official languages linked with **worse health outcomes**

³² [Assessment of Disparities in COVID-19 Testing and Infection Across Language Groups in Seattle, Washington](#)

³³ [COVID-19 in Immigrants, Refugees and Other Newcomers in Ontario: Characteristics of Those Tested and Those Confirmed Positive, as of June 13, 2020](#)

³⁴ [Disaggregating Asian Race Reveals COVID-19 Disparities among Asian Americans at New York City's Public Hospital System](#)

³⁵ [Stories from COVID-19 Reveal Hospitalized Patients with Limited English Proficiency Have Always Been Uniquely Prone to Social Isolation](#)

³⁶ [COVID-19: ICU delirium management during SARS-CoV-2 pandemic](#)

³⁷ [Environmental Risk Factors for Delirium in Hospitalized Older People](#)

³⁸ [Asian American mental health during COVID-19: A call for task-sharing interventions](#)

³⁹ [Telehealth for Home Dialysis in COVID-19 and Beyond: A Perspective From the American Society of Nephrology COVID-19 Home Dialysis Subcommittee](#)

⁴⁰ [Rapid implementation of telehealth in geriatric outpatient clinics due to COVID-19](#)

⁴¹ [Impact of COVID-19 on migrants' access to primary care and implications for vaccine roll-out: a national qualitative study](#)

⁴² [Lessons We've Learned — Covid-19 and the Undocumented Latinx Community](#)

⁴³ [A double-edged sword—telemedicine for maternal care during COVID-19: findings from a global mixed-methods study of healthcare providers](#)

⁴⁴ [Equal Access to Telemedicine during COVID-19 Pandemic: A Pediatric Otolaryngology Perspective](#)

- **Lower likelihood to participate in both vaccine research and intention to vaccinate** highlighted in individuals unable to communicate sufficiently in official languages
- Inability to communicate in official languages linked with **difficulties in accessing telehealth, in turn exacerbating existing health inequalities**

Religion⁴⁵

There have been multiple reports claiming that religious gatherings have been responsible for COVID-19 outbreaks. Religious traditions such as handshaking, embracing and passing offering plates may increase the risk of being in close proximity with others.⁴⁶

- In the **Netherlands** rates of hospitalisation due to COVID-19 were found to be higher in a highly religious areas of the country, and were strongly related to church attendance⁴⁷
- The Delhi conference for Sunni Muslim movement Tablighi Jamaat in **India** was labelled as a 'COVID super spreader event' as hundreds from across the globe met in early March 2020 leading to a surge in COVID infections⁴⁸
- In March 2020 in **France**, clusters of COVID-19 infections were associated with celebration in the Jewish community in Marseille⁴⁹

Religious services

During the pandemic **global organisations such as the World Health Organization (WHO) and the US Centres for Disease Control and the European Centre for Disease Prevention and Control have released guidance for religious leaders to promote safe practice.**^{50,51} Such guidance ranges from the introduction of sanitising stations, increased ventilation in places of worship, limiting in person gatherings and cancelling in person worship all together. Individual religious organisations have also released their own guidance. Figure 5 illustrates recent guidance provided by the Muslim Council of Britain for restrictions regarding the new Omicron variant. Some commentators believe that **online worship may be here to stay.**⁵²

⁴⁵ **The information presented within this section may not be representative of all belief systems due to denominational differences across religious traditions.**

⁴⁶ [When infection prevention enters the temple: Intergenerational social distancing and COVID-19 | Infection Control & Hospital Epidemiology | Cambridge Core](#)

⁴⁷ [Religions | Free Full-Text | Religion and the Transmission of COVID-19 in The Netherlands | HTML \(mdpi.com\)](#)

⁴⁸ [Tablighi Jamaat: The group blamed for new Covid-19 outbreak in India - BBC News](#)

⁴⁹ [main.pdf \(nih.gov\)](#)

⁵⁰ [Practical considerations and recommendations for religious leaders and faith-based communities in the context of COVID-19 \(who.int\)](#)

⁵¹ [Considerations for Communities of Faith | CDC](#)

⁵² [What does the rise of digital religion during Covid-19 tell us about religion's capacity to adapt? \(sagepub.com\)](#)

Figure 5: COVID-19 Omicron and winter guidance from the Muslim Council of Britain⁵³

Guidance issued: 30/11/2021

COVID-19 OMICRON & WINTER GUIDANCE MOSQUE CONTROL MEASURES

The Prophet (PBUH) said: There is no wisdom equal to good planning (Mishkat). We pray that this planning, along with the unity we have seen across our communities, will be rewarded by Allah SWT allowing us to emerge from this crisis stronger than ever.

COMMUNITY ADVICE


- Use of hand sanitizer/washing when entering Mosque
- Wearing a face covering when inside
- Avoid hugging and shaking hands
- Pray at home if you are from a vulnerable group (i.e. elderly or have underlying health condition)
- Use own prayer mat in Mosque
- Be mindful of others in Mosque; they may prefer to socially distance
- Do not go to Mosque if unwell, showing any Flu-like symptoms

MOSQUE MANAGEMENT ADVICE


- Maximise ventilation (e.g. open windows, open internal doors and HVAC)
- Schedule additional Jumah prayers, spreading out attendees over multiple Jamaats to reduce congestion
- Review to see if prayers can be held in larger halls (instead of smaller spaces)
- Manage capacity, reducing large numbers of people in any single space
- Frequent health and safety reminders for congregants (i.e. after prayers, Jumah and on social media)
- Have spare face masks and prayer mats available at entrance
- Continue enhanced cleaning of main touch points (e.g. door handles, hand rails and lift buttons)
- Provide disinfectant cleaning wipes for any shared equipment (e.g. microphones)
- Learn about the COVID-19 Omicron strain and keep congregants informed
- Highlight the benefits of being vaccinated to your communities

BEING PROACTIVE CAN REDUCE RISK


Management are advised to consider control measures previously in place, and review to see if there is a need to re-introduce them for the protection of the public and staff. Existing risk assessment should be updated to reflect adopted control measures. This list is not exhaustive and additional measures may be required. All MCB issued COVID-19 guidance and resources can be found on below webpage. For any queries, email BIMA on email listed below.




MCB
The Muslim Council of Britain



mcb.org.uk/coronavirus



covid@britishima.org



BRITISH ISLAMIC
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*Always refer to latest government advice where available

Religious rituals

As well as changing the way worship was conducted, COVID-19 restrictions have had an impact upon religious rituals across the globe:

- In **Poland**, Catholic churches suggested that the congregation should receive Holy Communion on the hand in order to reduce the risk of spreading COVID-19.⁵⁴
- In **New Zealand** communion practices amongst Catholics changed with congregation members drinking from alternate sides of the communion chalice.⁵⁵

⁵³ [Latest COVID19 Advice for British Muslims - Muslim Council of Britain \(MCB\)](#)

⁵⁴ [Religions | Free Full-Text | Alterations in Religious Rituals Due to COVID-19 Could Be Related to Intragroup Negativity: A Case of Changes in Receiving Holy Communion in the Roman Catholic Community in Poland \(mdpi.com\)](#)

⁵⁵ [New Zealand Religious Community Responses to COVID-19 While Under Level 4 Lockdown \(uwtsd.ac.uk\)](#)

- The **Orthodox Jewish tradition** of public prayer must adhere to *Halacha*, Jewish law. This traditionally requires the presence of a *minyán*, a group of at least 10 adult male Jews. Due to social distancing restrictions, this was not possible during the pandemic.
- **Prayer is similarly regarded as a congregational activity within Islam.** Traditionally same-gender congregation members line up with shoulders touching to preform prayer in the mosque. This practice was not possible under strict COVID guidelines.⁵⁶
- In **India** the Buddhist ritual *Riwo Sangchö*, the Mountain Incense Smoke Offering, become increasingly popular throughout 2020. **Due to the closure of temples and limited internet access many turned to outdoor rituals.**⁵⁷

Religious **pilgrimages** also constitute a significant aspect of religious life, with many being disrupted due to the pandemic:

- The **Kingdom of Saudi Arabia** implemented restrictions regarding the annual Islamic hajj pilgrimage. During usual rituals there can be up to 8 people per square meter making social distancing unattainable. The decision was therefore made to close the Grand Mosque and the Kaaba on March 6, 2020, for over 2 months. In 2020, the hajj took place between 28th July -2nd August, during which time there was a **ban of international visitors and access for the domestic population was denied to those at higher risk of COVID-19**, for example people with chronic diseases or aged 65 years and older⁵⁸
- Similarly, many **Catholic pilgrimage sites across Europe** experienced periods of closure during the first 6 months of the pandemic, and **tourism and pilgrimage movement were reported to have decreased by 90–95% during this time**⁵⁹

Death and burial rites

The pandemic also caused disruptions to traditional death and burial rites, which constitute a significant aspect of religious life. As religious buildings closed **in many cases death care was relocated from religious faith communities into civic and commercial settings.**⁶⁰

- The time-period allowed to hold wakes was significantly shortened and the **number of attendees was limited in accordance with social distancing guidelines**⁶¹
- The traditional ‘open-door’ policies surrounding death and grieving amongst the Muslim community were not possible under social distancing guidelines, creating **disruptions to the communal aspect of grieving.**
- Families were **unable to assist with the typical preparation of bodies** including dressing and washing. British case studies noted funeral directors’ use of zoom to enable relatives to participate in preparations⁶²
- In **Sri-Lanka**, authorities initially enforced the cremation of bodies irrespective of religious belief, presenting a significant problem for those with views against the practice of cremation. This was later changed in accordance with scientific evidence⁶³. **Discussions surrounding this led to conversations calling for a balance between scientific and spiritual needs. The WHO have since published evidence on the safe burial of bodies in the context of COVID-19**⁶⁴

⁵⁶ [How coronavirus challenges Muslims' faith and changes their lives \(theconversation.com\)](#)

⁵⁷ [View of Cleansing the Sacred Habitat in the Time of Coronavirus: Buddhist Sangha Rituals in Sikkim in Response to the 2020 Covid-19 Pandemic \(uni-muenchen.de\)](#)

⁵⁸ [Hajj and Umrah Mass Gatherings and COVID-19 Infection | SpringerLink](#)

⁵⁹ [The Impact of COVID-19 on Pilgrimages and Religious Tourism in Europe During the First Six Months of the Pandemic | SpringerLink](#)

⁶⁰ [British Ritual Innovation under COVID 19 \(adobe.com\)](#)

⁶¹ [Changing landscapes of death and burial practices: public health response in time of COVID-19 pandemic | Journal of Public Health | Oxford Academic \(oup.com\)](#)

⁶² [British Ritual Innovation under COVID 19 \(adobe.com\)](#)

⁶³ [Role of Religious Leaders in COVID-19 Prevention: A Community-Level Prevention Model in Sri Lanka \(springer.com\)](#)

⁶⁴ [WHO-COVID-19-IPC_DBMgmt-2020.1-eng.pdf;sequence=1](#)

Religious holidays

In addition to changes to regular worship, restrictions also impacted upon religious holidays and celebrations:

- In 2020, the Vatican office released recommendations on how to safely celebrate the **Easter** holidays in accordance with COVID-19 restrictions, which asked Catholics to **celebrate with the Pope ‘spiritually’ through the radio, TV and internet**⁶⁵
- During the holy month of Ramadan Muslims of good health are required to fast, however it was stated that during the COVID-19 pandemic health practitioners who were too weak or busy with patient care to take the predawn meal may break the fast if needed. **Muslims were advised to arrange ‘virtual Iftars’ rather than meeting together with family and friends to break fast**⁶⁶
- In Nepal restrictions on public gatherings within the country impacted upon many religious holidays and festivals, notably celebrations of the Dalai Lama’s birthday, and the Buddhist festival of Rato Machindranath, with the government recommending to celebrate days of religious significance in private⁶⁷

Religious responses during the COVID-19 pandemic

International evidence suggest that there have been various approaches within religious communities to address the challenges faced by COVID-19 (table 1).

Table 1: International religious responses to COVID-19

Country/ nation	International evidence
Bangladesh	In Bangladesh Imams used mosque megaphones to spread key coronavirus information to millions who did not have access to smartphones or TVs. ⁶⁸
Indonesia	A study focused upon Indonesian Muslims highlights the central role empathy, altruism and compassion play within the religion of Islam. These values increase public interest, especially within the context of COVID-19. ⁶⁹
Luxembourg	Baha’i faith communities in Luxembourg have been providing online ‘moral education’ classes, teaching children about being of service to one’s society and the importance of the selfless acts undertaken by those carrying out essential services during the pandemic. ⁷⁰
New Zealand	Porirua Hospital in Aotearoa New Zealand implemented ‘Spiritual Pastoral Therapists’ to provide spiritual care services to nurture well-being among patients and hospital staff during the pandemic. Examples of the care provided include the creation of local safe “bubbles,” maintaining chapel access, producing daily meditations for the employee newsletter, utilising social media and writing letters. ⁷¹
Norway	The Islamic Council of Norway produced and distributed information material about the coronavirus in the early phase of the pandemic, presenting public health messages and recommendations within a religious framing. ⁷²
Sri Lanka	The National Evangelical Christian Alliance for Sri Lanka sought to educate young people about responsible use of digital media and the identification of fake news during the pandemic. ⁷³
US	Detroit already had pre-pandemic church based health programs, such programs were able to continue running during the pandemic. Churches also provided food provisions and laptop loans to those most in need. ⁷⁴

⁶⁵ [Celebrating a unique Easter with Pope Francis during Covid-19 - Vatican News](#)

⁶⁶ [The coronavirus disease-2019 pandemic, social distancing, and observance of religious holidays: Perspectives from Catholicism, Islam, Judaism, and Hinduism \(nih.gov\)](#)

⁶⁷ [NEPAL 2020 INTERNATIONAL RELIGIOUS FREEDOM REPORT \(state.gov\)](#)

⁶⁸ [Religious leaders play key role in battle against COVID-19 | UNICEF South Asia](#)

⁶⁹ [IJIT-Vol-18-Dec-2020_1_1-12.pdf \(ukm.my\)](#)

⁷⁰ [Children in Luxembourg send love and encouragement to healthcare professionals | BWNS \(bahai.org\)](#)

⁷¹ [Spiritual Care Services Nurture Wellbeing in a Clinical Setting During COVID- 19: Aotearoa New Zealand | Finiki | Health and Social Care Chaplaincy \(uwtsd.ac.uk\)](#)

⁷² [Covid-19 and The Islamic Council of Norway: The Social Role of Religious Organizations | Diaconia \(vr-elibrary.de\)](#)

⁷³ [Impact of Covid19 and peace building report \(final\).pdf \(wvi.org\)](#)

⁷⁴ [Religion as a Health Promoter During the 2019/2020 COVID Outbreak: View from Detroit \(uwtsd.ac.uk\)](#)

Approaches to mitigate COVID-19 disparities associated to ethnicity

International evidence to address COVID-19 disparities based on ethnicity suggests:

- In order to address COVID-19 disparities societies need to **tackle ethnic inequalities which require cross-sector actions including reducing structural inequalities, addressing barriers to equitable care, and improving uptake of testing and vaccination**⁷⁵
- **Information targeting underserved ethnic minorities** is crucial for educating these communities about COVID-19 vaccines and their distribution⁷⁶

The US Centers for Disease Control and Prevention released its **COVID-19 Response Equity Strategy**,⁷⁷ which aims to support amongst others ethnic minority populations with the aim to:

- Reduce health disparities
- Use data-driven approaches
- Foster meaningful engagement with community institutions and diverse leaders
- Lead culturally responsive outreach
- Reduce stigma, including stigma associated with race and ethnicity

The strategy seeks to **improve the health outcomes of populations disproportionately affected** by focusing on four priorities:

1. **Expanding the evidence base** (e.g. collecting and reporting timely, complete, representative, and relevant data on testing, incidence, vaccination, and severe outcomes by detailed race and ethnicity categories taking into account age and sex differences between groups)
2. **Expanding programs and practices for testing, contact tracing, isolation, healthcare, and recovery from the impact of unintended negative consequences of mitigation strategies in order to reach populations that have been put at increased risk** (e.g. collecting and reporting timely, complete, representative, and relevant data on testing, incidence, vaccination, and severe outcomes by detailed race and ethnicity categories, taking into account age and sex differences between groups)
3. **Expanding program and practice activities to support essential and frontline workers to prevent transmission of COVID-19** (Examples of essential and frontline workers include healthcare, food industry, and correctional facility workers.)
4. **Expanding an inclusive workforce equipped to assess and address the needs of an increasingly diverse U.S. population** (e.g. build diverse responder workforce (for example, diverse racial, ethnic, and social backgrounds, multi-disciplinary, multi-lingual, and multi-generational)

⁷⁵ [Ethnic differences in SARS-CoV-2 infection and COVID-19-related hospitalisation, intensive care unit admission, and death in 17 million adults in England: an observational cohort study using the OpenSAFELY platform \(nih.gov\)](#)

⁷⁶ [Targeting COVID-19 Vaccine Hesitancy in Minority Populations in the US: Implications for Herd Immunity - PubMed \(nih.gov\)](#)

⁷⁷ [CDC COVID-19 Response Health Equity Strategy](#)

COVID-19 scientific advice to governments

Overview

The integration of scientific advice on how to address the COVID-19 pandemic has been a key feature of both government policy making and collaboration. Special scientific advisory groups were introduced around the world, as a means of providing contemporary and relevant information directly to policy makers in a timely manner.⁷⁸ When countries emerge from the acute phase of the COVID-19 pandemic, it will be important to understand how countries will manage the virus in the recovery phase.

A short questionnaire was sent to international stakeholders via professional networks, to gather information on how different countries propose to manage the integration of scientific advice into policy-making when they move into the recovery phase.

The questionnaire had the following objectives:

- to learn how different countries are managing COVID-19 responses and recovery
- to understand whether governments are still receiving scientific advice on COVID-19, or if this has been scaled back and/ or transferred to the relevant public health authorities/other bodies

Countries had four weeks to gather information and respond (over the months of October and November 2021). This work should be seen as an indication of countries situation in terms of COVID-19 scientific advice in October/November 2021 noting that since then the Omicron variant has spread rapidly.

In total, 10 responses were received from nine countries: Belgium, Burkina Faso, Canada, Germany (x2), Israel, Italy, the Netherlands, South Africa and Spain.

A summary of the key information is provided here:

Question 1: Were any scientific advisory group(s)/forums established to inform and advise Government on COVID-19 in your country/region?

- **Canada:** "Task Force's mandate is to catalyze, support, fund and harmonize knowledge on SARS-CoV-2 immunity for federal, provincial, and territorial decision-makers in their efforts to protect Canadians and minimize the impact of the COVID-19 pandemic"
- **The Netherlands:** "They discuss how to control the outbreak based on the latest information, their own professional expertise and available scientific literature. They also discuss the risks and uncertainties of measures"

Question 2: Are these scientific groups still advising Government on COVID-19 or have they been disbanded?

- In South Africa, scientific advisory groups advising government on COVID-19 have been disbanded and in Burkina Faso responsibilities have been transferred to the National Public Health Institute, in all other countries, established groups are still advising their respective government

Question 3: Has the structure or frequency of meetings of such groups changed as the pandemic moves towards the recovery phase?

- Most countries had reduced the frequency of meetings in October/November 2021

⁷⁸ [Following the science? Views from scientists on government advisory boards during the COVID-19 pandemic: a qualitative interview study in five European countries | BMJ Global Health](#)

- **Germany:** “The structure of these groups has been adjusted continually to the phases of the pandemic. Specific expertise has been included for specific issues and was released as issues became less relevant (e.g. ventilation and air-conditioning technology). Also the frequency of meetings has been adjusted – lower for less dynamic phases and higher in more dynamic phases as it is currently the case”
- **Italy:** “Initially only experts belonging to the health-scientific were included, then opened also to other sectors, such as statistics, mathematical-prediction or fields, to define the framework of the epidemiological situation and to carry out the analysis of the collected data necessary to prepare the measures to contrast the pandemic”

Question 4: Do COVID-19 responsibilities still lie with Government or have they been transferred to the public health institute/authority or another relevant body?

- **All countries that responded-** COVID-19 responsibilities still lie with Government.

A concise summary of all responses is provided in table 2.

Table 2: Summary of responses – COVID-19 advice to governments

Country	Were scientific advisory groups created to inform government?	If yes, are those groups still advising government?	Has the structure/frequency of meetings of changed as the pandemic enters the recovery phase?	Do COVID-19 responsibilities still lie with Government (instead of with public health body/authority?)
Belgium	Yes	Yes	No	Still with government
Burkina Faso	Yes	Yes	Yes – frequency reduced	Still with government
Canada	Yes	Yes	No	Still with government
Germany	Yes	Yes	Yes – frequency reduced, dynamic scheduling based on epidemiological situation	Still with government
Israel	Yes	Yes	Yes – frequency reduced	Still with government
Italy	Yes	Yes	Yes – to accommodate a broadening of expertise from health/scientific to other fields	Still with government
Netherlands	Yes	Yes	Yes – frequency reduced, dynamic scheduling based on epidemiological situation	Still with government
South Africa	Yes	No - disbanded	No	Still with government
Spain	Yes	Yes	Yes – structure of meetings has changed and reduced	Still with government

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