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EDITORIAL

COVID-19: Vulnerability and the power of privilege in a pandemic

On 11 March 2020, the World Health Organization announced that COVID-19 was characterised as a pandemic—a global first for coronavirus.[1] Coronaviruses are a large family of viruses that cause illness such as the common cold to more severe diseases such as Severe Acute Respiratory Syndrome.[2] A novel coronavirus is typically a new strain of the infectious disease that has not been previously identified in humans.[2] COVID-19 is the most recent version of a novel coronavirus.[2] COVID-19 has received significant public and government attention over the past weeks after it was first detected in the Wuhan province of China in December 2019, with subsequent epidemics in China, Italy, Republic of Korea and Iran.[1] As of 12 March 2020, 125 000 cases were reported from 118 countries and territories globally, with predictions this will continue to rise rapidly.[3] This has led to an array of public health measures being advocated by the WHO, including four critical areas for action—(a) prepare and be ready; (b) detect, protect and treat; (c) reduce transmission; and (d) innovate and learn.[3] This has been complemented, to varying degrees, through concurrent action by local, state and national governments worldwide.

There can be a tendency in the health promotion profession to think of infectious diseases from a biomedical viewpoint. As such, the prevention and treatment of infectious diseases is sometimes perceived to be the responsibility of the clinical realm. Yet, the reality is that both nonclinical and clinical public health responses are required—and sometimes we need to relax professional boundaries to work collaboratively for the health and wellbeing of our communities. We need to work in partnership with health surveillance teams, epidemiologists, environmental health scientists, public health physicians, infectious disease physicians, general practitioners, nurses, allied health professions, health policy-makers, health planners, health geographers and many others, to reduce the risks associated with pandemics. We also need to work across sectors to achieve the best possible outcomes.

The health promotion profession plays a vital role in pandemics, and this has been abundantly evident in the responses to COVID-19. Messaging about health and hygiene, particularly hand-washing, is one example of the role that health promotion has played—ultimately drawing on our expertise in delivering health education, and implementing health-related mass media and social marketing campaigns. Over the last two decades, information technology and social media have transformed the way we can reach people during pandemics. Indeed, social media has catapulted the ability to reach large populations, while also simultaneously targeting vulnerable and at-risk populations, to deliver health messages, such as those associated with hand-washing. Over the past few weeks, there has been a steady flow of memes urging people to wash their hands, often with thoughtful use of graphics alongside a successful use of humour. JS's personal favourite, was an online post from Round Rock Texas that read: 'Texas Coronavirus Protection—wash your hands like you just got done slicing jalapenos for a batch of nachos and you need to take your contacts out (that's like 20 seconds scrubbing, y'all)'. It delivers an essential public health message in a factual, yet contextually relevant and humorous way. However, social media can also have its pitfalls. Misinformation and fake news are rampant. This has the potential to stifle health promotion efforts in times of need, such as during the current COVID-19 pandemic. Therefore, it is important to know who is saying what, why, and with what level of authority.

As mentioned above, we also need to be mindful of cross-sectoral communication efforts during pandemics. As an example, JS received 12 emails from his children's schools and 14 from his current workplaces about COVID-19—a total of 26 emails from educational institutions in both Australia and the United States. Email topics ranged from: hygiene issues such as hand washing and sanitiser use; social distancing, self-isolation and self-quarantining strategies such as cancellation of school activities and fundraisers; proposed adoption of online learning options, and flexibility about attendance at school/work, including possible closures; travel restrictions imposed by schools and universities associated with concerts, plays, public events/seminars and conferences; guidance to limit travel on public transport; and advice about when to seek help and access local health services if myself or my family members experience symptoms associated with COVID-19. This bombardment of communication, albeit extremely useful, emphasises the importance of coordination in key messaging between health, education and various other sectors, when planning and implementing effective pandemic responses.

In health promotion, we need new strategies to communicate important health messages in a concise and meaningful way that makes it easy and accessible for citizens to understand, navigate and take action. We also need to be careful how we convey content through electronic communication channels and consider an appropriate level of frequency of such communication to achieve optimal impact. Without doing so, there is potential to reinforce community ambivalence at one end of the spectrum and create panic at the other. The recent toilet paper saga in Australia, whereby stocks of toilet paper were rapidly depleted from grocery stores in response

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to the perceived likelihood of home quarantining measures, is one such example (albeit somewhat humorous and embarrassing). Panic buying like this reinforces the powerful ramifications of communication gone wrong. Health literacy research that embraces new and emerging technologies will be particularly important to guide online health promotion efforts of this nature in the future.

To emphasise the importance of getting health communication right, the Australian Medical Association were particularly critical of the mixed-messaging of public health directives between the Australian, State and Territory Governments concerning COVID-19.[4] There was concern about how this mixed-messaging was being interpreted by the Australian public, but also how it was likely to impact health professionals and the use of Australia's hospitals and health care system more broadly. The Australian Government has since committed a $2.4 billion health package to protect all Australians from COVID-19, including vulnerable groups such as the elderly, those with chronic conditions and Indigenous communities.[5] The US Government pledged $50 billion on the same day. Importantly, the Australian health package includes $30 million for implementing an information campaign to provide people with practical advice on how they can play their part in containing the virus and staying healthy.[5] We trust health promotion professionals with expertise in health literacy, health communication, and social marketing will be consulted throughout its development. We also trust that health promoters will be involved in the multi-million dollar primary care and research responses outlined by the Australian Prime Minister.

At this juncture, it is worth reflecting on who is most vulnerable in pandemics. While COVID-19 has the potential to impact everyone in society, these impacts will be felt differentially. That is, the way we prepare, protect, treat, reduce transmission and innovate, needs to be viewed from a health equity lens. It is essential to recognise that pandemics—and the respective Government and corporate decisions that emanate—both influence and are influenced by social, economic and political determinants of health. As the WHO Director-General has recently stated—'all countries must strike a fine balance between protecting health, preventing economic and social disruption, and respecting human rights'.[3] However, knowing what this 'fine balance' constitutes can be difficult. As such, it helps to reflect on what we know.

While we do not know much about COVID-19, we do now how pandemics can impact vulnerable populations. We know that many developing countries do not have the surveillance systems, health resources and health infrastructure to respond in a manner that can slow the harms of COVID-19 in the way we would like.[6-8] We know that there are vulnerable populations, such as: the elderly, those with disabilities, people in prison, Aboriginal and Torres Strait Islander communities, people with chronic conditions, and people from Culturally and Linguistically Diverse (CALD) backgrounds, that will be impacted disproportionately by COVID-19, particularly if assertive health promotion action is absent.[9-13] We know that people from low socio-economic backgrounds, those who work in casual employment, and many racial and ethnic minorities, are unlikely to have the necessary financial resources to make self-distancing and self-isolation a viable option within the context of their daily livelihoods.[12-14] We know that access to health services in some countries, including basic primary health care, is contingent upon insurance and user-pays systems that already make them inaccessible to the people most at-risk.[15,16] We know that the elderly and people with disabilities rely on public transport to access essential services, including food shopping and health services that are required during pandemics.[17,18] We know that vulnerable populations may not have the necessary language and literacy skills to understand and appropriately respond to pandemic messaging.[19] We know that mental health concerns among the most vulnerable within our communities will be exacerbated by expectations to self-isolate if not approached sensitively.[20,21] We know that governments have trouble implementing strategies focused on reducing health inequities through action on social determinants of health.[22] We know all these things, but what do we do about them?

Most of the evidence-based discussion presented above demonstrates the power of privilege in a pandemic. It indicates that those most vulnerable will be the hardest hit. The health promotion community must ensure that considerations of health equity and social justice principles remain at the forefront of pandemic responses.[12,14] This will not be easy at a time when neoliberal forces pitch population health against national economic stability. While hand-washing is a significant health promotion intervention, it can also act as a useful façade for advancing actions that enhance equitable social and economic outcomes for those most vulnerable during pandemics. The WHO has encouraged us to think innovatively.[1,3] The health promotion profession can lead this charge and advocate for a national public health social media campaign and other pragmatic measures that reach people most in need. This will help support them to get accurate and timely information to prepare and reduce the risk to themselves, their families, friends and their community.

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