



**Healthy London
Partnership**



COVID, Inequalities and BAME Communities: Implications for HIV Prevention?

Presentation by Professor Kevin Fenton

London Regional Director of Health

Public Health England

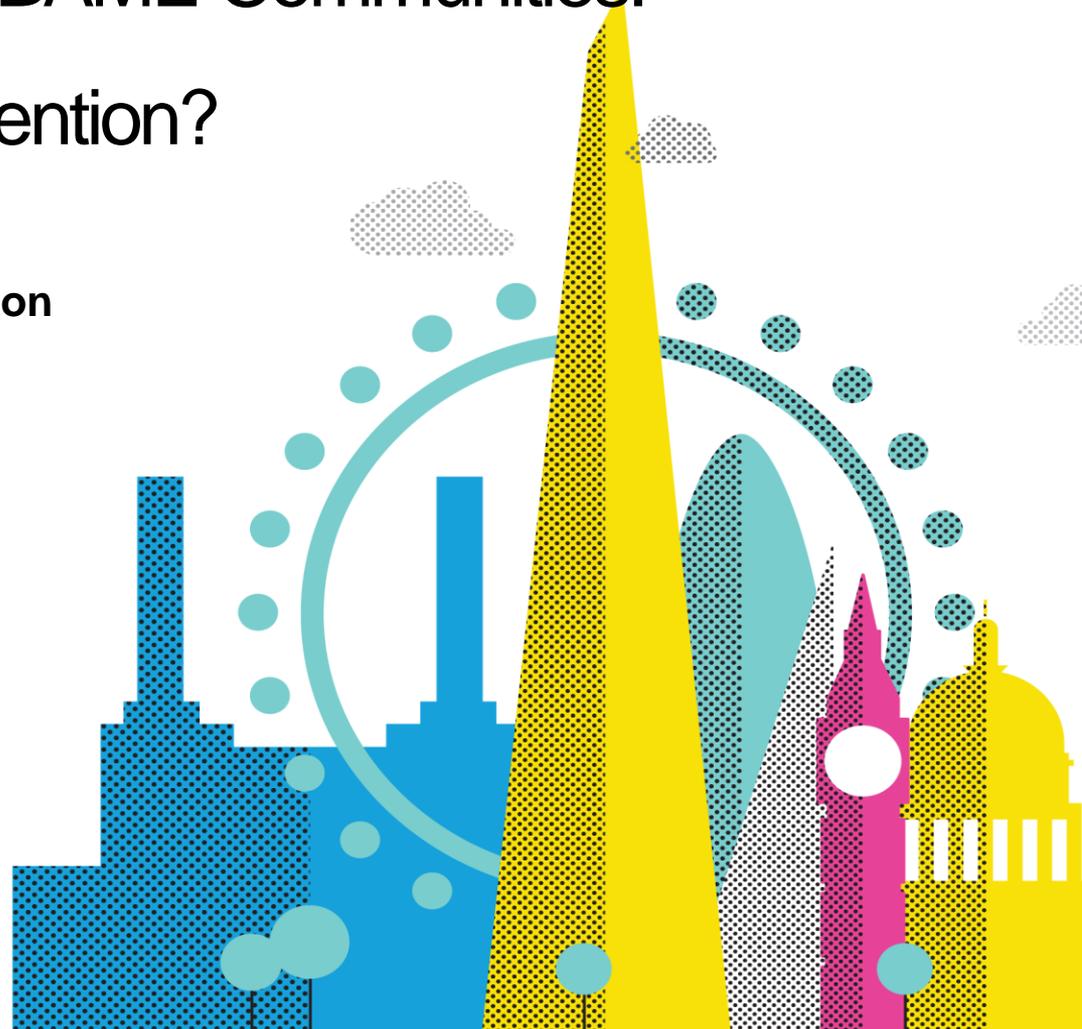
Hosted by Jemma Gilbert

Director of Transformation

Healthy London Partnership



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Beyond the data - Understanding the impact of COVID-19 on (BAME) communities

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Evolution of the COVID-19 pandemic

The Covid-19 pandemic

30 Dec 2019



Published Date: 2019-12-30 23:59:00

Subject: PRO/AH/EDR> Undiagnosed pneumonia - China (HU): RFI

Archive Number: 20191230.6864153

**Possible first infected person:
a Hubei resident aged 55 on
17 Nov 2019**



July 2020



No data 0 50,000 100,000 150,000 200,000 >250,000

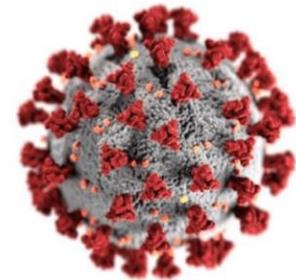
Source: European CDC – Situation Update Worldwide - Data last updated 1st Jul, 11:33 (GMT+02:00), European CDC – Situation Update Worldwide CC BY

Countries reporting cases: 188
Total confirmed cases: >10 million
Deaths: >500,000

What we know about COVID-19 -1

SARS-CoV-2 Transmission

- **Person-to-person transmission (<6 feet) via respiratory droplets (>5 μ m diameter)**
- **?Aerosols: <5 μ m particles that remain in the air over time and distance**
- **Infected surfaces**
- **Virus found in stool, blood, semen and ocular secretions; role in transmission unknown**
- **Animals (including domesticated) not major source of human infection**



What we know about COVID-19 - 2

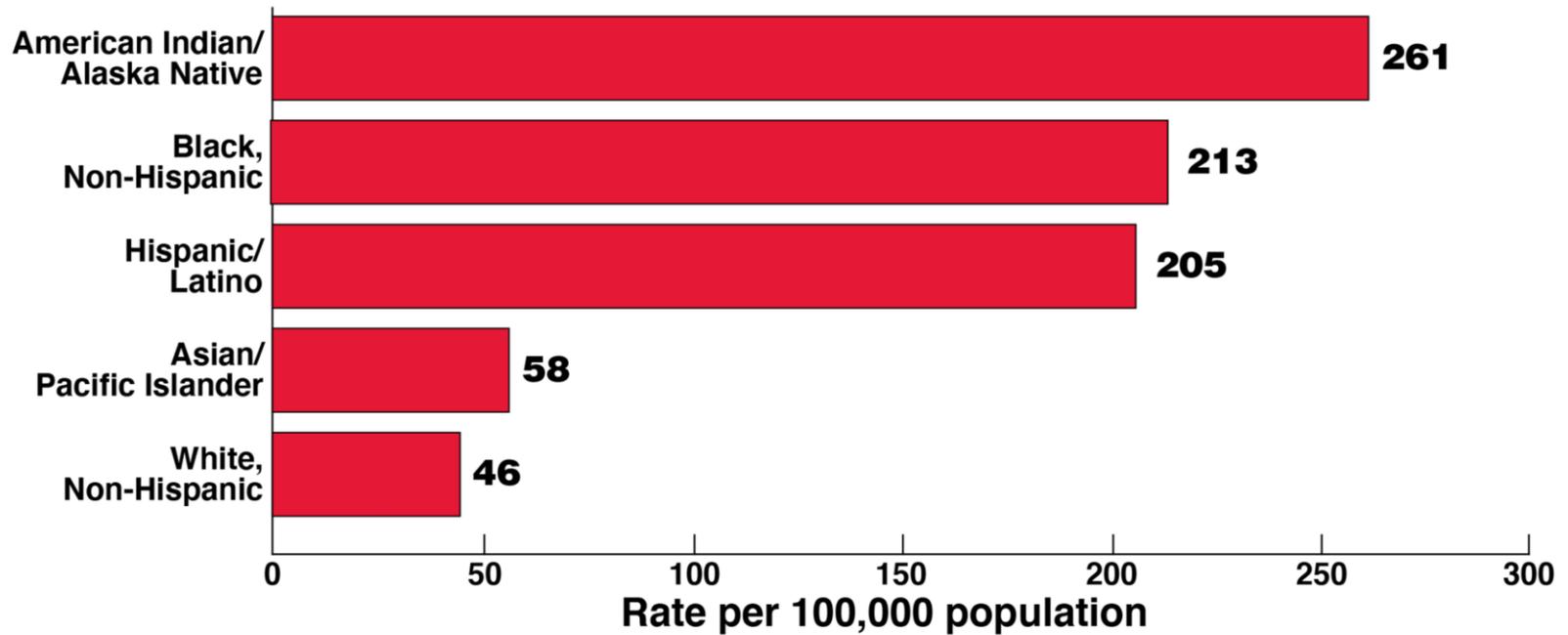
Underlying Medical Conditions Strongly Associated with Increased Risk for Severe COVID-19 Illness

- **Chronic kidney disease**
- **Chronic Obstructive Pulmonary Disease (COPD)**
- **Immunocompromised state from solid organ transplant**
- **Obesity (BMI \geq 30)**
- **Serious heart conditions (e.g. heart failure, coronary artery disease, cardiomyopathies)**
- **Sickle cell disease**
- **Type 2 diabetes mellitus**

Source: CDC, 6/25/2020

Racial/ethnic disparities in the U.S.

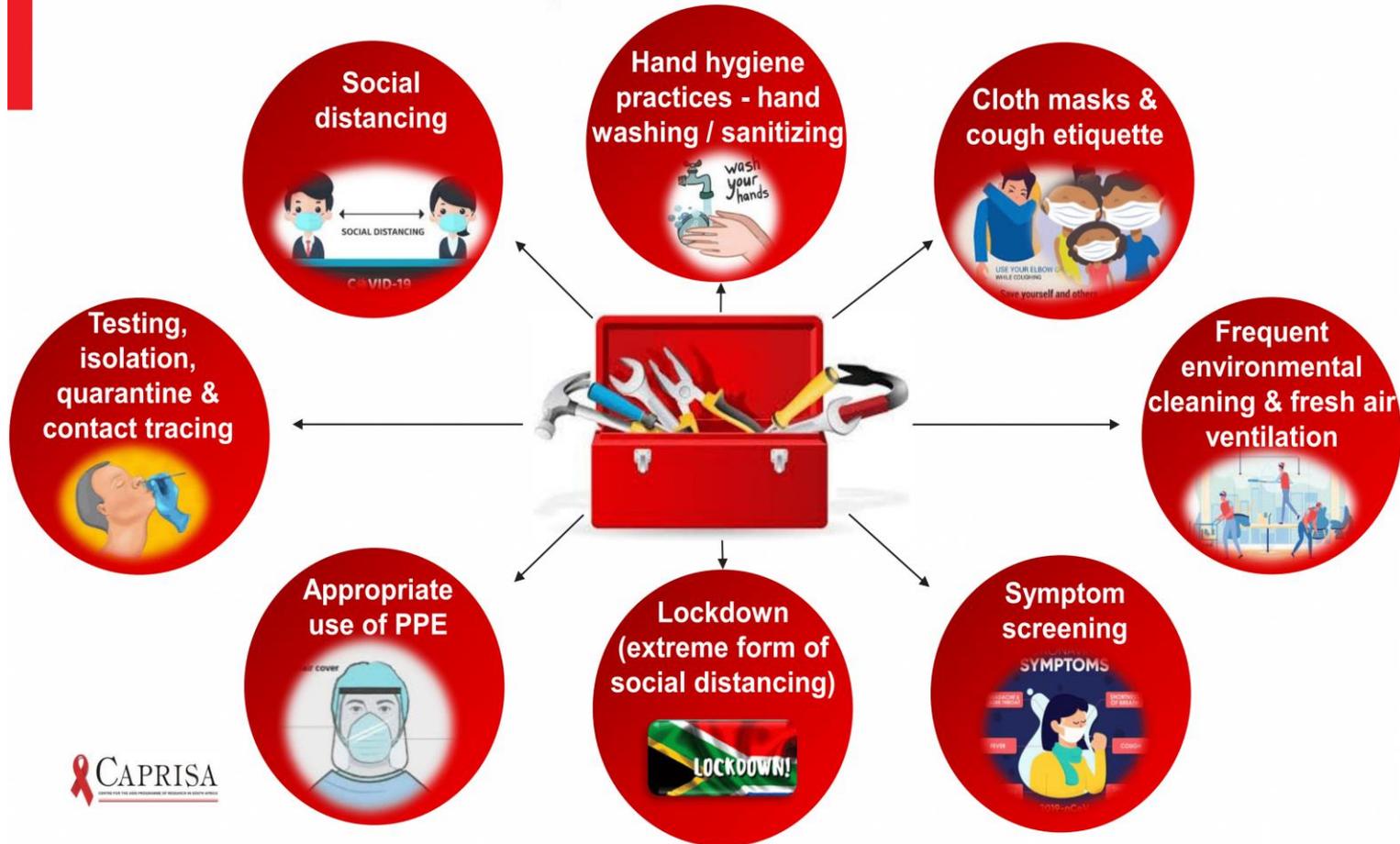
Age-Adjusted COVID-19-Associated Hospitalization Rates by Race and Ethnicity, United States, March 1 – June 27, 2020



Source: CDC COVID-NET. Data from 14 states.

COVID-19 Combination prevention

The coronavirus prevention toolbox...





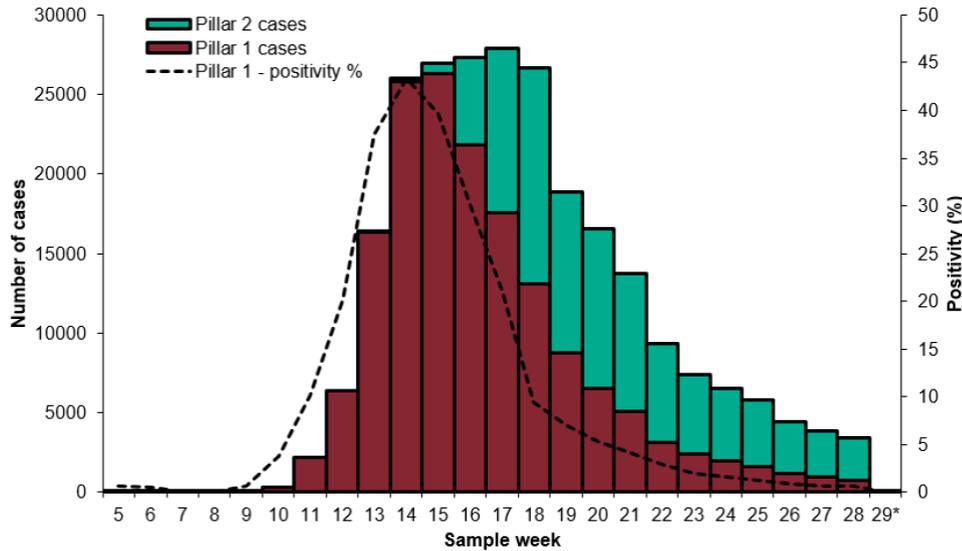
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Disparities in the risk and outcomes of COVID-19

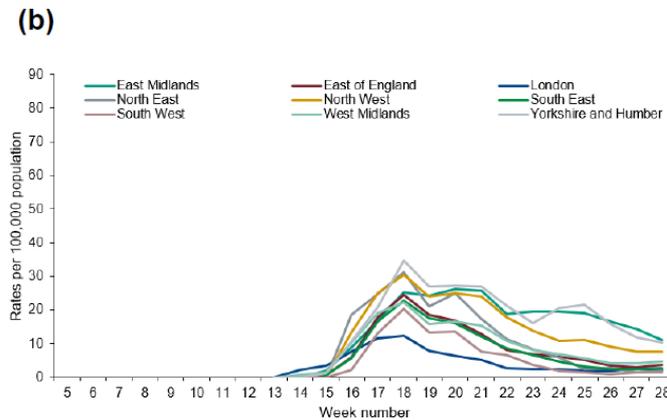
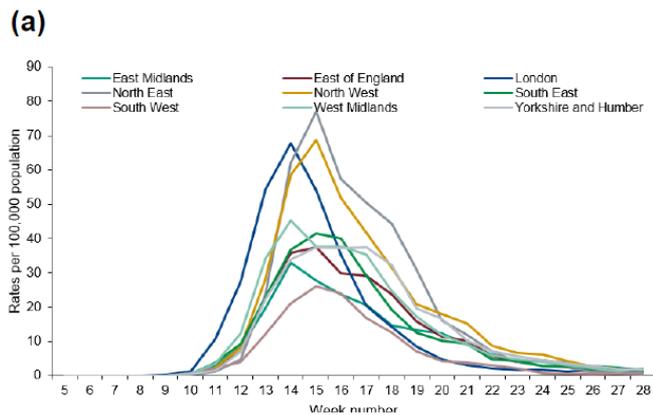
For queries relating to this document, please contact:
coviddisparitiesreview@phe.gov.uk

National context



Overall case numbers and positivity continue to decrease in week 28. The highest number of cases continued to be seen in the older age groups, in particular in the 85+ age group. Rates and positivity of cases continue to be highest in the North and Central regions of England.

Laboratory confirmed COVID-19 cases tested under Pillar 1 (n=162,420) and Pillar 2 (n=87,959), based on sample week with overall positivity for Pillar 1 only (%)



Weekly laboratory confirmed COVID-19 case rates per 100,000 population tested under (a) Pillar 1 and (b) Pillar 2, by PHE Centres and sample week

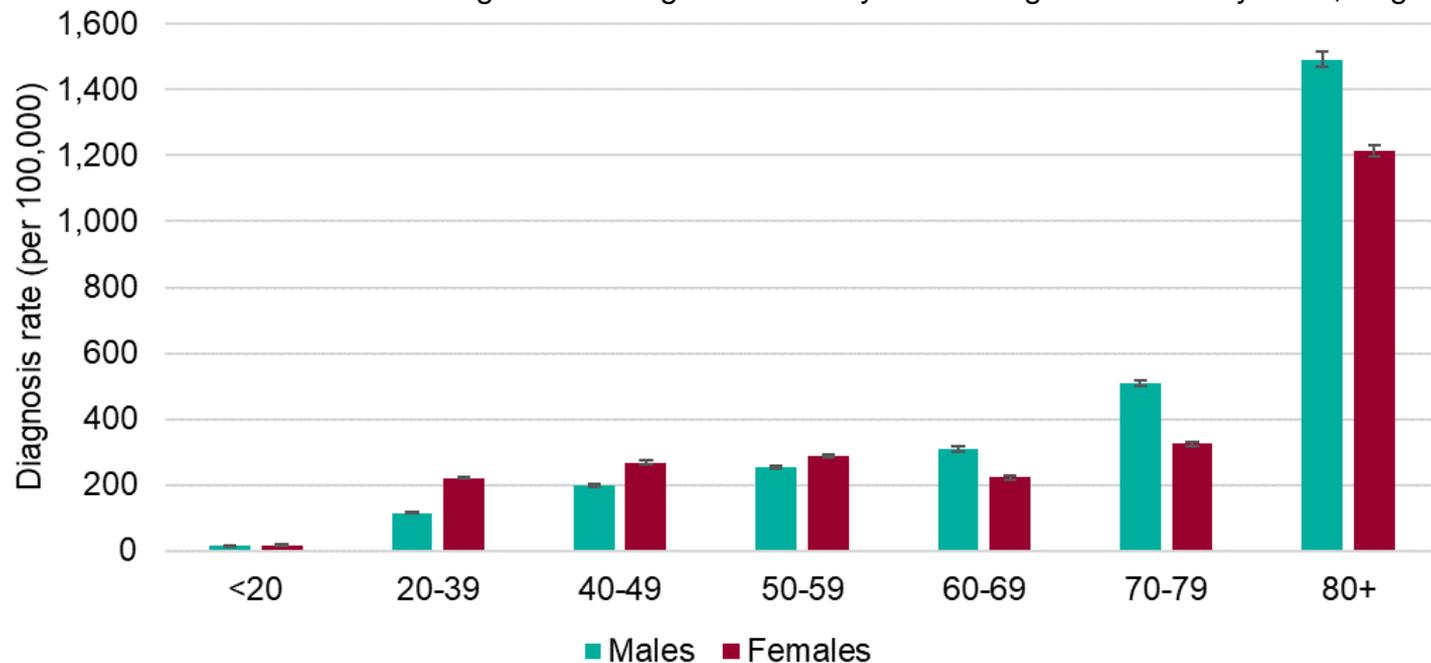
PHE Review on Disparities

- Summarised the findings of the descriptive review of data on disparities in the risk and outcomes from COVID-19.
- These findings are based on surveillance data available to PHE at the time of its publication, including through linkage to broader health data sets.
- It confirms that the impact of COVID-19 has replicated existing health inequalities and, in some cases, has increased them.
- These results improve our understanding of the pandemic and will help in formulating the future public health response to it.

Cases - Age and sex

- **Diagnosis rates increase with age.**
- **Among people under 60, diagnosis rates were higher in females than males, and among people aged 60 years and older, diagnosis rates were higher in males**

Figure 1.2. Diagnosis rates by sex and age as of 13 May 2020, England

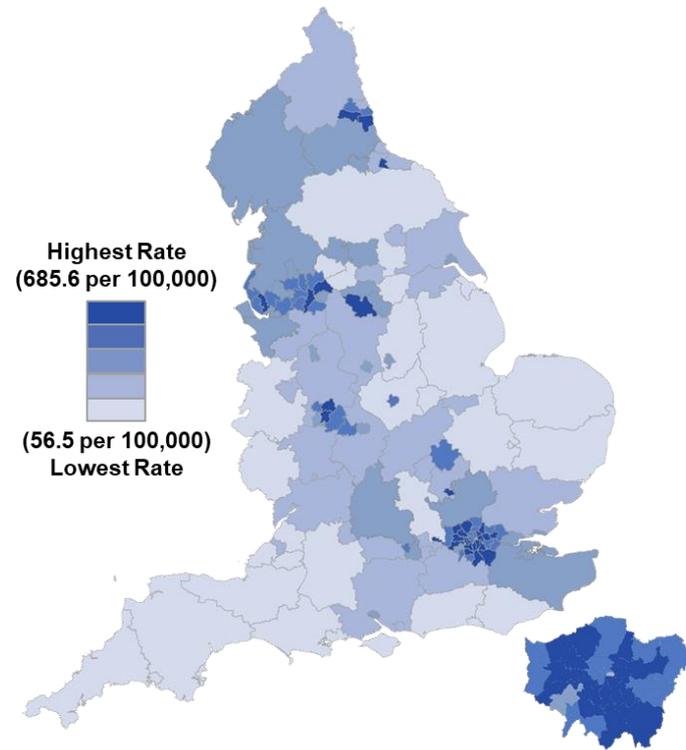


Source: Public Health England Second Generation Surveillance System

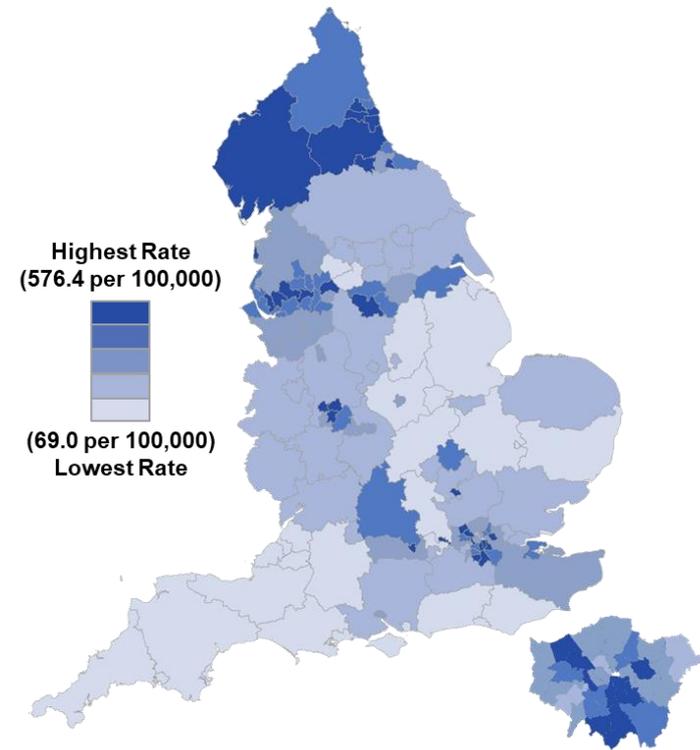
Cases - Geography

Maps 2.1A and 2.1B: Age standardised diagnosis rates by local authority and sex, as of 13 May 2020, England

Males



Females



Among males there was a 12-fold difference in age standardised diagnosis rates between local authorities and an 8-fold difference in the rates among females

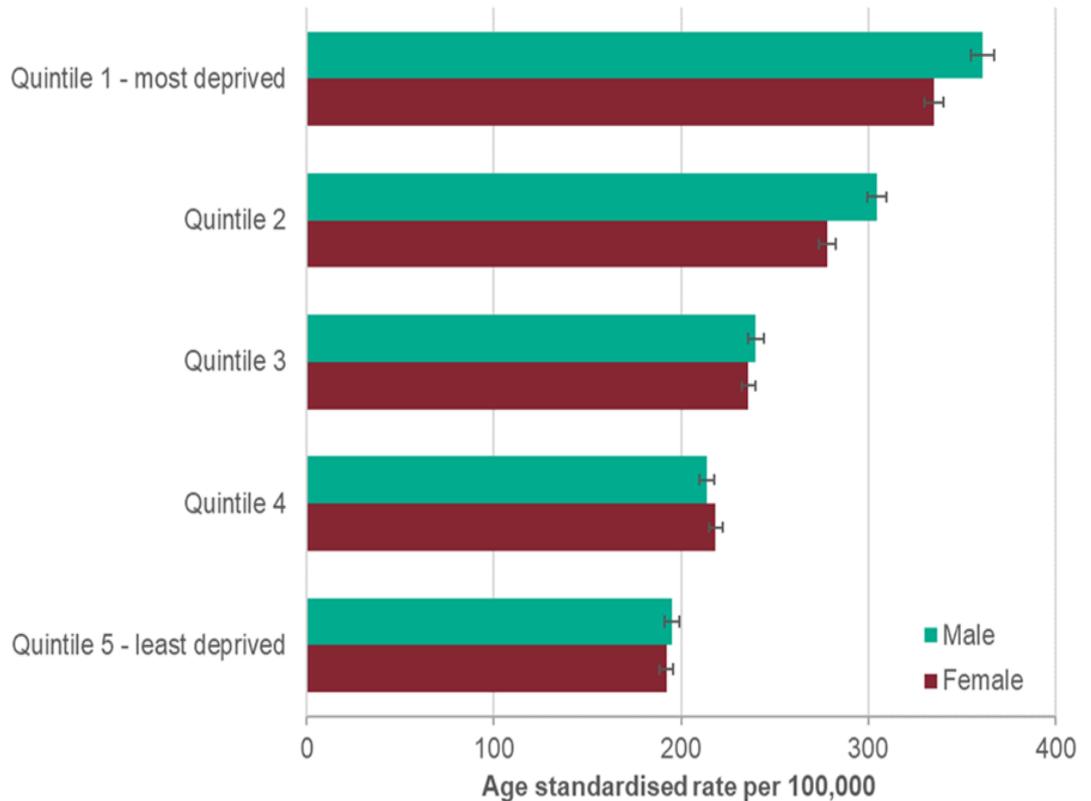
Source: Public Health England Second Generation Surveillance System

Cases - Deprivation

The rate in the most deprived quintile was 1.9 times the rate in the least deprived for males and 1.7 times the rate for females

Figure 3.2: Age standardised diagnosis rates by deprivation quintile and sex, as of 13 May 2020, England

IMD 2019 deprivation quintile

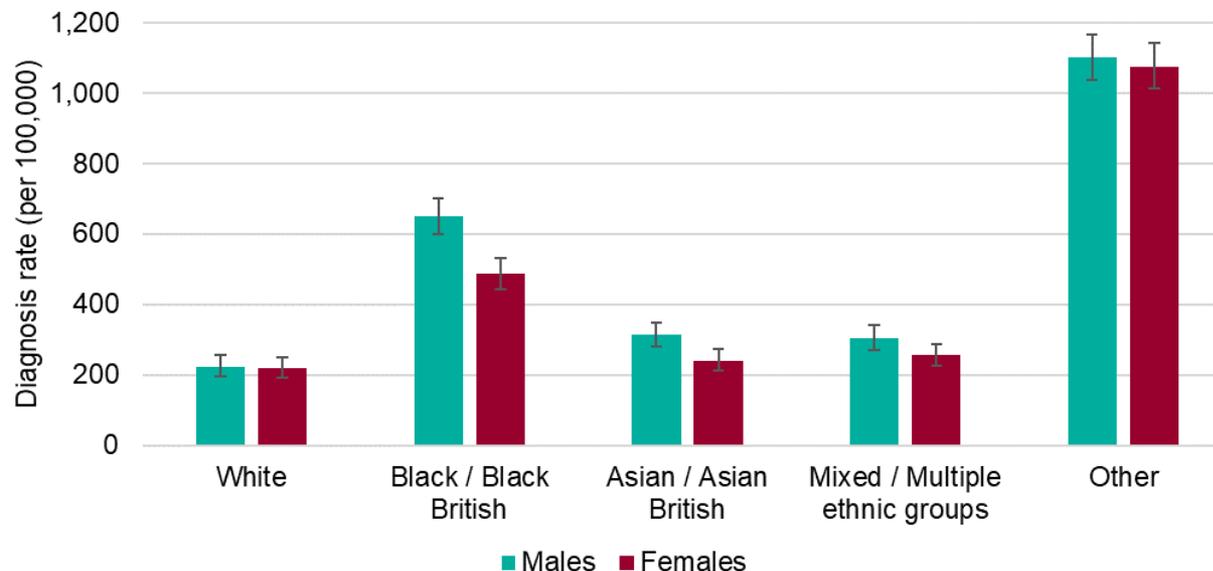


Source: Public Health England Second Generation Surveillance System

Cases - Ethnicity

The highest age standardised diagnosis rates of COVID-19 were in people in the Other and Black ethnic groups, and the lowest rates were in the White ethnic groups

Figure 4.2: Age standardised diagnosis rates by ethnicity and sex, as of 13 May 2020, England



The rates in the Other ethnic group are likely to be an overestimate due to the difference in the method of allocating ethnicity codes to the cases data and the population data used to calculate the rates

Source: Public Health England Second Generation Surveillance System

COVID-19 – Mortality by Sex



Public Health England

Review of data on disparities in the risk and outcomes from COVID-19

CORONAVIRUS MORTALITY RATES BY SEX



Working age males diagnosed with COVID-19 were **twice as likely to die** as as working age females

Between the **ages of 40 to 79**, the death rates among males were **around double the rates** in females, compared with **1.5 times** for all causes in previous years

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[GOV.UK/coronavirus](https://www.gov.uk/coronavirus)
[NHS.UK/coronavirus](https://www.nhs.uk/coronavirus)

COVID-19 – Mortality by Age

CORONAVIRUS MORTALITY RATES BY AGE

The largest disparity
found was by **age**



Among people already diagnosed with COVID-19, people who were 80 or older were **70 times more likely** to die than those under 40

75%

of excess deaths occurred in those **aged 75 and over**

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[GOV.UK/coronavirus](https://www.gov.uk/coronavirus)
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COVID-19 – Mortality by Deprivation

CORONAVIRUS INEQUALITIES AND MORTALITY RATES

Risk of dying among those diagnosed with COVID-19 **was higher** in those living in the **more deprived areas** than those living in the least deprived



The mortality rates from COVID-19 in the most deprived areas were

more than double for both **males** and **females**

This is greater than the inequality seen in mortality rates in previous years

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[GOV.UK/coronavirus](https://www.gov.uk/coronavirus)
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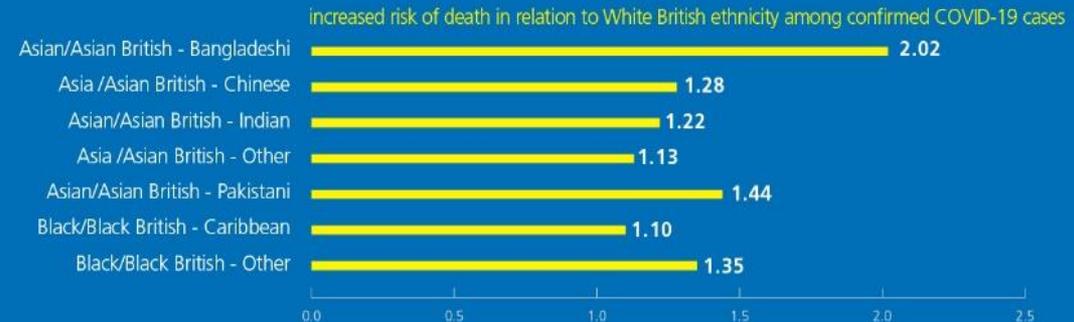
COVID-19 – Mortality by Ethnicity

CORONAVIRUS MORTALITY RATES BY ETHNICITY

Risk of dying among those diagnosed with COVID-19 **was higher** in those in **Black, Asian and Minority Ethnic (BAME)** groups than in **White ethnic** groups

In previous years, the mortality rates were lower in BAME groups when compared to White ethnic groups

An analysis of survival among confirmed COVID-19 cases, using more detailed ethnic groups and after accounting for the effect of sex, age, deprivation and region:



Among people who tested positive for COVID-19 Bangladeshi ethnicity had **around twice the risk of death** than people of White British ethnicity

People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had **between 10 and 50% higher risk of death** when compared to White British ethnicity

People of Black Caribbean ethnicity have **approximately 10% higher risk of death** than people of White British ethnicity

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GOV.UK/coronavirus
NHS.UK/coronavirus

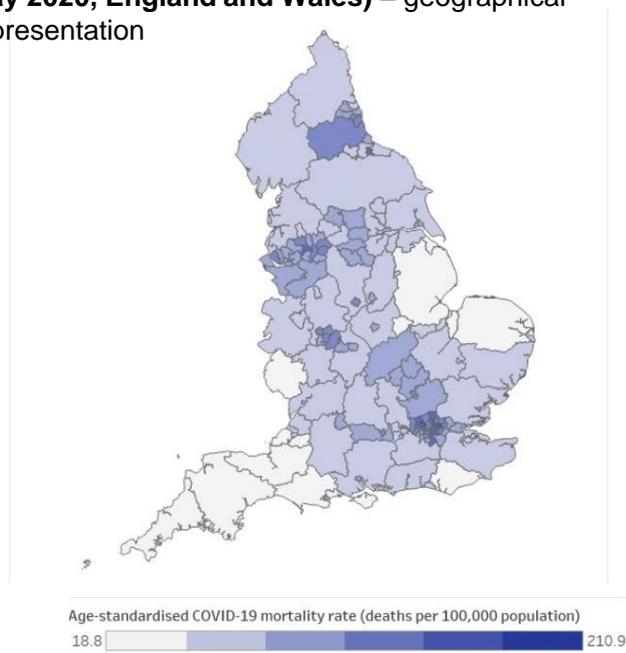
Survival summary

- Influenced by survival factors such as comorbidities, but may also be influenced by any variation in testing between areas
- Risk of dying following a positive test for COVID-19 (pillar 1):
 - 70 times higher in people 80 years or older than those under 40
 - Higher in males than females (2x in working ages)
 - Higher in those living in the more deprived areas vs those living in the least deprived areas (2x)
 - Higher in many Black, Asian and Minority Ethnic (BAME) groups than the White British ethnic group (up to 2x)
- Adjusted for age, sex, deprivation, region and ethnicity, but not the existence of comorbidities
- Other evidence has shown that when comorbidities are included, the difference in risk of death by ethnic group among hospitalised patients is greatly reduced.

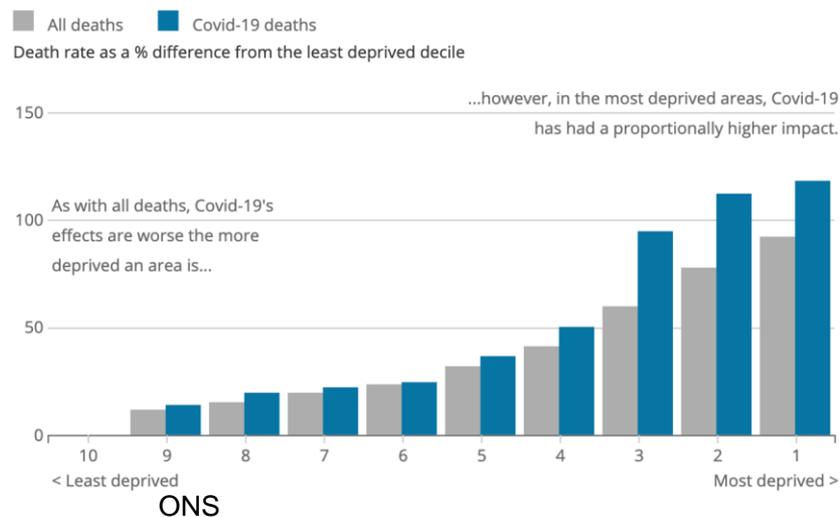
Health inequalities and COVID-19

- PHE's recent review: *Disparities in the risks and outcomes of COVID-19* confirms that COVID 19 has replicated existing health inequalities and, in some cases, has increased them.
- This reinforces the need for targeted action.

Age-standardised COVID-19 mortality rates (March to May 2020, England and Wales) – geographical representation



Age-standardised mortality rates, all deaths and deaths involving COVID-19, Index of Multiple Deprivation, England, deaths occurring between 1 March and 31 May 2020

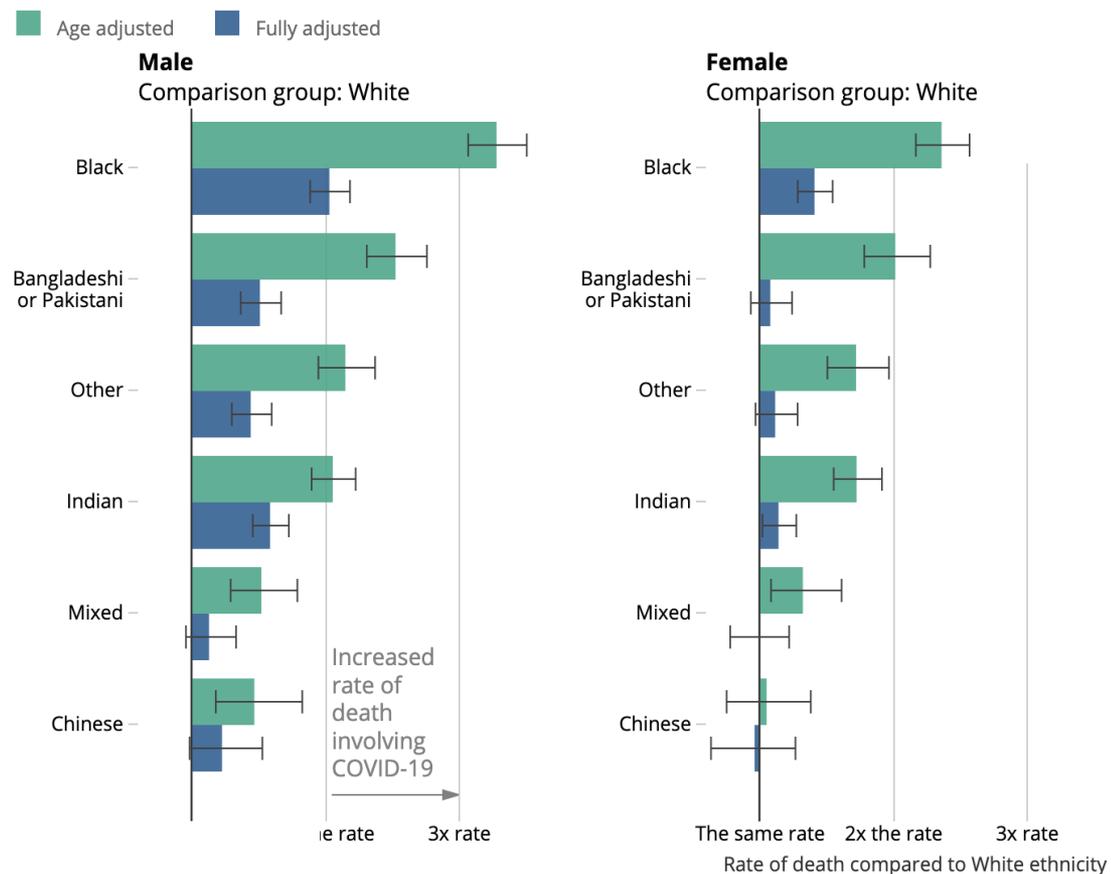


COVID-19 Ethnicity death rates

Rate of COVID-19 death by ethnic group and sex relative to the White population, England and Wales, 2 March to 15 May 2020

PHE's disparities report and other emerging evidence has also demonstrated a disproportionate impact on BAME communities:

- Critical care admission was 28% more likely in South Asian and 36% more likely in Black ethnic groups, compared to the White group (after taking into account age, sex, location, deprivation and comorbidities)
- Risk of death was between 10-50% higher amongst BAME communities compared to people of White British ethnicity after accounting for the effect of age, sex, age, deprivation and region





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Beyond the data - Understanding the impact of COVID-19 on (BAME) communities

Professor Kevin Fenton MD PhD FFPH

Regional Director, PHE London & Regional Director of Public
Health, NHS London

Beyond the data: Understanding the impact of COVID-19 on BAME communities

Stakeholder engagement exercise

- Engaged with over 4000 stakeholders from range of backgrounds
- Devolved nations, CVS, faith groups, local government, DPHs, Royal colleges, private sector, mental health organisations, academia and think tanks. Key objectives were to:
 - Clarify the PHE's research review terms of reference.
 - Engage a broad cross-section of external partners on current concerns, activities, and priorities for work.
 - Identify opportunities for individual & collective action.

Rapid literature review produced in collaboration NIHR

- Report was peer reviewed by the PHE publication process & by external stakeholders.

Beyond the data: Literature review findings

PHE and NIHR found evidence that:

- **BAME groups are more likely to be tested and to test positive**
- **BAME groups have increased risk of death associated with COVID-19**
- **Ethnicity and income inequality are independently associated with COVID-19 mortality**

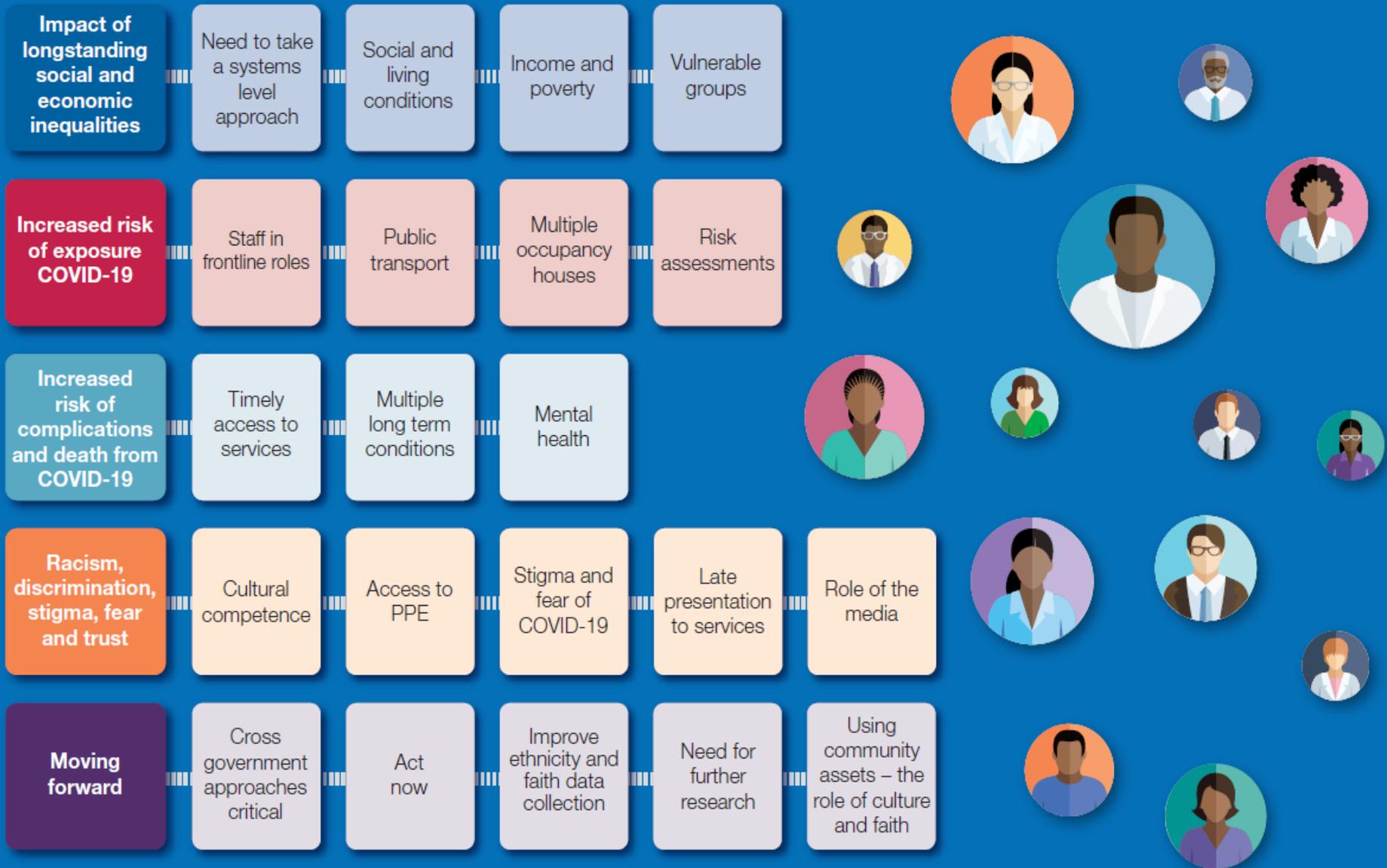
Individuals from BAME groups are more likely to:

- **Live in overcrowded housing**
- **Work in occupations which place them at increased exposure to COVID-19**
- **Use public transport to travel to work**

Individuals from BAME groups may be less likely to:

- **Seek care when needed**
- **Speak up when they have concerns about PPE or testing**

Major and sub-themes emerging from stakeholder engagement sessions



Main themes from stakeholders

1. Longstanding inequalities exacerbated by COVID-19

- **Structural and societal environments & socio economic factors.**

“We have deprivation that is not new - this is an ongoing issue “

2. Increased risk of exposure to and acquisition of COVID-19

- **Key workers, higher use of public transport, multiple occupancy households.**

“BAME workers are significantly more likely to be reliant on public transport than White people. More must be done to recognise, safeguard & protect our vital front-line workers –we must take greater care of those who take care of us & our loved ones”

3. Increased risk of complications and death from COVID-19

- **Higher rates of MLTC, mental health, poorer uptake of prevention services and importance of risk factors such as diabetes, obesity and CVD.**

“For too long we have known that ethnic minorities are at higher risk of CVD, diabetes & obesity & that prevention services are not accessed in time by high risk groups – more must be done.”

Main themes from stakeholders

Racism, discrimination, stigma, fear and trust

- Late presentation for treatment, access to PPE,
- Occupation risk assessment, role of faith and culture, need to rebuild trust.

“BAME members have felt concerned about raising issues because of either previous instances of poor treatment, or a fear that they will face adverse consequences if they speak up.”

“we suffer a lot of racist comments in the Chinese community due to COVID19”

Moving forward

- Act now, cross government action, sustainable change, communications culturally and faith specific, more research needed.

“It’s important that we reframe how we work with communities. We shouldn’t wait for the data reports before taking action, but should be thinking now about what to do differently”

Recommendations

- **Mandate comprehensive and quality ethnicity data collection and recording in NHS and social care data collection systems, including at death certification**
- **Support community participatory research to understand the social, cultural, structural, economic, religious, and commercial determinants and to develop solutions**
- **Improve access, experiences and outcomes of NHS, local government and Integrated Care Systems commissioned services including audits, equity in workforce and employment and rebuild trust.**
- **Accelerate development of culturally competent occupational risk assessment tools for a variety of occupational settings.**
- **Fund, develop and implement culturally competent COVID-19 education and prevention campaigns in partnership with local BAME and faith communities**
- **Accelerate efforts to target culturally competent health promotion and disease prevention programmes for non-communicable diseases**
- **Ensure that COVID-19 recovery strategies actively reduce inequalities caused by the wider determinants of health to create long term sustainable change.**



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COVID-19 and implications for HIV prevention

Professor Kevin Fenton MD PhD FFPH

Regional Director, PHE London & Regional Director of Public
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COVID-19 and HIV: Implications

- 1. Expanding obstacles to treatment access and HIV prevention services**
 - There is limited data on health outcomes among people living with HIV who have COVID-19.
 - Continuity of treatment for HIV is essential during the COVID-19 pandemic as scientists determine how COVID-19 affects people living with HIV.
 - Additional precautions should be taken for people with advanced or poorly controlled HIV
- 2. Exacerbating social and structural barriers to care**
 - In many countries, people living with HIV are no strangers to social and structural barriers that hinder access to HIV-related services, now aggravated by COVID-19.
 - Emergency powers invoked during the pandemic have negatively impacted mental and physical health and may have disproportionately impacted the most vulnerable
- 3. Exposing vulnerabilities at the systems level**
 - The COVID-19 pandemic has highlighted existing vulnerabilities in healthcare systems and their knock-on effects.
 - The lack of serious investment in building functional and resilient health systems in has brought into sharp focus the challenges of providing quality routine healthcare.
 - The HIV response and the COVID-19 pandemic are testing the resilience of many systems.

Conclusions

- **It is a time of unprecedented demands on our public health and community-based HIV prevention partners, and we must work together to help prioritise the steps needed to combat COVID-19, while also delivering essential HIV prevention and treatment services in both traditional and novel ways.**
- **Many of the same systems, organisations, and approaches that have been developed to fight HIV are now integral to the lifesaving efforts to protect vulnerable populations from COVID-19.**
- **Now is the time to move forward with efforts to end the HIV epidemic while considering the needs of the communities and individuals at risk for COVID-19 in every decision.**



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