

Guidance on the provision of support for medically and socially vulnerable populations in EU/EEA countries and the United Kingdom during the COVID-19 pandemic

3 July 2020

Key messages

- The COVID-19 pandemic has had a huge and unprecedented impact on the EU/EEA and the UK, both in terms of morbidity and mortality, but also in social and economic terms.
- Some individuals are much more vulnerable than the rest of the population, whether to COVID-19 itself, insofar as they are at elevated risk of severe disease and death, or to the consequences of the public health measures that have been imposed in order to control the spread of the virus, which have exacerbated their already challenging life situations. These people could be described as medically or socially vulnerable, respectively.
- Many people have experienced both medical and social vulnerabilities during the COVID-19 pandemic, while others have faced a particularly extensive set of challenges due to their belonging to two or more recognised categories of social vulnerability. These challenges have included the need for targeted information, problems accessing services, de-prioritisation of routine services, stigma/discrimination, and legal as well as financial barriers.
- Civil society and other organisations have worked to provide essential services throughout the pandemic to support these people. An ECDC survey has identified a range of cross-cutting good practices that underpin the successes that have been achieved in spite of the considerable financial and logistical challenges faced. These include flexibility and an ability to adapt services to the emerging situation, thereby ensuring the continued provision of material and social support; creative use of online technologies; and a foundation for the work based on the principles of community engagement.
- National and regional authorities have facilitated civil society groups in many areas through provision of financial support; working to ensure good communication, collaboration and coordination with them; and facilitating a wider framework for action based on equity and human rights.
- However, coordination between civil society organisations and the authorities has not always been ideal. There have also been cases where the rights of vulnerable populations have not been upheld, as detailed in this document.
- The efforts of civil society support organisations over the course of the pandemic to date have been remarkable, but they may not be sustainable over the longer term, and they do not replace states' obligations to ensure access to care and support for people on their territory.
- Financial and political support from national and regional authorities along with collaborative efforts to coordinate and streamline services may be essential if the support organisations are to survive and continue to serve the most vulnerable populations in the EU/EEA.

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Scope

The objective of this document is to provide guidance for civil society and non-governmental organisations (NGOs) as well as for national and regional authorities in the European Union and European Economic Area (EU/EEA) and the United Kingdom (UK), who are providing support for people who have medical and social vulnerabilities during the coronavirus disease (COVID-19) pandemic. Specifically, it aims to identify some of the major cross-cutting challenges, successes and lessons learned by these organisations during the period of stay-at-home and other measures from March-May 2020. It is hoped that the findings presented may be applicable to support service providers across the EU/EEA and the UK as the pandemic evolves, and in particular in the event of an upsurge in cases over the coming months that necessitates a subsequent return to stay-at-home measures or other restrictions in movement.

Note that this document is based on exploratory research. It takes a broad brush approach, and it does not aim to provide a definitive account of all the issues facing support services for all medically and socially vulnerable populations during the pandemic. Note also that the absence in the text of specific reference to particular vulnerable populations does not in any way imply that they are of any less importance than those that are discussed. It is not possible in one document to cover all vulnerable populations, but we believe that, in broad terms, the issues highlighted for those that are discussed would in large part also be relevant for those that we have not been able to include.

Target audience

The target audience for this guidance document comprises organisations in the EU/EEA and the UK that have been providing direct support services for different vulnerable populations during the COVID-19 pandemic (including civil society actors, NGOs, and local authorities); umbrella organisations that advocate for specific vulnerable populations; and the national and regional authorities in the countries and areas where these organisations work.

Definitions

The following categories of vulnerable populations are included in this report. They are not presented in any perceived order of importance.

Ethnic minorities is a term that describes groups of people sharing a different 'sense of identity and common characteristics such as language, religion, tribe, nationality, race or a combination thereof' from the majority population in the place where they live [1].

Irregular migrants: An irregular migrant, also sometimes referred to as undocumented migrant, is, within the context of the EU/EEA, 'a third-country national present on the territory of a Schengen State who does not fulfil, or no longer fulfils, the conditions of entry as set out in the Regulation (EU) 2016/399 (Schengen Borders Code), or other conditions for entry stay or residence in that EU Member State' [2,3]. Note that migrants in reception/detention centres and people in prisons are outside the scope of this report as they have been discussed in relation to COVID-19 in other reports from the European Centre for Disease Prevention and Control (ECDC) [4,5].

LGBTI communities: Lesbian, gay, bisexual, trans and intersex people collectively comprise those who are categorised under the heading 'LGBTI'.

People at elevated risk of severe COVID-19-related disease: These people include, but are not limited to older people (defined here as aged 60 years and above, due to higher hospitalisation rates, severe disease and mortality in COVID-19 cases reported in Europe [6]), those living in long-term care facilities, and people with underlying health conditions, such as high blood pressure, overweight/obese, diabetes, etc.

People experiencing homelessness are people who do 'not have access to accommodation which [they] can reasonably occupy, whether this accommodation is: (i) legally their own property or whether the property is rented; (ii) provided by institutions; (iii) provided by employers; (iv) occupied rent-free under some contractual or other arrangement' [7].

People living in abusive household settings can include those who are subject to any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse from people who are, or have been, intimate partners or family members regardless of gender, gender identity, or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial and emotional issues [8].

People with alcohol or drug dependence are people who find it difficult to cut down or stop using a drug or drugs and/or alcohol, and continue to use it despite it harming their health and well-being [9].

People with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others [10]. For the purposes of this document, three sub-categories of people with disabilities are presented:

- i. **People with intellectual and developmental disabilities:** People with intellectual and developmental disabilities (IDD) include those with Down syndrome, cerebral palsy, autism and other related conditions.
- ii. **People with mental illnesses or psychosocial disabilities** are people with 'conditions that affect a person's thinking, feeling, mood or behaviour, such as depression, anxiety, bipolar disorder, or schizophrenia. Such conditions may be occasional or long-lasting (chronic) and affect someone's ability to relate to others and function each day' [11].
- iii. **People with physical and sensory disabilities:** A person is considered to have a physical and sensory disability if they have a self-reported long-standing illness, condition or impairment, including with regard to their senses of sight or hearing, that reduces their ability to carry out day-to-day activities [12].

Sex workers: Sex workers include cis and trans female, male, and non-binary adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally.

Background

COVID-19 is a newly identified, acute respiratory illness that emerged in China in late 2019 [13]. Spread through respiratory droplets, COVID-19 has developed into a pandemic [14] which, as of 1 July 2020, has caused 10.44 million reported cases and 511 037 deaths worldwide [15].

The rapid spread of the disease in Europe during February and March 2020 led many countries to implement a range of preventive measures such as 'stay-at-home' policies, alongside other community and physical distancing measures, including the cancellation of mass gatherings, and the closure of educational institutions, work places and public spaces [16]. This approach has substantially reduced transmission and, while there have been 1.56 million cases and 177 122 deaths in the EU/EEA and the UK as of 1 July 2020 [17], modelling evidence suggests that 3.1 million lives may have been saved in 11 selected European countries by these measures [18].

However, while these efforts have been successful in reducing the number of cases and deaths, they have also proven to be highly disruptive to society, both socially and economically [16]. Indeed, economic figures suggest that the EU/EEA will enter a deep recession in 2020 [19], and those in precarious employment will be particularly vulnerable to the forthcoming economic shocks [20]. Further, some individuals are much more vulnerable than the rest of the population, whether to COVID-19 itself, insofar as they are at elevated risk of severe disease and death, or to the consequences of the public health measures that have been imposed in order to control the spread of the virus, which have exacerbated their already challenging social and economic life situations.

The former group, who are identified here as people who are medically vulnerable to COVID-19, include older adults and people who have underlying health conditions, such as high blood pressure, overweight/obesity, or diabetes [21]. The latter group, identified here as people who are socially vulnerable, includes a heterogeneous range of people including, among others, those with long-term physical, mental, intellectual or sensory impairments; homeless people; people living in abusive household settings; ethnic minorities; sex workers; people from the LGBTI community; and irregular migrants¹ [22]. Some individuals may be both medically and socially vulnerable during the COVID-19 pandemic, and many have also faced a particularly extensive set of challenges due to their belonging to two or more recognised categories of social vulnerability. These overlapping vulnerabilities highlight the importance of ensuring coherent policy responses that recognise both the particular challenges faced by each vulnerable population, and that also include more comprehensive approaches that respond to shared needs and challenges.

Protecting medically vulnerable populations during the pandemic is a legal obligation of EU/EEA Member States and the UK. General Comment 14 of the United Nations (UN) International Covenant on Economic, Social and Cultural Rights, which has been ratified by all EU/EEA Member States and the UK, makes explicit reference to the need to take into account and protect vulnerable groups with regard to the right to health [23]. At the EU level, the Charter of Fundamental Rights of the European Union, which has the same legal value as the EU Treaties, prohibits discrimination under Article 21, and also includes the right to healthcare under Article 35, stipulating that 'everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices' [24]. In addition, Article 25 of the UN Convention on the Rights of Person with Disabilities – to which the EU and all Member States are party – states

¹ Note that the lists given here do not necessarily include all socially or medically vulnerable populations. Rather, they represent examples that will be examined in the present document, but we fully recognise that there are other groups that experience their own vulnerabilities.

that governments 'shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation' [10].

Protection of socially vulnerable populations is imperative for reasons of human rights and equity. To this end, the Sustainable Development Goals (SDGs), which were adopted by all UN Member States in 2015, include obligations for governments to ensure good health and wellbeing for their populations (SDG 3), achieve gender equality (SDG 5), reduce inequalities within countries (SDG 10), and promote peaceful and inclusive societies (SDG 16) [25]. Within Europe, Article 14 of the European Convention on Human Rights prohibits discrimination based on 'sex, race, colour, language, religion, political or other opinions, national or social origin, association with a national minority, property, birth or other status' [26]. The Convention acts as an important protection for many people who may be considered as socially vulnerable during the COVID-19 pandemic. In addition, the founding principles of the EU include 'respect for human dignity, freedom, democracy, equality, the rule of law and respect for human rights, including the rights of persons belonging to minorities' [27].

On a practical level, there are myriad organisations across the EU/EEA and UK that provide support for medically and socially vulnerable people, and their task has been of critical importance during the COVID-19 pandemic. The support they have given has been invaluable, but the urgency of the work in recent months has meant that many organisations have been focusing on adapting to new circumstances and delivering their services. This means that lessons learned and any innovations that have been developed may not yet have been shared widely. In advance of any potential upsurge in cases, it is important to provide an account of any such lessons learned during the early phases of the pandemic, and thereby to inform future actions and strategies.

Methods

Two complementary sets of data were used in this project: material from a rapid literature review and material from a survey.

Rapid literature review: A rapid literature review was conducted for each of the included vulnerable populations. Search terms included a descriptive title for each of the groups concerned (e.g. 'homeless', 'sex worker' etc.) and 'COVID-19'. The search included grey literature as well as material from the peer-reviewed literature, and reference lists of the selected articles were also reviewed to identify additional relevant material. The literature collected was then analysed to take into account (i) details of the particular vulnerabilities of the given population during the COVID-19 pandemic, and (ii) suggested approaches for addressing the challenges faced. Based on this analysis, a short sub-section on each of the included vulnerable populations was drafted.

The survey: ECDC developed a survey that included both multiple choice and open-ended questions as a means of gathering (primarily qualitative) data regarding the successes and challenges of supporting medically and socially vulnerable populations during the COVID-19 pandemic. The online survey (see Annex 1) included 10 questions, and was distributed across the EU/EEA through the ECDC National Focal Points for Preparedness and the ECDC Country Coordinators, through formal ECDC networks as well as the survey team's professional networks, and through ECDC social media accounts on Facebook, Twitter, and LinkedIn. The survey was also circulated throughout relevant sections and through the newsletter of the European Public Health Association (EUPHA).

The survey tool was available online between 22 May and 2 June 2020. Data were therefore collected towards the end of the stay-at-home period that was mandated in many European countries.

Analysis of the responses to the questions concerning the services provided, challenges faced, successes in service provision, and lessons learned was conducted with all the material together: the data were not disaggregated by category of population served. This approach was taken in order to identify and highlight the cross-cutting issues facing civil society and other service providers during the pandemic, irrespective of the particular communities being served – indeed, many of the issues were overlapping between the support groups serving different populations. The major themes emerged inductively while reviewing the data, and relevant quotes from the survey respondents have been included under most of the headings in the relevant sub-sections in order to illustrate the key points.

The final section of this report includes a synthesis of the findings from the literature review and the survey. By triangulating these two complementary data sources, we aim to draw out some major principles of good practice that could be of relevance for support service providers during the COVID-19 pandemic, and in particular in the event of an upsurge in cases over the coming months and a subsequent return to stay-at-home and other movement restrictions along with all their associated challenges.

Results

Findings from the literature review

This section presents the findings from the rapid literature review. It aims to introduce some of the major, recognised issues faced by each of the vulnerable groups included in the survey, as well as some of the means by which support organisations have attempted to address the challenges.

Ethnic minorities

A recently published report from the UK showed that different ethnic groups are disproportionately affected by COVID-19, with higher infection and mortality rates [28]. Different causes have been identified to explain elevated infection rates and excess mortality within ethnic minority groups, including medical (e.g. higher rates of diabetes or hypertension, which are often the result of the poverty in which many people from ethnic minorities live) and sociological factors (e.g. employment patterns) [29]. Ethnic minority groups work disproportionately in jobs that particularly expose them to risk of a COVID-19 infection, such as check-out clerks or delivery drivers [30]. As these jobs cannot be carried out from home, travelling to these jobs is required which also increases the risk of infection.

Roma are one example of a specific ethnic minority in the EU/EEA and UK. The particular challenges facing the Roma population in many parts of Europe illustrate their increased vulnerability to COVID-19 infection:

- Up to 30% of the Roma population lives in households without running water, which makes it difficult for them to adopt enhanced hand hygiene practices [31].
- The vast majority of the Roma population lives in shared and cramped neighbourhoods or housing, limiting their ability to physically distance themselves from others [31].
- Many Roma families live from street vending and they have suffered substantial losses in income due to the closure of shops and markets during the pandemic. One study suggests that over one-third of Roma people have lost their job in one setting during the pandemic [32].
- In some countries, up to 80% of the Roma population lives at risk of poverty, which makes them unable to purchase different types of protective equipment [31] and Roma populations in many CEE countries live without proper access to healthcare services and without proper health coverage [33].
- Roma populations have a lower than average level of health literacy, which might prevent them from understanding some preventive and protective measures [34,35].

Given the increased vulnerability to infection for Roma and other ethnic minority groups, efforts need to be made to support these populations to prevent and control COVID-19. For many Roma, the main challenge may not be primarily the COVID-19 infection itself, but rather accessing basic necessities and food, which has become more difficult during the pandemic [32]. Consequently, it is important to direct efforts not only towards the prevention and control COVID-19, but also on people's social needs. Different stakeholders have addressed this by providing Roma communities with basic food and sanitary products [36].

Irregular migrants

While it is difficult to find reliable data on numbers of undocumented people, it has been estimated that approximately four million irregular migrants live in the European Union [37]. During the COVID-19 pandemic, irregular migrants have faced a range of challenges, most of which pre-date COVID-19 but whose negative impacts have been exacerbated by the pandemic. They are based fundamentally on issues surrounding the migrants' irregular status, which reduce their entitlements to healthcare in most countries, limit their access to labour markets, and increase their likelihood of being socially excluded and criminalised. Those who are able to find work often find themselves in sectors where there are poor working conditions and with a higher likelihood of exposure to infection, such as the agricultural sector, the domestic work and care sectors, cleaning, tourism, construction, and transport. Other challenges include, inter alia, crowded living conditions; linguistic, cultural, financial and legal barriers; poor health literacy and limited access to reliable sources of health information; and concomitance with other health and social determinants, such as chronic diseases, mental health issues, low socioeconomic status, unemployment or homelessness [38-44]. According to one study, fifteen percent of migrant populations, including both Roma and irregular migrants, have been denied medical care, five percent of them have experienced racism when seeking medical help and, as a result, twenty percent of them have given up seeking medical care when ill [45].

Although some EU/EEA Member States provide newcomer migrants with language courses, irregular migrants are not entitled to benefit from these as they are 'invisible' to the authorities [46].

Implementation of some COVID-19 control measures, such as border closures, mobility restrictions and mass gathering cancellations, have had a negative impact for irregular migrants. Direct effects have included loss of income, delays in administrative and legal decisions, and increased fear of being reported to immigration authorities when seeking healthcare. In addition, many civil society organisations providing services to this group have been obliged to stop their activities in order to abide by locally mandated physical distancing measures [39,47].

Intergovernmental and civil society organisations are advocating for a package of measures aiming at protecting irregular migrants and including them in the national responses to COVID-19 [39,43,48,49]. Some of the proposed measures are:

- Universal and equitable inclusion in national public health systems [39,48].
- Prioritisation of health over immigration status, including protection of irregular migrants' personal data from immigration authorities when they seek care [49].
- Ensuring public health information strategies that are migrant-inclusive [39,48,50].
- Providing emergency support to irregular migrants, including funding to organisations supporting them and other marginalised communities [49].
- Temporary suspension of immigration detention, return decisions and removals [49,51,52].
- Temporary regularisation of immigration status and prevention of further irregularity by extending or issuing temporary permits [49].

The current public health emergency has exacerbated some of the social vulnerabilities affecting irregular migrants, such as stigmatisation, discrimination and exclusion [39,47]. WHO has outlined the following actions to counteract stigma [53]:

- Spread factual information about COVID-19 transmission, treatment and prevention.
- Engage social influencers (e.g. religious leaders, respected celebrities) to prompt and amplify messages that reduce stigma.
- Amplify the voices, stories and images of people who have experienced and recovered from COVID-19.
- Portray ethnic diversity and joint community efforts preventing the spread of COVID-19 in information materials.
- Disseminate evidence-based information through balanced and contextualised media reporting.

LGBTI communities

Lesbian, gay, bisexual, trans and intersex (LGBTI) people may be particularly vulnerable during the COVID-19 pandemic, both medically and socially [54]. Some LGBTI individuals, including gay men and other men who have sex with men and transgender men and women, have a higher risk of HIV infection. People living with compromised immune systems, including those living with untreated HIV/AIDS, face an elevated risk of severe disease from COVID-19, and this is increasingly recognised as a major concern [55]. In addition, COVID-19 has led to the exacerbation of existing social inequalities that LGBTI individuals have already been contending with prior to the pandemic [56,57].

A major challenge for the LGBTI community during the COVID-19 pandemic has concerned access to health services. This has arisen both as a result of discrimination based on sexual orientation and gender identity/expression [54,57], and because access to HIV testing and treatment services has been limited during the period of restricted movements, sexual health clinics and counselling services have been closed, and there have also been interruptions in supply chains with subsequent stock-outs of essential medicines such as antiretrovirals [58]. Further, concerns have been raised about the de-prioritisation of some required health services, such as hormonal treatment and gender affirming treatments for trans people [54,57], even though certain components of transition-related medical care (e.g. ongoing hormonal therapy and surgical aftercare for previously-conducted surgeries) should be considered as urgent and not optional [59]. Stigmatisation and discrimination towards LGBTI people have also reportedly increased during the stay-at-home period, both within domestic settings [54,57,60] and more widely in the community, with some religious leaders and politicians blaming LGBTI people for COVID-19 [57,59].

Addressing these issues will require that:

- Access to free or affordable screening, testing and care is assured, consistent and uninterrupted [59,61]. This should include HIV-related medications as well as continuing hormonal treatment. Innovative strategies for these issues have included provision of multi-month dispensing of antiretrovirals, online clinics and support networks, and postal testing for sexually transmitted infections [58].
- Health services that are particularly relevant to LGBTI people must not be deprioritised on a discriminatory basis [54].
- Continuity of transition-related medical care, most specifically hormone treatments, should be classified as a vital service, and efforts should be made to ensure that there are no interruptions [54].

- Political leaders and other influential figures should speak out against stigmatisation and hate speech directed at LGBTI people in the context of the pandemic [54].
- Legal protection must be assured for LGBTI people [62].

LGBTI communities have developed considerable resilience over the decades in which they have been responding to HIV/AIDS, including advocating for rights to legal partnership and marriage. Today there are legal protections, community-based resources and social support networks for LGBTI people that go far beyond what existed when the AIDS epidemic emerged in the 1980s. While the need for this advocacy and social support work arose out of long-standing and deeply entrenched discrimination, and it could not reasonably therefore be described as 'good practice', it has nonetheless been argued that this experience may offer some hope and guidance when facing the COVID-19 pandemic [63].

People at elevated risk of severe COVID-19-related disease

People above 60 years of age and those with underlying health conditions including hypertension, diabetes, cardiovascular disease, chronic respiratory disease, cancer and obesity have higher COVID-19 related morbidity and mortality compared with younger individuals and those without co-morbidities [64-66]. Men in these groups also appear to be at a slightly higher risk than females [67-75]. It has been estimated that up to 30% of the population of the EU/EEA and the UK is either above 60 years or has one of the co-morbidities associated with COVID-19 risk [76]. Although most people with elevated risk of severe COVID-19 disease live independently or with family, some reside in long-term care facilities. Estimates indicate that in 2016–2017 there were more than 64 000 nursing homes, rehabilitation centres and mixed long-term care facilities in EU/EEA countries, representing more than 3.4 million beds [77]. Such settings can provide a conducive environment for the spread of infection.

Because of their elevated risk of severe disease, physical distancing has been recommended for these populations, and these recommendations are likely to remain in most settings for as long as COVID-19 remains a public health threat. However, the lack of meaningful social connection that physical distancing can bring about is associated with substantially reduced quality of life, with increases in depression, loneliness and other adverse mental health issues [78,79]. While protective to minimise COVID-19 exposure, physical distancing may also negatively impact the ability of older adults and others with co-morbidities associated with higher risk for COVID-19 to seek or receive social and medical care for any existing health issues, to exercise, to shop or to run errands. Physical distancing can lead to the closure of gathering places (community centres, churches, cafes) which promote social interaction and it may also reduce opportunities for physical activity. Therefore, it is important to strike a balance between physical distancing and social contact/physical activity in order to promote overall well-being.

Many of the solutions for promoting healthcare access and providing opportunities to socialise during the pandemic are technology-based. Some adults, particularly older adults, may lack access to or knowledge of the use of social media or other applications to promote social connection [80].

The experience of marginalisation may be more intense for older adults or people with co-morbidities who are also members of the other groups covered in this report (homeless, substance using, LGBTI, ethnic minorities, people with disabilities etc.) [80-82]. In such individuals, the combination of challenges is likely to have a more severe impact on their health and wellbeing than that faced by other people.

Some of the suggested practical measures to ensure that the needs of older adults and other groups with co-morbidities are met during the pandemic have included:

- Transmit clear and specific messages via accessible media on COVID-19 risk and protective measures to take, including physical distancing, and on the importance of seeking medical care by telephone early in case of COVID-19 compatible symptoms. These messages should be targeted to older people, as well as their caregivers, family members and healthcare providers. Messages should also target the younger generation about how their actions impact their risk of developing COVID-19 and that of medically vulnerable groups.
- Use of online (video or telephone) consultations with health providers to ensure that any needs for healthcare are met.
- Delivery of medications, food and other needs should be promoted through affordable and accessible channels, or accessed with the help of family, friends or volunteers [80,83].
- Promote meaningful social connection with others, despite physical distancing. This includes the use of 'Connection plans' for coping with social isolation, and the use of internet-based communication systems, social media, and phone [84].
- Encourage people to engage in physical activity – whether in their homes, or, physically distanced outside – and to eat healthy, well-balanced meals; drink enough water; and try to avoid smoking, alcohol and drugs [85].

- Develop plans to prevent the risk of contagion and address the medical and social needs of people in congregated settings, such as long-term care facilities, including surveillance for COVID-19 in these facilities [77,86,87].

People experiencing homelessness

It is estimated that there are more than 700 000 people experiencing homelessness in the EU [88]. These people tend to live in environments that facilitate the spread of infectious disease, which makes them susceptible to epidemics such as COVID-19. Having no place of residence, people experiencing homelessness are obliged to stay at housing shelters or informal sleeping facilities such as encampments [89]. Their shelters are often crowded, with shared living spaces and rooms and limited access to hygiene facilities and supplies [89,90]. This reduces people's ability to comply with many of the public health measures necessary to counter infection, such as increased hand hygiene, physical distancing or stay-at-home orders. Cases have also been reported of homeless people being fined for not staying indoors during the period of stay-at-home orders [91]. Stay-at-home measures imposed by countries and closures of shops and public place further challenges on the homeless population, who rely on public facilities to, for example, use the bathroom or find a place to sleep [90,92]. Further, many services provided to the homeless, such as food distribution centres, have been impacted by the COVID-19 pandemic [90].

In addition to people experiencing homelessness being at increased risk of infection due to their living circumstances, many also have an increased risk of severe disease outcome [90,93]. Their health status tends to be poorer than that of the general population, with higher rates of chronic conditions and substance abuse [92,94]. Several rapidly spreading outbreaks of COVID-19 have been reported in homeless shelters, including with fatal outcomes [95,96] [97].

Movement between shelters and sleeping facilities occurs quite frequently, which can limit people's access to healthcare and health information. This poses both an additional infection risk to this population while also creating difficulties for surveillance as well as prevention and control of COVID-19 [98].

Efforts to protect the homeless population have included the separation of infected and non-infected, and/or medically susceptible and less susceptible individuals. One example of this comes from the UK, where a Homeless Sector Plan foresees the establishment of COVID-CARE facilities (for symptomatic and positive cases) and COVID-PROTECT (for individuals with medical vulnerabilities, as well as for asymptomatic or negative people who need to self-isolate) [98,99]. Hotels and hostels have also been made available for the homeless population [100,101], and different buildings have also been repurposed into shelters for people experiencing homelessness, including a building of the European Parliament and the Cannes Film Festival venue [102,103]. Besides providing shelters, it is important to ensure that people experiencing homelessness have access to hygiene facilities/products and food [88].

People living in abusive household settings

Social isolation and increased stress may put people with substance dependency at risk of relapse. Alcohol consumption increases the occurrence and severity of intimate partner violence, and excessive drinking can exacerbate marital conflicts and childcare issues, also leading to increased frequencies of abuse [104].

Evidence shows that children are at increased risk of domestic violence during periods of school closures associated with health emergencies. For parents who attempt to telework or who are unable to work, and who must balance childcare needs with employment stress, the unknown duration of quarantine during the pandemic has led to increased parental stress, abuse, and violence against children [105].

Shelter-in-place recommendations put survivors of domestic violence at risk of further violence while also isolating them from social support networks. Containment policies may lead to higher rates of domestic violence, substance abuse, anxiety, major depression, suicide, and other mental health needs [106]. In April 2020, EU/EEA Member States reported a surge of up to a 60% increase in emergency calls by women reporting violence by intimate partners compared to levels reported last year [107]. Increased incidence of domestic violence towards LGBTI people has also been noted in numerous European countries, when they have been forced into confinement with others who may be LGBTI-phobic [57]. There is also evidence that elder abuse, either by a partner or another family member or caregiver, may have increased during the pandemic [108].

In the pre-pandemic period, survivors of domestic abuse could seek help when their abuser was at work or out of the house. However, when stay-at-home quarantine measures are mandated, those facing domestic abuse may be unable to escape their abuser or place a phone call for help. Many abusers use the health risks of the pandemic to increase their need to control and abuse their partners and limit their contact with the outside world [66].

Teachers are often the most frequent reporters of child abuse, but with long-term school closures during the COVID-19 pandemic, they are no longer in regular contact with children living in abusive households, so they are not in a position to report their concerns. In addition, the children no longer have access to their external social networks, food, or other support necessary for coping with an abuse home life [109].

Organisations need to employ creative solutions to help people living in abusive households while stay-at-home orders are in place, such as opening texting and online chat help to women's shelters instead of requiring phone calls, as it may be difficult to make voice calls while the abuser is at home [110]. They can also provide educational materials, including computers, to children in the women's shelters so they can complete their education remotely [111], while some shelters have shipped safety devices like door jambs, window bars, and alarms to women at risk so they could shelter in place safely [112]. In addition, it is also important to continue support for perpetrators who want to stop abusing [113].

Some other suggested practical measures to ensure that people living in abusive households are supported during the COVID-19 pandemic have included:

- Urge communities to conduct swift and visible outreach with clear communication and acknowledgement that domestic violence rates increase during public health emergencies with clear calls to action for how women can find support [111]. Shelters should remain open and continue to advertise that they accept all those in need.
- Provide a text line or chat box to allow for all those in need to receive support, therapy, and advice in ways other than by calling by telephone [112].
- Provide personal protective equipment in communal living arrangements and secure cleaning supplies for shelters [111]

Coupled with unemployment and financial insecurity, public health recommendations must balance the need for COVID-19 transmission prevention with the full scope of the impact of containment strategies on the health of the population. The pandemic has not created situations for domestic violence, but rather it has exacerbated them, and organisations assisting this population need to conduct active outreach and mobilise resources quickly in order to help all those people who are vulnerable to it [112].

People with alcohol or drug dependence

People who are dependent on alcohol or drugs may be at increased risk for COVID-19, along with poorer outcomes such as hospitalisation and death, particularly if they experience unstable housing, substance use sharing practices, or if they have compromised immunity (through, for example, untreated HIV, chronic obstructive pulmonary disorder, or other comorbidities) [114,115]. Additional concerns for this population include limited access to treatment services due to clinic closures and physical distancing measures put in place in response to COVID-19.

Preliminary findings in a study conducted by the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) indicate that COVID-19 pandemic resulted in a decline in the demand for and availability of drug treatment services [116]. As with other health services, drug and alcohol treatment services had to restrict their access to clients, and some were closed down. Interventions involving prolonged physical contact, such as psychosocial treatment, had to be limited, and group therapies were cancelled.

Moreover, confinement measures made it difficult for clients to reach treatment centres, especially for people travelling from rural areas, due to a lack of public transport [116]. While there have been reports of increased use of mobile or online services or remote services to provide harm reduction, difficulties in using such services to effectively reach some segments of the user population have also been reported.

The EMCDDA study showed that, unlike drug treatment services, harm reduction services did not experience a reduction in demand for their services. More requests for social support and basic services (accommodation, food, hygiene) were noted. Some countries lowered their access threshold for opioid substitution treatment such as methadone to meet the higher demand, which was presumed to be caused by a shortage of heroin on the illicit market [116].

Further challenges in service provision have been the lack of personal protective equipment for staff, challenges to provide drug and alcohol services to COVID-19 infected clients, and staffing shortages [116].

Some of the suggested practical measures to ensure that the needs of people who are dependent on alcohol or drugs are still met during the pandemic have included:

- Putting in place treatment continuity plans, which include, as appropriate, online or telephone consultations, rapid treatment initiation, phone-based prescription refills, increased take-home doses for clients with pharmacological treatment, transfer of prescriptions to pharmacies near clients' homes, increased outreach, and diversified delivery options for treatment or support services [114].

- Ensuring that social support plans for treatment clients are in place, as social isolation can be a risk factor for relapse or increased use. Although face-to-face meetings may not be possible, virtual meetings, including virtual peer support groups, can be promoted [117,118].
- Expanding telemedicine as an alternative to face-to-face services. This is, in particular, beneficial for individuals with less serious drug or alcohol dependence [119].
- Ensuring that harm reduction services remain accessible to those in need. This has been prioritised in many countries, with innovative solutions including a temporary relaxing of regulations or legal frameworks around opioid substitution treatment to allow low-threshold access, the use of mobile services for prescriptions, and extended pharmacy- and home delivery of medications through outreach teams. Further, needle and syringe services were providing larger quantities of equipment to their clients, and self-service and postal delivery systems of drug use equipment were introduced in some locations [116].
- Ensuring prevention and continuity of harm reduction services in prisons, where the prevalence of drug use is high [120,121].
- Ensuring housing and primary care for people who use drugs experiencing homelessness [100,101,116].
- Ensuring HIV and Hepatitis C testing and treatment continuity, which is particularly important at a time when harm reduction services might be disrupted.
- Preparing drug services for new clients and/or new drug use patterns that could emerge during lock-down measures.

People with disabilities

i. People with intellectual and developmental disabilities

Medically, it has been found that COVID-19 patients with intellectual and developmental disabilities (IDD) have a substantially elevated risk of mortality. For patients aged 0–17 years, the case-fatality rate in one study was 1.6% among patients with IDD as compared to <0.1% among patients without IDD; while for those aged 18–74 years, the case-fatality rate was estimated at 4.5% among patients with IDD as compared to 2.7% among patients without IDD [122]. Further, people with IDD can be at elevated risk of infection, as they frequently rely on hands-on assistance from other people, which makes physical distancing challenging. In addition, since professional care workers may feel obliged to come to work regardless of their own health status (because of contractual issues or their own financial situation), there is the risk of them coming to work while infected themselves, which could facilitate their infecting those they are caring for [123]. Another issue concerns people with IDD, of all ages, who are placed in care homes which may not always be adequately equipped to allow for physical distancing [124].

Socially, there is a wide range of challenging issues for people with IDD arising out of the pandemic, many of which are directly or indirectly the result of their dependence on support from services and skilled carers, or a lack of accessibility. Services and carers may currently be in short supply or otherwise sub-optimal [125]. The challenges include:

- Risk of increased agitation and distress for the individual;
- Placement breakdown because of behavioural challenges arising out of the ongoing pandemic situation;
- Students with IDD struggling to participate in remote schooling, including because of accessibility barriers, or being denied the opportunity to learn in the first place [126];
- Limited access to clear and understandable information on COVID-19, including on the necessary physical distancing measures, in accessible formats;
- Discrimination in access to healthcare for people with IDD, over and above that which pre-dated the COVID-19 pandemic [127,128];
- People with IDD who live in institutional settings being put at risk after untreated infected individuals have been placed back among other residents of the institution [129];
- Social isolation through being denied the opportunity to keep social and/or family connections, even via online tools; or by being kept in isolation even after official government policy has deemed it no longer necessary [130];
- Increased pressure on family caregivers due to the closure of day support centres, who may then risk losing their jobs because of the need to stay home and provide care [131,132].

In order to address these issues successfully, there needs to be a willingness by all stakeholders to collaborate in supporting services and families to reduce both the risk of infection and the impact that the situation has imposed on people with intellectual and developmental disabilities [131]. People with IDD and their carers also need to be properly informed about what to do to protect themselves and others, through accessible, easy-to-understand information presented using a range of media (i.e. not only the written word), including online. Further, they need to be supported to overcome feelings of isolation while physical distancing measures are in place. Personal protective equipment is required both for those being cared for at home and for those residing in care facilities. At a more structural level, disability rights and related funding must be protected, while discussions about emergency measures taken to support people and businesses should include people with IDD and their families, disability organisations, and service providers on an equal basis with other stakeholders [133].

ii. People with mental illness or psychosocial disabilities

The COVID-19 pandemic is having a significant negative impact on the lives of people with pre-existing mental health issues, including those with diagnosed mental illnesses or psychosocial disabilities. There is evidence that such people have higher rates of chronic medical conditions, rendering them more vulnerable to severe COVID-19-related disease [134]. People with severe mental illness or psychosocial disabilities can also struggle with poverty and the ability to access stable housing [135], which can limit their options for practicing physical distancing and obtaining access to hygiene facilities. Further, reports suggest that pre-existing psychiatric conditions may worsen during the COVID-19 pandemic [136], and there is an elevated risk of relapse along with increased feelings of fear, anxiety and depression due to social isolation and disruptions to services [137]. Particular vulnerabilities to infection have been noted for those residing in inpatient mental health facilities where they can find it difficult to physically distance from each other and where there may be a lack of personal protective equipment for both patients and staff [138].

In addition to those with pre-existing mental health issues, there is now an increasing need for mental health services for the general community, particularly for healthcare workers, first responders, COVID-19 positive patients, children and older people who are vulnerable to increasing mental health issues as a result of the difficult challenges that have arisen for many people during the pandemic [135].

Disruptions to services are having a major impact on essential mental health support such as outpatient visits, counselling, group therapy, evaluations and access to prescriptions and medications. Some of the suggested practical measures to ensure that mental health needs are still met during the COVID-19 pandemic have included:

- Increasing the use of online mental health services, such as online counselling, videoconferencing [139] and expanding the availability of telepsychiatry [140].
- Limiting outpatient visits to those identified as urgent by the patient or physician, along with frequent, brief telephone updates [141].
- Encouraging support service staff to proactively identify those with severe mental disorders who may be at increased risk, and calling them via telephone to ensure that they have fully understood the government stay-at-home measures and other restrictions on movement, and that they are properly instructed on how to protect themselves by following basic hygiene norms [141].

Inpatient mental health settings should develop capacity to rapidly isolate people with suspected and confirmed COVID-19 [142].

iii. People with physical and sensory disabilities

The COVID-19 pandemic has significantly impacted upon the health and well-being of people living with physical and sensory disabilities, as well as their social and economic welfare. While disability itself may not elevate people's risk of getting COVID-19 or of having severe illness, adults with disabilities are three times more likely than adults without disabilities to have heart disease, stroke, diabetes, or cancer than adults without disabilities [143]. These underlying medical conditions can substantially increase their risk of severe disease. Similarly, people with disabilities often cannot avoid coming into close contact with others who may be infected, such as direct support providers and family members, thereby increasing their own chances of infection [143].

The COVID-19 pandemic has presented a range of challenges to people with physical disabilities which, collectively, could exacerbate existing societal inequalities. With this in mind, the UN Special Rapporteur on the rights of persons with disabilities has argued that insufficient efforts have been made to provide these people with the guidance and support needed to protect them during the pandemic [144]. The challenges they face include, among others:

- Loneliness and isolation could have a serious impact on the mental health of people with physical disabilities. One study found that 45% of disabled adults, compared with 30% of non-disabled adults, reported being 'very worried' about the effect the pandemic is having on their life [12].
- People with disability may face difficulties in accessing information because of limited availability of sign language interpreters at press conferences, lack of captioning, or inadequate provision of information in accessible, easy-to-understand formats [145].
- People with physical disabilities may face disruptions to the essential services they rely on during the pandemic [146].
- Clinical guidelines have been produced in some countries aimed at ensuring safety of patients and staff, but these have had the effect of de-prioritising physical disabled people who rely on a personal assistant, even though their disabilities have no direct impact on how well they could recover from COVID-19 [147].

Some of the suggested means of addressing these challenges include:

- Data collection on rates of infection, hospitalisation, clinical outcomes and deaths, disaggregated by disability status, to facilitate an understanding of the impact of COVID-19 on people with physical disabilities and to provide an empirical basis for advocacy [148].
- All risk communication concerning COVID-19 should be disseminated in plain language and across accessible formats, through mass and digital media channels [149].
- Protective measures should be prioritised for communities and households where there are people living with physical disabilities, so care workers and family members can continue to safely support them [149].
- The use of legal challenges to counter discrimination against disabled people has proven demonstrably effective as a means of facilitating access to health care during the COVID-19 pandemic [147].

Sex workers

Sex workers are reported to have been amongst the groups hardest hit by the COVID-19 pandemic in Europe [150]. The public health measures that have been imposed on populations, such as the requirement to stay at home, have put many sex workers out of work, while significantly increasing their risk of being forced out onto the streets and into destitution. Further, the recognised elevated prevalence of underlying health conditions among many sex workers [151] has the potential to increase risk of COVID-19 progressing to severe illness [152]. Any pre-existing mental health problems that they may have are also likely to be substantially exacerbated by anxiety over income, food, and housing, alongside concerns about infection if they are obliged to continue working in unsafe conditions [153].

The criminalisation – to a greater or a lesser degree – of sex work in most countries of the EU/EEA and the UK has created a barrier to sex workers being able to access the safeguards provided for many other workers during the pandemic, such as sick pay and social benefits [154]. The challenges faced by undocumented migrants working in the industry as well as trans sex workers and women of colour are particularly acute [150].

Looking forward, concerns have been noted that after the lifting of stay-at-home orders, an increasing number of women, migrants and LGBTI people will enter sex work, having lost their jobs, accumulated debts and been pushed into precarious living situations [150]. The urgent requirements of these people will also need to be addressed.

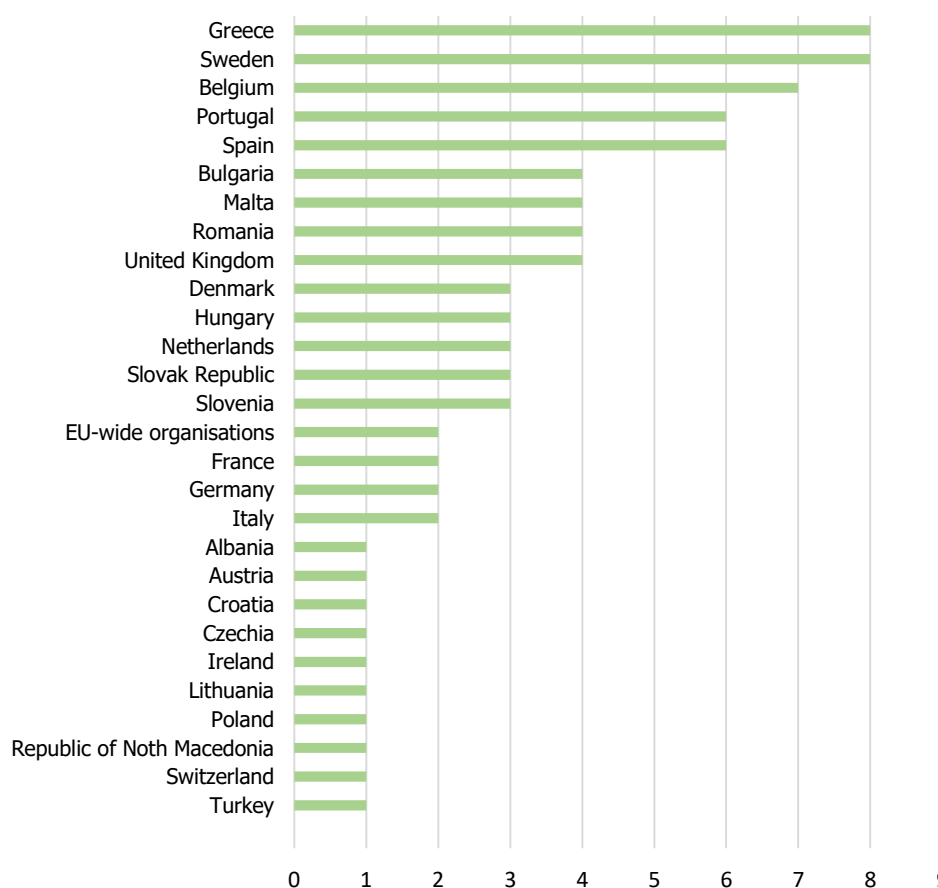
One of the key ways to facilitate effective support for sex workers, both now and through the future course of the COVID-19 pandemic, is ensuring that the design and implementation of all services is done in collaboration with sex-worker-led organisations [154], following the principles of community engagement [155]. Building on this foundation, a range of possible social and structural interventions has been identified, including financial benefits and social protection for all sex workers; the cessation of arrests, raids, and prosecutions for sex work; and the provision of emergency housing to those who are homeless. From a health service perspective, suggested interventions have included targeted advice on prevention of COVID-19 (translated into minority languages as necessary); the distribution of hand sanitiser and personal protective equipment; COVID-19 testing and contact tracing among sex workers; and ensuring access to services that address mental health, substance abuse, physical and sexual violence, and sexual and reproductive care [154].

Findings from the survey

Descriptive summary of the survey responses

A total of 81 responses to the survey was received. Twenty-seven countries were represented, and two organisations working across most or all of the EU/EEA and the UK also contributed. The largest number of responses came from Greece and Sweden (eight each), while one organisation responded from each of ten countries (Figure 1).

Figure 1. Number of responses to the survey by country (n=81)



A variety of different types of organisations and actors responded to the survey. The vast majority (53/81) were from civil society, followed by governmental health authorities and research institutes, international or intergovernmental organisations, hospitals and universities, and EU wide organisations (Figure 2).

Figure 2. Number of responses from different categories of organisations (n=81)

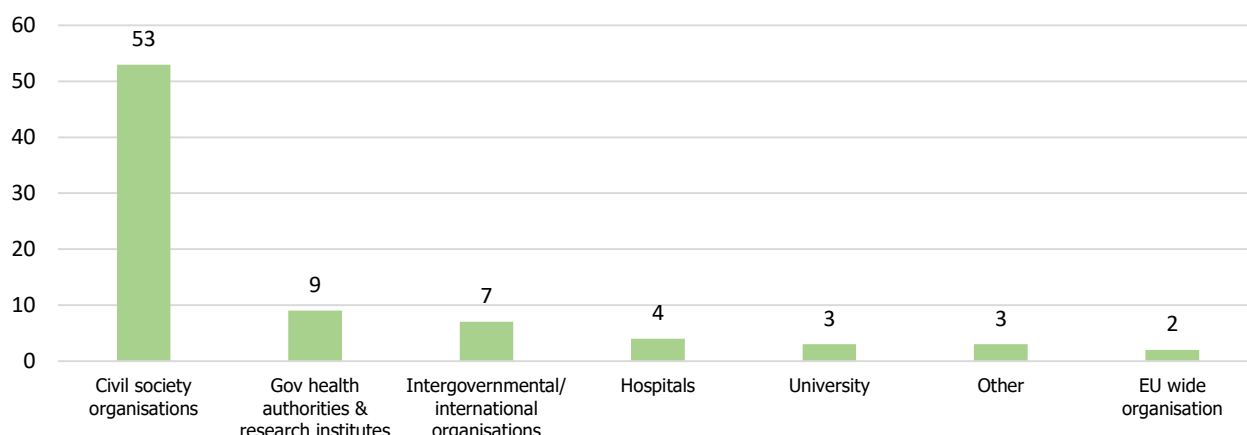
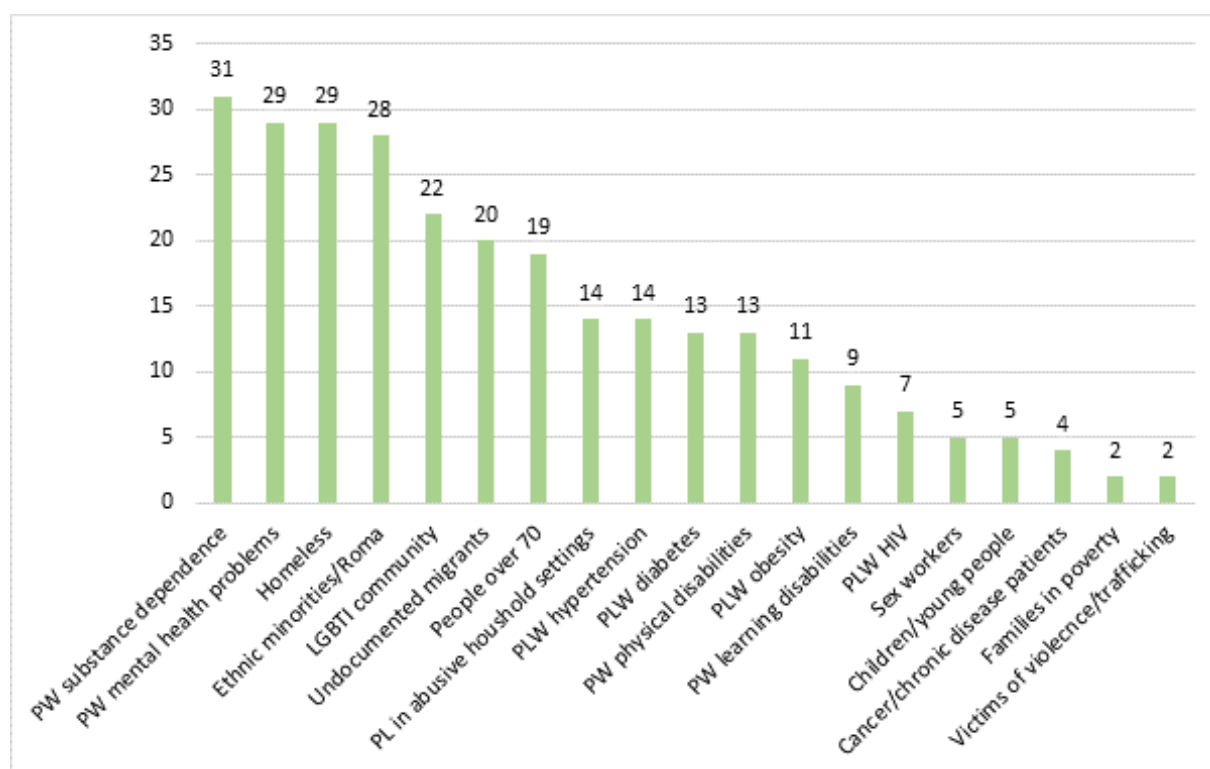


Figure 3 presents details of the different populations being supported by the organisations which responded to the survey. The number of organisations supporting different groups ranged from two (for victims of trafficking and trafficking-related violence) to 31 (for people with substance dependence). Forty-three percent (35/81) of the responding organisations focus on serving the needs of one specific group, with the remaining 57% supporting two or more groups. Note that, as outlined above, most of the support organisations provide services to more than one category of vulnerable populations (as defined in the survey), which, in many cases, is because one individual can fall into two or more of these different categories of vulnerability.

Figure 3. Number of organisations associated with different categories of vulnerable people (n=81)



PW: 'People with'; PLW: 'People living with'

Services provided by the reporting organisations

All of the 81 organisations responding to the survey provided information on the services that their organisation provides. Respondents were asked to give at least one example of services provided by their organisations, but many reported provision of several types of services. Because the survey took a qualitative approach and did not aim to count all the services provided by all the providers, the numbers given in the text below are not exhaustive. The numbers of organisations presented for each category should therefore be seen as indicative but not definitive.

Changed services due to COVID-19: Nearly all of the organisations mentioned either new services that they needed to provide or amendments to the services that they already provided in response to COVID-19. Some of these changes were in the mode of service delivery such as increased outreach in some cases, or a movement to online services, counselling and support on the phone, email and chat in other cases. One organisation indicated that, 'All of our services are now delivered online with face-to-face contact only when absolutely necessary. Crisis advice and support [are provided] by phone, housing and housing support by video phone. [We deliver] food, hygiene supplies, art therapy packs, books and games. [We provide] phones/SIMs with unlimited data for all young people in services. Health and wellbeing support and group work [are carried out] by video call.' Several organisations indicated that operational protocols and the physical set-up of the organisation had to be modified in response to the physical distancing measures put into place.

Information and educational resources: About one-quarter of the organisations indicated that they provide information and educational resources either to affected populations or to public health agencies or governmental organisations to inform planning, or to both. The direct provision of information about COVID-19 to affected populations targeted marginalised Roma communities, people who use drugs, people with intellectual disabilities and their families, and parents of infants and young children. Much of this information was provided through social media, webinars, or through other online fora. The provision of information to public health agencies or other governmental organisations included conducting risk assessments or research in affected populations.

Counselling and mental health support: More than half of the organisations provide some type of counselling or mental health or psychosocial support. This included mental health counselling and peer support, either by phone or through home visits. Support to those who felt socially isolated was also mentioned, including organising virtual church services, discussion forums, and videos with virtual museum visits. One organisation described a programme to support mental health: '[We have] regular phone contact, at least two phones call per week. We have organised a [project] called 'write during the pandemic' which stimulates our users [to be] active and express their feelings while being in lockdown.'

Drug/alcohol treatment: Eleven organisations provided services to support people with drug or alcohol dependence including harm reduction services (needle exchange or opiate substitution treatment), drop-in centres, drug consumption rooms, and community or residential therapy. Most of these mentioned a need to change protocols to ensure the provision of essential support services to these, at times, hard-to-reach populations, while ensuring compliance with physical distancing requirements.

Patient care, testing and contact tracing: Nine organisations provided patient care, including hospital care, outpatient care and home care or support to people following hospital discharge. Some of the home care support included helping people to get or stay in contact with health care providers, provision of testing or treatment services in home-based settings, or provision of essential medications when people were unable to access them. One organisation described a tool for monitoring people in their homes, via self-registration and automatic movement sensors.

Three organisations specifically described activities in the community on testing and screening for COVID-19 or for other health conditions such as HIV. This testing included active follow-up and linkage to care for positive cases. Two additional organisations mentioned that they carried out outreach activities to screen people with symptoms or to assist with contact tracing of positive cases.

Personal protective equipment: Five organisations mentioned activities focused on provision of personal protective equipment (masks, gloves, disinfectants) to community workers or to very vulnerable members of the community. 'Our organisation responded to the COVID 19 pandemic and to the situation caused by the pandemic by providing humanitarian help to the communities in need. Our first response was to provide necessary protective materials for our mediators (protective gloves, glasses, masks, disinfection, etc.) By distributing these prevention supplies, we have been able to allow our mediators to carry out their activities, amended to current situation.' One organisation also mentioned training on infection prevention and control.

Quarantine support/housing services: Services to support housing of vulnerable groups was mentioned by many organisations, including services specifically organised for homeless people, women and children experiencing domestic violence, and people who use drugs. As described by one organisation, '[We run] a hostel to accommodate about 70 people with active drug use.'

The third floor of the hostel has been set up in order to confine those people with suspected COVID-19 infection and their contacts'. Services in the hostel needed to be adapted to minimise the spread of COVID-19.

Material support: Twenty-seven organisations mentioned material support as a crucial need and a large part of their services. Material support was provided as money for lost wages and/or to prevent homelessness by four organisations serving sex workers and by one organisation working with Roma families. Material support was also provided as food for families or others living in extreme poverty: '[We focused on] activities to provide and distribute material help to families that found themselves struggling during the pandemic, either by losing employment (and therefore their only source of income) or because the preventive measures, combined with discrimination from service providers, prevented them from obtaining food and other necessities. Material support also took the form of child care provision or activities for children under stay-at-home measures. Finally, four organisations provided support to older or otherwise medically vulnerable populations by doing shopping, delivering medications, and providing warm meals, often combined with psychosocial support.

Advocacy: Seven organisations described advocacy activities, including advocacy for the rights and inclusion of marginalised groups in COVID-19 response and recovery. One organisation explained that, 'Our advocacy actions have been increased during this pandemic at European and National level. We have continued with our work to fight discrimination, to raise awareness and to exert influence in political and social spheres. We are in constant contact with the public administration and with other agents involved in this social and public health crisis, making proposals to Government and insistently reminding national, regional and local authorities of the need to urgently apply the agreed social measures'.

Research/needs assessment: Two organisations described carrying out research in order to inform public health services about the impact of the COVID-19 pandemic and the resulting measures on the groups with which they work. This included large population based and telephone surveys of, for example, the Roma community.

Challenges faced by the responding organisations

Of the 81 organisations that replied to the survey, 78 (96%) listed challenges that they are facing in service provision as a result of the COVID-19 pandemic. The majority of organisations described multiple challenges, many of which were new issues that the organisation had not faced previously. The challenges reported are listed in thematic groups below.

As with the section above, because the survey took a qualitative approach and did not aim to count all the challenges faced by all the providers, the numbers given the text below are not exhaustive. The numbers presented for each category should therefore be seen as indicative but not definitive.

Increased demand: Six organisations described facing increased workload and demand as a result of the COVID-19 pandemic and its effect on the populations that they serve. As one organisation explained, 'The main challenge has been the increased number of requests for services of psychological support and counselling, which has increased the demand for financial resources we use for covering the services, and therefore [we] reached the yearly limit we have set for this type of services.'

Disruption of services: Three organisations specifically listed disruption of services as a challenge, including with regard to treatment facilities doing 'in-reach' into prisons, remote drug treatment, HIV testing and linkage to treatment, and specialised healthcare for trans and intersex people: 'Generally these services are not considered officially 'vital' by health authorities during the pandemic, meaning that these communities have experienced significant gaps in continuing care during this crisis.'

Need for new approaches and modification of services delivered: Twenty-nine organisations indicated that they needed to develop new approaches to service delivery in order to accommodate physical distancing orders. These issues were particularly pressing given the need to ensure continuity of services. One organisation explained that, 'With the pandemic, we had to transform support and all face-to-face activities into 'distance support'. The use of the telephone and the use of new technologies was/is a daily challenge for our teams, but we are managing to maintain contact and support for all our users.' Furthermore, organisations described struggles with the sudden need to diversify services to respond to the emerging challenges posed by COVID-19. Several organisations also described the challenge of needing to re-organise the physical space (e.g., homeless shelters, drug treatment facilities) so that services could be provided while still ensuring physical distancing.

Fear within the target group: Fear was described by several organisations as a challenge in providing effective services to marginalised populations. One organisation described how, 'People were afraid to reach (us). They preferred to stay at home without medication. We didn't manage to overcome these barriers so we only helped people in great need.'

Financial constraints: Financial constraints have been a major challenge for many organisations. These were linked to an increasing demand for services by a population with increased needs. Ten organisations also described their decreasing possibilities to receive funding from their usual funding sources.

Lack of coordination or confusing messages from the government: Four organisations indicated that a major challenge had been and continues to be coordination. Examples were given describing a perceived lack of, or poor coordination, by public health officials, who, in addition to not coordinating activities at operational level, sometimes provided confusing messages. One respondent expressed this by saying that it had been a challenge, 'trying to work when you get mixed and different recommendations from the state.'

Lack of correct information on COVID: Eight organisations described the difficulties associated with what was perceived as inadequate, insufficient and untimely information. 'The main challenge was the lack of information on the process of how to combat the pandemic and at the same time keep the whole system safe.' Several organisations also mentioned the related challenge of developing and providing new messages and information about COVID-19 to the users of their services.

Exclusion from policy making: Two organisations listed exclusion from policy making as a challenge. This related to not having been consulted on the response or recovery planning

Special needs of particular groups are harder to meet: Twelve organisations mentioned challenges with specific groups that were considered harder to reach and harder to support during the period of mandated movement restrictions and physical distancing. For example, 'Moving people into housing whilst maintaining safety has also proven difficult but with the right PPE is possible. Enabling young people to stay at home has involved thinking creatively about engagement and resources for activities at home. Supporting young people who have mental health issues as the situation exacerbates their health has been challenging.' Many groups, which had moved to online services to comply with physical distancing recommendations, described that their most marginalised users did not have cellular phones or computers to enable them to link to services. For these groups, the continued use of face-to-face options, undertaken with precautions, was described as essential.

Lack of personal protective equipment: Lack of personal protective equipment for both staff and clients was identified as a challenge by six organisations. One organisation described, 'A lack of personal protection equipment (PPE) for staff and clients and a lack of basic food and hygiene products due to panic buying in the first 2-3 weeks, although buying food stuffs returned to normal, there was a lack of PPE for around 6 weeks or more. Online buying helped but there were limited stocks available and long delivery times.'

Successes and lessons learned in service provision

Seventy-eight responses were provided for the question concerned with the main successes in the services provided during the COVID-19 pandemic. Of these 78 responses, only two organisations indicated no or very limited success in their work, suggesting that the overwhelming majority of those who responded felt that their work has had a positive impact.

Seventy-two responses were provided for the question concerned with lessons learned in the provision of services during the COVID-19 pandemic.

There was considerable crossover in the way respondents answered these two questions. The data for the two were initially analysed separately, but given the many similarities, the responses were then synthesised and they are presented in combined form below.

Note that the questions focused more on reflections about the organisations' successes and lessons learned rather than the findings from formal evaluations, and consequently, most of the responses were concerned with process rather than impact. In addition, some organisations reported several different categories of success or lessons learned (as defined below), while it is likely that other organisations may have had somewhat similar experiences but they did not report them in their survey responses. As above, therefore, the numbers of organisations presented for each category below should be seen as indicative but not definitive.

Continuity, flexibility and innovation: Sixteen responses pointed to the continuation of service provision as a success in itself, given the challenging circumstances of the pandemic. As one explained, 'The main success is that most of the services – such as providing a place to live, access to social workers and medical help – were maintained. All employees were dedicated to continue working. Closing the service and leaving the clients without a place to live was never an option.'

One possible reason for this was exemplified by the nine organisations that reported that they had been able to adapt quickly and effectively to the new challenges presented by the COVID-19 pandemic. This was made possible by the fact that many of the organisations are locally based and relatively small, but this adaptability was also reported from at least one government agency: 'Employees within the organisation adapted rapidly to continue offering their services under supervision in the smoothest way possible, notwithstanding the total overhaul of certain protocols and methods of operations'. A respondent from another government agency noted that, 'COVID gave us the opportunity to revise some of the practices and improve them so that better use of human resources and more efficient service delivery was possible'. However, an umbrella organisation for several NGOs warned that this flexibility should not be seen as a way of replacing publicly funded basic services:

'Community-based organisations and civil society has radically refitted their organisations to do work during this time to provide for [our target community's] basic needs. This is not a sustainable solution...This [has been] a success because of the flexible and forceful response of our communities to ensure their own survival, but must not be seen as the solution itself.'

Several of the reporting organisations described their having developed new ways of supporting their service users as a result of the particular challenges brought about by the pandemic. As one respondent wrote, 'The epidemic opened our mind to new perspectives and actions.' An organisation working with people who use drugs described providing mobile services and 'take-home' opioid substitution treatment as a means of avoiding crowding at their centres and thereby maintaining safe operations. Others described, more generically, their 'creativity in reaching out' to users, and of the importance 'for any organisation to be ready to adapt, remodel and rethink itself: flexibility is the most important asset during a crisis.' The process is not always straightforward, however; 'The first few weeks were not easy, but we were perfecting this new way of working.'

It is not known how many of these innovations will continue once the initial acute phase of the COVID-19 pandemic passes, but their emergence does point to the inherent adaptability of many service providers. As one explained, 'I think we are very unprepared for epidemic disasters, but we are successful in crisis resolution.'

Going online: Thirteen respondents reported that the use of social media, mobile phones and video conferencing had facilitated their work and contact with clients. For example, 'We were able to get Phones and SIM cards to young people during the first week of lockdown, so engagement has increased as the period has extended and young people have become more isolated. Many young people have engaged in virtual groups, but would not have attended our usual sessions so it has given everyone new opportunities.' Another respondent said, 'Saying hello and waving after each [religious] service reduces isolation and anxiety, and has provided important support for members in isolation. The discussion forums provide an opportunity to air frustrations and share good advice.'

While digital technologies have been crucial means of delivering some of the core support services, they have also facilitated the emergence of new initiatives. Online counselling sessions have now been included into the normal operational procedures of one service provider, with the hope of reaching people who had previously found attending face-to-face sessions to be too difficult or too demanding. Another explained how digital technology has permitted them to maintain contact with users, and that it has given them a means of staying active while under stay-at-home orders through, for example, virtual get-togethers, writing, music, and cultural online activities such as watching theatre shows. This, they said, was 'very important for [users'] emotional stability'. An additional innovation was described by an umbrella/network organisation, whereby a Google Group was established for the service provider/member organisations, through which, 'our members could share immediate updates and share their experience with organisations from other countries. While each country's health authorities provided guidance for service providers (often in a much later stage), our members have found this swift exchange extremely helpful to see what is happening elsewhere and what solutions are proposed.'

However, it was also noted that online communications cannot replace some activities that inherently need to be conducted face-to-face. For example, while some consultation services can be provided for men who have sex with men, online services for people who inject drugs or for homeless people cannot, we were told, realistically be provided at scale. Similarly, access to online material in migrant camps can be challenging because of the poor internet services that often exist in these settings; while those lacking computers and relevant IT skills – for example, some people over 70, the blind and the deaf – might also face difficulties in finding accessible digital services. Digital technologies therefore offer great advantages in some respects, but they are not a panacea for all communications issues when working to support vulnerable populations.

Collaboration and coordination between organisations and between levels: Eleven respondents reported that good collaboration and coordination with other providing stakeholders had, one way or another, facilitated the provision of their support services. This included work on the production of reports, work with other frontline service providers, work with organisations that had access to medications, and work with official organisations. With regard to the latter, one respondent reported that, 'What helped a lot was the willingness of the local government to act quickly, without losing time in bureaucratic procedures.'

Collaboration and coordination enabled the mutual sharing of information and experiences, as well as materials for educating clients. In one setting, coordination between the government and NGOs, and between the NGOs themselves was quickly established in order to divide up the tasks and prevent duplicate activities. In this case, however, it was noted that the distribution of tasks required the creation of some sort of hierarchical structure, whereby one of the partners (in this case, a state institution) needed to act in a coordinating role. In sectors where bureaucratic structures are already well aligned – for example, between health, housing and social care authorities – it has reportedly been easier to coordinate more effectively than if the structures are not aligned.

The risks of inadequate coordination by governments were highlighted by several respondents. One wrote of the 'unrealistic' government requirement in their country to have staff working in temporary accommodation centres (in their case, for homeless people) to be quarantined in 14-day rotas, when the legislation in that country had apparently been put in place specifically to protect older people living in care homes. This situation could have been averted through a more fully coordinated consultation process. Another wrote of the decision by their government to coordinate their strategic planning with just one single, high profile stakeholder to the exclusion of all others, thereby limiting the range of input into their national decision-making process.

Evidence and advocacy: Ten respondents reported that they had been engaged in advocacy activities of some sort during the COVID-19 pandemic. These ranged from advocating for inclusive policies; drafting materials for publication aimed at raising awareness among state authorities and/or influencing public opinion; petitioning the European Parliament; highlighting legal issues concerning, for example, discrimination; highlighting needs of the population of concern in employment, education and the provision of basic needs; and creating methodological materials for working with marginalised communities in crisis situations, which have since been distributed to municipalities and government.

Several respondents wrote of the importance of collecting reliable data, in part as a means of providing a good evidence base for advocacy. One respondent highlighted the importance of collecting data on similar indicators and issues at EU and/or regional level in order to ensure a coordinated advocacy process: 'How can countries and the EU assess the impacts caused by the coronavirus, have an appropriate response to this crisis and learn the lessons and be prepared for a future health crisis if there is no harmonisation in the data collection process?'

Data were also reportedly collected as part of needs assessments prior to initiating work, for evaluation purposes, and to monitor community perceptions and concerns as a means of countering misinformation.

Dedication among staff/volunteers: Eight respondents mentioned the dedication of staff members and volunteers as being one of the major successes of working during the pandemic, apparently gained through a sense of being united in adversity. As one said, 'This situation that we all live in has created a feeling of unity and strength in which physical distance did not mean real distance.' Another explained that, 'The whole organisation has started working much more closely together to identify ways of responding to problems, and there has been significant support from management to ensure that these responses are carried through as quickly as possible.' It was also noted how, 'staff were daily in touch, sharing our experiences and our fears', 'we experienced the crisis as one community', and of how, 'the team has been united, tolerant and patient'. Another respondent described the way in which, 'a huge network of volunteers was created throughout the country to help anyone in help.'

Minimising COVID-19 infections: Seven organisations reported that no or very few clients or co-workers had been infected with COVID-19, which was seen as an important indicator of success. As one reported, 'Our main success was keeping the whole of our population of users COVID-free. We had one example of a COVID-19 positive volunteer, but we manage to keep safe all other volunteers and our users.' The vigilance and effort required to bring about this success did create some upstream challenges in at least one other setting, in which women and children were allowed into a particular facility only after being symptom-free for 14 days while staying at a 'waiting station', where fever measurements and other health surveillance were conducted. Thus, it is possible that there could have been COVID-19 cases there, but they never entered the facility that was described in the survey response.

Equity and human rights: The principles of equity and human rights lie at the centre of any efforts to provide support services to medically and socially vulnerable groups, but, as indicated by seven respondents, it is clear that much work remains to be done in this respect. One said, 'We realised, one more time, that sex workers are unprotected in [country A], with policies that conflate the two different realities of consensual sex work and trafficking. This doesn't allow for either of the groups to be attended properly.' Similarly, 'sex work is still criminalised in [country B], and sex workers do not have access to government financial aid [including during the pandemic].'

LGBTI individuals and communities were identified as 'targets of misinformation and hate speech, for example in blaming LGBTI people for the pandemic. Governments must be proactive to address this kind of scapegoating, as it inevitably leads to increased general hate speech and violence.'

Another respondent focused on the plight of ethnic minorities, who are 'often employed in high risk jobs with direct consumer, passenger, patient contact, but without protection. Often they live as larger households in small apartments with a crowding risk.'

Three respondents wrote about the human rights challenges faced specifically by the Roma community. One wrote simply that, 'Nobody cares about the Roma'; while another explained that, 'The municipalities and the local institutions are not ready to address complex issues like coronavirus epidemic in Roma neighbourhoods. The most common action was closing the neighbourhood and leaving people inside to 'natural selection'. A third argued that, 'Safeguarding public health must not be the excuse for gross rights violations, excessive policing, racial profiling etc., that hinder social inclusion and increase stereotypes and anti-Gypsyism.'

It was also noted that, 'This pandemic may bring about a paradigm shift for the Roma communities, because we are forced to view health as a collective: no one will be safe unless everyone is safe.' In other words, while the protection of human rights and the promotion of equity are of central importance in and of themselves, they also have clear and direct implications for the protection of public health throughout the whole community.

Community engagement: Community engagement aimed at empowerment and the creation of trust was mentioned by seven of the organisations. The approach was articulated by one of these as follows: 'In addition to successfully combating food deprivation, we consider the main success of this intervention to be the emergent sense of belonging within the community. Through short videos, messages and drawings, we have begun to encourage contacts and exchanges between mothers who give, mothers who receive and mothers who pack [food] parcels, with the effect of creating a certain sense of common belonging. This is not self-evident but we know it needs to be organised in order to further develop and grow. The parcels are packed once a week in the open air in the garden of the community centre by this heterogeneous group of well-spaced volunteers who are creating a community based on altruism and activism.' The central importance was highlighted of 'seeing communities as partners, not only as beneficiaries, no matter how vulnerable they are', which reflects a core principle of community engagement.

Another respondent wrote of how, 'when a collaborative relationship is established with clients, they [the clients] become very open to cooperation and help. They showed understanding for the overall situation, and care for employees and other service users'. A third emphasised how, 'the institutions had open ears for the issues of vulnerable groups.' Such a two-way, listening approach is also key to the development of trust, which was identified as an important pre-requisite for the effective provision of support services. For example, 'the work was made possible thanks to the trust built over time and the association's first-hand knowledge of the contexts. This is another important point that should not be taken for granted, as any response has to be quick, and trust cannot be built overnight.'

It is encouraging that community engagement principles are so central to the work of these service providers. However, some respondents working with advocacy also noted the opposite, whereby, for example, 'there is a lack of meaningful participation of persons with disabilities; we have aimed to ensure their organisations are included in decision-making.' Another organisation explained how they had been obliged to advocate to bring their group of concern onto the agenda: 'At the beginning, there were not so many responses by EU authorities to mitigate the effects of the pandemic to people with intellectual disabilities. After great advocacy work from organisations in the disability field at the European level, the EU was quite responsive and willing to listen and dialogue with disability NGOs.'

The need for self-care: Providing services to vulnerable populations requires a certain level of mental and emotional stamina during regular, non-crisis situations. During a global pandemic, when the service providers themselves may feel emotionally drained, maintaining that emotional and mental health support may be especially taxing. It is crucial that volunteers and organisation members also safeguard their own mental health and emotional strength in order to continue to serve during times of crisis. One respondent said, 'There is an increase in verbal violence and psychological violence among the women [in the shelter]. Suicidal thoughts and therefore need for psychiatric support increased. As an expert and as a psychologist, I feel exhausted and helpless. Throughout this process, we are like melting candles.'

No one-size-fits-all: The heterogeneity of the different vulnerable populations was exemplified by one respondent's observation that, 'Substance abusing homeless persons are not one homogeneous population. Some can survive in accommodation given through mainstream homelessness shelters whilst others need to have specific services for themselves. This relates especially to substance abusers that might still be abusing substances at any point in time. These people cannot go under lockdown in a homeless shelter because their substance abuse affects their ability to stay drug free and within regulations set by homelessness institutions.' Hence, as suggested by another organisation, it may be important to have a network of field officers who are able to identify and monitor the specific needs of sub-groups within the wider vulnerable population.

Evaluation of the interventions

Table 1 presents data on the numbers and proportions of support organisations that have conducted an evaluation of the services they have provided during the COVID-19 pandemic. Just over one-third of the organisations reported that they have conducted an evaluation of their services, with one-half saying that have not (yet).

Table 1. Numbers and proportions of organisations having conducted an evaluation of their services (n=79)

	Number of responses N (%)
Yes	28 (35%)
No	40 (51%)
Don't know	11 (14%)

Of those organisations that had conducted an evaluation, several said that they had not yet finalised the process, so results are not yet available. Of those who had findings to report, a number stated that they had collected process data relating to, for example, supplies delivered, the numbers of people involved in providing services, and changes in the proportion of clients accessing essential medicines or health services. Others focused on:

- The response to the pandemic of the people being supported, with reference to: (i) an enhanced sense of community brought about by the challenging situation, and (ii) unexpected behaviours of clients (which were unspecified in the survey response) brought about by the 're-traumatising' pandemic.
- Highlighting the challenges faced by people, including reported community isolation being imposed by the police (no further details given); and misinterpretation of some of the public health advice being provided because of language difficulties.
- The relationships between the organisation and the community being supported, with findings from one organisation suggesting an enhanced understanding of the challenges and the situation faced by the people they are supporting.
- Organisational changes: better collaboration was reported, both internally (between section teams), and externally (between different civil society service providers).
- The improved use of digital technologies and mobile phones for reaching the vulnerable populations.

Overall, while the findings pointed, as expected, towards increased challenges for the vulnerable populations themselves, several positive changes emerged through the pandemic situation in terms of (i) organisations' relations with the communities they serve; (ii) internal and external organisational relationships; and (iii) the possibility of using digital technologies to effectively reach out to their clients. The organisations and the people working in them appear to have risen well to the challenges brought about by the COVID-19 pandemic.

Most of the organisations that reported not having conducted an evaluation stated that it was still too early for them to do so. Many of these organisations are small, and they are currently focusing their time and efforts on fundraising and service provision. Others said that they do not have the resources or technical capacity to conduct evaluations. Of those who reported that they had not (yet) conducted an evaluation, 26/40 (65%) said that they have plans to conduct one in the future.

Conducting needs assessments for vulnerable populations

Several of the survey respondents indicated that they or their organisation do not have the technical skills to conduct an evaluation of the services they provide. It is possible, therefore, that they may also find it challenging to conduct a needs assessment, which could help them to identify both the gaps and needs experienced by the group they are serving, and the resources and capacities that already exist within the group and that could be harnessed to contribute to meeting their own needs. Such a community engagement approach can be very empowering [155].

Academics at University College London have produced a simple field manual for conducting needs assessments with vulnerable populations, which aims to guide the most effective allocation of available resources in addressing their needs, and to help identify local networks most capable of building social capacity in periods of instability and systemic change [156]. Organisations may want to review this and utilise it for their own purposes.

Suggested good practices for action during the COVID-19 pandemic

This final section presents a synthesis of what has been presented above, both from the literature and from the survey material. A set of eleven strategic good practices is outlined, based on work that has been conducted as well as suggestions that have been made for additional improvements. These, it is suggested, could assist organisations that support vulnerable populations – and also the organisations and agencies that support them – to optimise their services during the COVID-19 pandemic.

Note that some of the proposed good practices are targeted at national and/or regional authorities, while others are focused on the support organisations themselves. Table 2 provides an indication of which points are for consideration by which of these two categories. Most of the suggested actions for national and regional authorities are concerned with providing financial support to the support groups; working to ensure good communication, collaboration and coordination with them; and facilitating a wider framework for action based on equity and human rights. The suggested actions for the support groups focus on the actual provision of the services.

The suggested good practices are not presented in any perceived order of importance.

Table 2. Proposed good practices for consideration by national/regional authorities and by civil society and other service providers

Proposed good practice	Action needed by national and/or regional authorities	Action needed by civil society/service providers
1. Continuity of service provision	✓	✓
2. Provision of material support	✓	✓
3. Use of online and other digital technologies	✓	✓
4. Prevention of COVID-19 infection for both users and staff/volunteers		✓
5. A community engagement approach	✓	✓
6. Clear communication between service providers and service users		✓
7. Staying socially connected		✓
8. Collaboration between national/regional authorities and civil society service providers	✓	✓
9. Equity and human rights	✓	✓
10. Needs assessments and evaluations of services	✓	✓
11. Flexibility with service level policies while ensuring continued legal protection	✓	

Continuity of service provision

The pandemic has increased the needs of many vulnerable populations, so it is critically important that support services continue to function and that they can manage the increased workload and demand. Most of the organisations responding to our survey have reportedly achieved this, but some have not. Several organisations described how they have ensured continuity of services in these challenging circumstances.

- Staff and volunteers have proven to be remarkably flexible and willing to devote extra time and effort during the pandemic period. However, this cannot be taken for granted over the longer term: proper staffing, support, training and supervision is needed in order to sustain the response. This also entails volunteers and organisation members safeguarding their own mental health and emotional wellbeing in order to continue to serve during this time of crisis.
- Treatment continuity plans have been implemented for certain vulnerable populations, including online or telephone visits, phone-based prescription refills, take-home doses, remote drug treatment, transfer of prescriptions across pharmacies, outreach and delivery options for treatment or support services, postal testing for sexually-transmitted infections, HIV testing and linkage to treatment, multi-month dispensing of antiretrovirals, and specialised healthcare for trans and intersex people.
- Many groups, which had moved to online services to comply with physical distancing recommendations, stated that some of their most marginalised users did not have cellular phones or computers to enable them to link to services. For these groups, the continued use of face-to-face options, undertaken with physical distancing precautions, was described as essential.
- Financial constraints were described as a major challenge for many organisations. State authorities could consider increasing their support for civil society groups during the pandemic.

Provision of material support

Given the severe economic impact of the COVID-19 pandemic, the difficult financial situation already faced by many vulnerable populations has been exacerbated. Civil society groups have worked to fill the gap through provision of emergency housing, child care, SIM cards and/or mobile devices along with airtime, as well as food and other necessities, including medications. However, with their own resources already stretched through reduced fundraising opportunities, provision of these services has proven increasingly challenging. As indicated in the point above, authorities may therefore want to consider extending additional financial support to civil society groups to facilitate their provision of essential material support to the vulnerable populations they serve.

Use of online and other digital technologies

Online technologies have proven to be an essential means of providing support services over the course of the pandemic. Some pre-existing online services have continued, while others have been expanded or adapted, as required by the circumstances. Such services have included video or telephone consultations with users, virtual peer support groups, provision of chat boxes to facilitate an exchange of support and advice between users, and group sites for service providers and member organisations as a means of sharing experiences and lessons learned.

However, online work is not a panacea for all problems:

- Face-to-face meetings may still be needed for those with certain severe vulnerabilities.
- Some people, particularly older adults, lack access to or knowledge of digital technologies.
- Airtime may be limited due to poor WiFi facilities or an inability to procure a contract with sufficient airtime.
- People with visual or audio impairment cannot easily access all online materials. Other means need to be sought to reach such individuals.
- People with visual or hearing impairment cannot access all online materials, video conferencing systems, remote education, or teleworking tools, especially when they are not design in accessible formats. Other means need to be sought to reach such individuals while ensuring that those systems are made accessible.

Service providers could consider providing mobile devices, airtime, and training as necessary to people who have limited or no access to the internet. Funding, including providing reimbursement for costs incurred by support services, may be needed for this, which could be sought from national or regional authorities.

Prevention of COVID-19 infection for both users and staff/volunteers

Every effort should be made to minimise the risk of infection both for service users and for staff/volunteers. Support organisations may want to consider the following:

- The principles of physical distancing as applied in the wider community should, as a priority, also be applied when vulnerable populations are housed in hostels or other institutional settings. This may require investment and the adoption of novel approaches.
- Personal protective equipment (including masks, gloves, disinfectants etc.) should be prioritised for communities and households where vulnerable people are living, both for the vulnerable people themselves but also so that care workers and family members can continue to safely support them. Supplies of cleaning supplies and hand sanitiser should also be ensured.
- Since there have been shortages of many preventive materials over recent weeks, it would be important to consider stocking up in advance of any potential upsurge in cases.
- It would be beneficial to provide training on infection prevention and control practice for staff and volunteers.

A community engagement approach

Following the principles of community engagement:

- Representatives of all vulnerable populations should be engaged throughout all stages of the pandemic in the development and implementation of all response measures. This will help to build and sustain trust, ensure suitability, sustainability and effectiveness, while avoiding indirect or unintended harms.
- Dialogue between service providers and the respective vulnerable populations should be conducted on the basis of two-way communication, collaboration, and mutual listening. People want to be seen as partners, not only as beneficiaries, no matter how vulnerable they are.

Clear communication between service providers and service users

Standard principles of risk communication should be employed when communicating with service users. These include:

- All information concerning COVID-19 should be disseminated in plain language, translated into minority languages as necessary, and including in languages that irregular migrants understand.
- Information should be provided using a range of formats (i.e. not only the written word, and also following accessibility standards), including through mass and digital media channels.
- Information should be targeted according to the specific audience/s that it is intended to reach.
- The development of appropriate and effective messages can be a challenging process. It is important always to test the materials that are developed with representatives of the intended user population in order to ensure that the messages are received as intended.

Staying socially connected

Physical distancing should not lead to social isolation, and efforts should be made to ensure that people remain connected with each other in order to maintain wellbeing and avoid adverse mental health impacts. Such efforts could include:

- Developing 'connection plans' to assist service users to stay in touch with friends and family.
- Counselling or mental health/psychosocial support.
- Organising virtual religious services, discussion forums, videos with virtual museum visits.
- Ensuring regular phone contact with users.
- Virtual get-togethers, writing, music, and cultural online activities such as watching theatre shows.

Collaboration between national/regional authorities and civil society service providers

Collaboration and support by national and regional authorities for civil society service providers is important in order to strengthen services and ensure coordination of activities. Such work could include:

- Actively engaging with and consulting a diversity of civil society groups in policy discussions to do with response and recovery.
- Working to avoid duplication of activities by different service providers.
- Providing financial support in order to facilitate the continued functioning of support services.

Equity and human rights

The principles of equity and human rights are essential in their own right, but – on the principle that the whole population is threatened by an infectious disease such as COVID-19 if any of the population is threatened – they also represent a means of ensuring good public health practice for the wider community. Some of the good human rights practices that have emerged in this study have included:

- Governments should provide access to financial aid to all people in need, irrespective of the legal status of their work (e.g. sex workers) or of their residency (e.g. irregular migrants).
- Leaders and other influential people should speak out against stigmatisation and hate speech directed at specific populations in the context of the pandemic.
- Those who work in settings where they must work in close proximity with others should be provided with the necessary personal protective equipment.
- Quarantine measures should be implemented proportionately and take into account the rights of the people being quarantined.
- Health services that are particularly relevant to specific vulnerable populations should not be deprioritised on a discriminatory basis, on the basis of there being limited resources during the pandemic.
- Legal protection should be assured for all vulnerable populations.

Needs assessments and evaluations of services

Needs assessment is an essential means of ensuring that support services target the people who need them in the most effective way. Vulnerable populations are often heterogeneous, which means that it is important to identify the specific needs of different communities within a larger vulnerable population. To this end, data should be:

- Collected in order to identify the needs of the specific population/s of concern prior to the initiation of work.
- Disaggregated by population sub-groups, as necessary.
- Quantitative (in order to provide estimates of scale) and qualitative (in order to provide insights into the experiences, concerns, and opinions of users and others as appropriate).

The great majority of the responding organisations reported that they had either conducted an evaluation of their COVID-related work, or they had plans to do so. These efforts should be strongly encouraged, as a means of ensuring that lessons are learned and applied in future and thereby optimising services to the extent possible.

Evaluations should be:

- Focused on both process as well as (where possible) on impact.
- Presented in easily digested formats for use as an empirical basis for advocacy and information purposes, aimed at both the public and at decision makers.

Technical capacity for needs assessment and evaluations is reportedly sub-optimal in many civil society organisations, so authorities may want to facilitate training and financial support for these essential activities. Civil society groups themselves can also enhance these skillsets by reviewing freely available, online evaluation training materials.

Flexibility with service level policies while ensuring continued legal protection

Organisations responding to the survey pointed out various legal obstacles to ensuring the health and safety of particular vulnerable groups. Law enforcement agencies and local authorities may therefore want to give consideration to:

- Relaxing regulations around opiate substitution treatment.
- Bringing about a cessation of arrests, raids, and prosecutions for sex work.
- Facilitating temporary regularisation of immigration status and suspension of returns and removals of irregular migrants.

This does not imply that there should be any relaxation of the legal rights that are enshrined in national and European law that protect vulnerable groups in our societies.

Limitations of the study

Due to competing priorities or lack of awareness of this survey, not all organisations supporting the different vulnerable populations in the EU/EEA and the UK had the opportunity to complete the survey. Although we received two or more responses in relation to each of the vulnerable populations that we had targeted, we may still be missing important insights and experiences from organisations that did not respond.

Further, time constraints required that our literature review was conducted rapidly. It is therefore possible that we may have missed some key documents for some of the vulnerable populations.

In spite of these acknowledged limitations, triangulation between the findings from the survey and the literature points to broad consistency between the two datasets. This indicates that we have identified the key areas of concern on the topic of support service provision for medically and socially vulnerable populations in the EU/EEA and the UK during the COVID-19 pandemic.

Consulted experts

ECDC experts (in alphabetical order): Lisa Ferland, Tjede Funk, John Kinsman, Teymur Noori, Kate Olsson, Anastasia Pharris, Senia Rosales-Klitz

External experts (in alphabetical order): Tamas Molnar, Cianán Russell, Annabel Seebohm, Thomas Seyler, Alyna Smith, Luca Stevenson, Milan Šveřepa, Bernadett Varga, Julia Wadoux.

All external experts have submitted declarations of interest, and a review of these declarations did not reveal any conflicts of interest.

We also acknowledge comments on a draft version of this report from the European Commission's Directorate-General for Employment, Social Affairs and Inclusion (DG EMPL).

Annex 1. The survey instrument

Survey on socially and medically vulnerable populations in the EU/EEA and the UK during the COVID-19 pandemic

Background

This survey is being conducted across the EU/EEA and the UK as part of ECDC's efforts to identify good practices aimed at addressing the challenges faced by people living in vulnerable situations during the COVID-19 pandemic. The results of the survey – including the good practices identified and the lessons learned – will be synthesised and included in guidance documents to be published by ECDC.

Our focus in the survey is on two broad groups of people who may have specific needs or vulnerabilities with regard to Covid-19 prevention and control:

- **People who are medically vulnerable:** These include the elderly (defined here as aged 60+), and people with underlying health conditions (e.g. high blood pressure, overweight /obese, diabetes etc.) that could make them more likely to develop severe disease if infected. Medically vulnerable people may face a range of difficulties caused by their need to be shielded, or 'cocooned', from the rest of society for an extended period as a means of reducing their risk of infection.
- **People living in socially vulnerable situations:** These could include, among others, physically disabled people, people with mental health problems, people with learning disabilities, homeless people, people living in abusive household settings, ethnic minorities, people from the LGBTI community, and undocumented migrants. The challenges that people living in socially vulnerable situations already face in their daily lives may be substantially exacerbated by the various restrictions that have been imposed by national authorities since the Covid-19 pandemic struck the EU/EEA and the UK.

Objectives of the survey

1. To develop an understanding of efforts by civil society, NGOs and religious organisations as well as by national and regional authorities in the EU/EEA and the UK aimed at supporting people who have medical and social vulnerabilities during the Covid-19 pandemic.
2. To identify good practices, innovative approaches, operational challenges, and lessons learned that could be applied in other Member States.

Tip for completing the survey

When responding to the questions below, please bear in mind that this is a qualitative survey that does not aim to develop a comprehensive or complete database of all the activities currently ongoing in the EU/EEA. Rather we are aiming to capture details of the key issues involved in supporting these different populations throughout the region. Therefore, we would prefer to receive more detail on fewer interventions – the ones that best illustrate the operational challenges faced in your country, and the lessons learned – than limited details on many interventions.

Please note:

- The deadline for responses to the survey is 11.59 CET on Tuesday June 2.
- You are welcome to write your response in any European language, though English is preferred if possible.
- The best practices and lessons learned presented in our reports will be given anonymously, though if relevant, mention may be made of the country in question. No specific, named examples will be highlighted without the explicit written consent of the organisation/agency /institution concerned.

Thank you very much for your important contribution to this work.

ECDC COVID-19 Response team

1a. Please give the name of the country (or, if appropriate, the countries) that you are reporting about (more than one option allowed).

- Albania
- Austria
- Belgium
- Bulgaria
- Croatia
- Cyprus
- Czechia
- Denmark
- Estonia
- Finland
- France
- Germany
- Greece
- Hungary
- Iceland
- Ireland
- Italy
- Latvia
- Liechtenstein
- Lithuania
- Luxembourg
- Malta
- Montenegro
- Netherlands
- Norway
- Poland
- Portugal
- Republic of North Macedonia
- Romania
- Serbia
- Slovak Republic
- Slovenia
- Spain
- Sweden
- Switzerland
- Turkey
- United Kingdom

1b. If relevant, also indicate which region/province/state you are reporting about (100 characters maximum)

2a. What is the name of the agency, organisation or institution that you work for? (100 characters maximum)

2b. Please give the agency's/ organisation's/ institution's web address (50 characters maximum)

3. Please provide a relevant contact email address if you are interested in receiving a link to the final report/s, and if you are willing to be contacted by ECDC for follow-up questions or clarification of your responses. (50 characters maximum).

4. Which group/s does your agency or organisation focus on? (more than one response allowed):

- Ethnic minorities
- Homeless people
- People aged over 70 years
- People in the LGBTI community
- People living in abusive household settings
- People living with diabetes
- People living with hypertension
- People living with obesity
- People with learning disabilities
- People with mental health problems
- People with substance dependence/problematic substance use
- Physically disabled people
- Undocumented migrants

Any other groups that are not mentioned above (please identify the group/s) (200 characters maximum)

5. Please give at least one example of the services that your organisation has provided/provides for the group/s indicated in Question 4 during the COVID-19 pandemic. (1500 characters maximum)

6. What have been the main challenges in providing these services? How have you in your organisation or agency attempted to overcome these challenges? (1500 characters maximum)

7. Overall, what do you consider to have been the main successes in the services your organisation has provided for the populations identified above during the COVID-19 pandemic? (1500 characters maximum)

8. Briefly describe the main lessons that you have learned in your country – based on both the challenges and the successes – in the provision of services to the people you support and that could be transferable to other EU/EEA Member States. (1500 characters maximum)

9a. To your knowledge, has your agency or organisation conducted any sort of evaluation of the support services it has provided during the COVID-19 pandemic?

- Yes
- No
- Don't know

If you answered 'yes', please briefly summarise the findings of the evaluation. (1500 characters maximum)

If you answered 'no', please explain why no evaluation has been conducted. (1500 characters maximum)

9b. If you answered 'No' or 'Don't know', are there plans to conduct evaluations of these services?

- Yes
- No
- Don't know

10. Please add below any additional information, and/or links to documents and reports, that you think could be helpful for this survey. (1500 characters maximum)

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