

Inclusion health principles and practice:

**An equalities and human rights
approach to social and systems
recovery and mitigating the impact
of COVID-19 for marginalised and
excluded people**

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Further information

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1. Purpose

This document outlines how a human rights-based approach will support recovery from the COVID-19 pandemic and the associated control measures. This is necessary to prevent any unintended negative impacts on health for the most marginalised and excluded people in our communities, and to promote equality and reduce health inequalities.

Who is this briefing for?

This briefing provides guidance for policy- and decision-makers in public bodies, planners and managers at all levels in local authorities, Community Planning Partnerships, health and social care, third sector organisations, Public Health Scotland and the Scottish Government.

Key points

- The most marginalised and excluded people in our communities are most at risk of the unintended, non-viral health impacts of the COVID-19 pandemic.
- A participative, human rights-based approach will strengthen our response to mitigate the unintended negative impacts of COVID-19 and protect those who are marginalised and excluded.
- Increases in inequalities are already being seen due to COVID-19. More action is needed to prevent a further rise due to disproportionate increases in morbidity and mortality rates in those who experience the most disadvantage and marginalisation.

2. Background

Inequalities in Scotland already account for 30% of ill health and early deaths.¹ The causes of these inequalities are socially determined, most fundamentally by income, power and wealth. Wider environmental influences, such as health and social care services, work, social and interpersonal factors, also have an impact. These will all be affected by the pandemic itself, the control measures in place, and the easing of those control measures. Unless our responses are carefully planned, it is the most disadvantaged and excluded in our communities that are likely to be the most negatively impacted.

Particular subpopulations with multiple and complex needs experience significant inequalities in health and wellbeing. These groups have experienced inequalities in the major determinants of health and wellbeing, often over generations, which has led to marginalisation and an increased risk of susceptibility to the impacts of COVID-19 and the negative impacts of the control measures.

3. Introduction

The COVID-19 pandemic has caused an exceptional set of circumstances and unprecedented measures to be introduced in an attempt to control the spread of the virus and minimise the loss of life. To prevent these restrictions impacting on people's human rights – not only the right to health, but also the right to food, work and education, housing, safety and security – a human rights-based approach must be taken to mitigate any unintended, longer-term consequences to health and wellbeing.

Inclusion health² is a service, research and policy agenda that aims to prevent and redress health and social inequities among the most vulnerable and excluded populations by taking a human rights-based approach.³ This includes the protection of the fundamental right to health, which is the right of everyone to the highest attainable standard of physical and mental health. An approach underpinned by human rights will

strengthen our response to mitigate the unintended negative impacts of COVID-19 and protect the most marginalised and excluded members of our communities.

4. A human rights-based approach

The right to health⁴ includes not only the right to health and social care services, but also to the wide range of factors that help us to achieve the highest attainable standard of health. The World Health Organization (WHO) endorsed the AAAQ Framework⁵ as standards that ensure services, systems and all the things that influence our health are:

- **Accessible:** Services must be accessible to everyone without discrimination, especially the most vulnerable people. They must be physically and economically accessible.
- **Available:** Facilities, goods and services – both health-related and those that influence health – must be available in sufficient quantity. For example, hospitals, clinics, trained health workers, essential medicines, preventive public health strategies and health promotion, as well as the underlying determinants such as education and childcare.
- **Acceptable:** Health services must be respectful of medical ethics, culturally appropriate, trauma informed and gender sensitive. Medical treatment must be explained in an understandable manner and health workers need to be aware of cultural sensitivities.
- **High quality:** Services must be scientifically and medically appropriate and of good quality. Quality also extends to the manner in which people are treated, and the underlying determinants of health, which must be appropriate and of good quality.

The PANEL principles⁶ provide a framework, which is underpinned by international agreements, to ensure a human rights-based approach to public health work, to make it person focused and ensure support is targeted at the people who need the most help.

- **Participation:** People should be able to voice their experiences and take part in decision-making. Policies and practice should support people to participate in society and lead fulfilling lives.
- **Accountability:** Organisations and people should be accountable for realising human rights. There is a floor below which service standards must not fall, but above that human rights should be understood as a progressive journey towards fulfilling the full potential of every human being.
- **Non-discrimination:** Everyone has the same rights, regardless of their ethnicity, gender, income and religion.
- **Empowerment:** People, communities and groups should have the power to know and claim their rights in order to make a difference.
- **Legality:** All decisions should comply with human rights legal standards.

5. Intersectionality and protected characteristics

Inclusion health refers to those who experience the most marginalisation, exclusion and deprivation in our communities. Inclusion health, therefore, is not a targeted approach for all those with protected characteristics under the Equality Act 2010,⁷ but takes a universal approach (one that includes the whole population) that will proportionally impact on those most in need. A human rights-based approach includes freedom from discrimination, which is covered for some marginalised communities by the Equality Act 2010.

Inclusion health considers the cross-cutting nature (intersectionality) of the features that make up people's identities. This approach to promoting equality addresses the social determinants of health that are common to the inequalities experienced by those who are marginalised and excluded, by focusing on their human rights.

This of course does not counter the crucial responsibility of all public bodies to meet their duties and uphold the principles of the Equality Act 2010 and the public sector equality duty.

6. Non-viral impacts of the COVID-19 pandemic control measures, recovery and renewal

The control measures in response to the COVID-19 pandemic have had the potential to significantly widen inequalities by impacting on the determinants of health. Care must be taken with the implementation and easing of these measures on the road to renewal, remobilisation, planning for recovery and to prevent further unintended impacts of a second wave or local outbreaks of the virus. The non-viral health impacts of the measures put in place to control the spread of COVID-19 have been assessed in health inequality impact assessments.⁸ Of these, some are particularly relevant to those who are marginalised and excluded:

- Increased risk of developing or exacerbating physical health problems, due to an increased underlying vulnerability and lower resilience. Non-COVID care services being displaced, or not being seen as a priority to access social care at this time. Issues with access to medicines and at-home medical treatments.
- Prolonged isolation with social distancing increasing the risk of, or exacerbating, mental health problems; experience of previously lived trauma; and reliance on negative coping mechanisms, such as problematic alcohol and substance use, and online gambling, due to fear and anxiety, uncertainty, stress or boredom. It also has the potential to increase suicidal thoughts and actions.
- Prolonging and intensifying of any already stressful living circumstances such as increased caring responsibilities, poor familial relations, financial concerns, poor-quality housing, alcohol and substance use, and gender-based violence and abuse.

- Isolation, limiting contact with informal support networks such as families, friends and communities.
- Conversely, circumstances such as homelessness or housing insecurity, shared accommodation, rehabilitation services and caring responsibilities could make it difficult for some people to self-isolate or shield and lead to increased fear and anxiety.
- Reduced or changes in capacity and capability of, and ability to access, support services (such as social care services withdrawn or diverted to respond to pandemic, staff off sick or self-isolating or home visits suspended). Increased difficulties accessing mental health services.
- Reluctance to present to services due to own circumstances (for example migrants, people with no recourse to public funds), stigma or due to current situation (not seen as a priority).
- Digital exclusion – a reliance on digital communication channels for messages about the virus, control measures, changes to service provision and education – can make it difficult for people with less stable circumstances, less financial resources, literacy/language or digital literacy issues to access key information and advice. Lack of home-working opportunities.
- Increased exposure to harmful online activities such as grooming and cyber scams.
- Increased financial difficulties and worries for those who have low income, debt, insecure employment, work in the gig economy, have issues with access to benefits or who have no recourse to public funds, or are less able to take employment working from home.
- Those with fewer financial and social resources or physical capabilities may have fewer opportunities to engage in physical activity, or obtain food and other basic necessities.

- Difficulties accessing substances or support services (due to social distancing, loss of income, prescriptions) for problematic users could lead to increased risk of harm including physical withdrawal, anxiety, stress and crime.
- Increased risk and incidence of stigma and discrimination for some population groups due to misperceptions of origin or transmission of COVID-19 leading to hate crime and racist abuse.
- Increased social disorder and unrest, certain types of crime (for example cyber, financial) and other exploitation such as 'doorstep criminals'.
- Women in particular are at increased risk of loss of income (as often primary care givers), stress, gender-based violence and abuse, sexual exploitation and unintended pregnancy.
- Children and young people – particularly those already in vulnerable situations including poverty, experiencing abuse, in the care system, in periods of transition (for example, leaving care or school leavers) – are at increased risk of unintended negative impacts including increasing/start of abuse, disruption to education and social development, malnutrition affecting growth and physical development, and worsening mental health.

7. Short-, medium- and long-term impacts

It may be helpful to consider the wider, non-viral health impacts of the COVID-19 pandemic in the short, medium and longer term. These will not be linear and will vary depending on needs and circumstances. Key populations will incur different stages of response as waves or outbreaks occur, which may continue into the eventual post-viral 'new normal'.

Short term: Crisis response and control

Responding flexibly to the daily challenge of increased transmission in the population to achieve an evidence-based service response to the increased workload on the health and social care system.

Examples of impacts

- Staff, resource and service delivery implications.
- Exclusion from Scotland's economy and wealth through poverty via a reliance on a complex, multi-layered welfare system and systemic barriers to education and employment opportunities.
- Exclusion from the right to acceptable, available, accessible and good-quality housing and thereby the right to an adequate standard of living and health.
- Demand for social housing not met.
- Difficulty accessing food, due to demand, access or exclusion from priority shopping.

Populations most affected

- Those at most critical risk due to health conditions (including shielded people) or with multiple and complex needs.
- People who are 70 years or older, pregnant or have certain clinical conditions at a higher risk (those advised to self-isolate as per NHS inform guidance⁹ and invited to use the national helpline).
- People with physical disabilities.

Medium term: Recovery

Viral pandemic management leading to the point at which the condition is under acceptable population control.

Examples of impacts

- Mental health: Major increase in population anxiety and mental health problems.
- Exclusion through stigma and a lived history of multiple disadvantage and trauma.
- Becoming unemployed, erosion of rights at work, gig economy and reliance on zero-hour contracts.
- Bias against women in the workplace: gender pay gap, adequate provision for parenting.
- Re-establishment of sanctions, fines and prosecutions.
- Difficulties accessing or wearing face masks leading to anxiety and/or verbal abuse.

Populations most affected

- Those most excluded or disadvantaged in society – people who are homeless; those with drug or alcohol issues; some migrants; refugees; people with no recourse to public funds; Gypsy Travellers; people with physical or learning disabilities; people with long-term mental health conditions; care-experienced children; those experiencing domestic violence; and those in contact with the justice system.

Longer term: Renewal

This is the point at which areas regain a steady state for social and economic activity and the longer-term consequences become more evident.

Examples of impacts

- Increase in mental health problems (see above).
- Increased risk of suicide.
- Increase in gender-based violence.

- Exclusion from the right to health.
- Services not sharing data, co-operating or collaborating.
- Disruption of access to public services and support through sanctioning, criminalisation and misuse of personal data.
- Impacts on women who carry the greater burden of care.
- Impacts on future employment opportunities and income due to disrupted education.
- Employment opportunities.

Populations most affected

- People who are newly traumatised – for example from gender-based violence, bereavement, work pressure or post-traumatic stress disorder (PTSD).
- Carers and frontline staff.
- Children and young people who are less able to engage with home schooling or blended learning approaches.
- Adults of working age who are less able to take up home-working and upskilling opportunities.

8. Recommendations and further information for an inclusive response to social and systems recovery from COVID-19

The following recommendations are intended to provide a starting point for partners working in the public and voluntary sectors across Scotland. They aim to support them to take a human rights-based approach to planning responses to COVID-19, recovery and renewal, thereby mitigating the impact on the most marginalised and excluded in our communities. The recommendations should be read in conjunction with the points for further information.

Recommendations

- 1** National and local partnerships to demonstrate explicit consideration for marginalised communities in their response to COVID-19 and plans for recovery and renewal.
- 2** Consideration of human rights underpinning all work, identifying opportunities for participative and assets-based approaches wherever possible.
- 3** Multi-agency approaches to be taken that support the efforts of the third and community sector organisations that are best placed to reach and engage successfully with the most marginalised communities.
- 4** Seek out and understand lived experience to inform service development to remove the barriers for the most marginalised and excluded.
- 5** Identify and increase opportunities for greater participation of marginalised communities in service planning, policy and strategy groups, both local and national.
- 6** Identify and support people who are living in challenging and vulnerable circumstances to follow COVID-19 guidance, if their circumstances make this difficult (for reasons outlined above).

- 7** Identify and support people living within vulnerable circumstances who may be more at risk of infection during a second wave of COVID-19.
- 8** Support people to understand their rights, responsibilities and entitlements to health and health services.
- 9** Ensure a variety of approaches to communicating with marginalised communities, including any translation needs. Consider use of language/s, and plain language that is clear, concise and appropriate to the audience, avoiding use of complex vocabulary.
- 10** Consider the effectiveness of certain communication channels, formats and cultural interpretation of key messages and access to information on control measures and service responses.
- 11** Consider health literacy needs within marginalised communities and the need to continue to support people to access, engage with and interpret public health information and guidance. Consider learning styles, formats and any impairments that may affect the ability to receive and adopt information, and adapt written and verbal communications accordingly.
- 12** Recognise the risks of digital exclusion. Ensure public health messages and guidance is accessible by people without access to the internet, telephones, or other digital services, or who may not have good levels of digital literacy, and that online access does not exclude people with communication needs.
- 13** Embed trauma-informed approaches to consider both pre-existing needs and the potential psychological impact of COVID-19.
- 14** Understand the stigma experienced by some communities, and how this can exacerbate health inequalities. Take steps to tackle stigma, including the impact of the social stigma of COVID-19. Be aware of the terms and words used in communications and verbal interactions – avoid generalisations and correct misperceptions (see WHO guide below).

- 15** Be aware of the differing needs relating to gender and ability to respond to changes in control measures.
- 16** Multi-agency working to capture data on the impact of COVID-19 on marginalised communities.
- 17** Monitor and evaluate strategic guidance/funding for learning about how these approaches are inclusive of marginalised communities and where there are gaps.
- 18** Be aware of the policy landscape and how this can support your work and vice versa.
- 19** When making budget decisions (money spent and revenue raised), identify ways in which these decisions could be improved to advance human rights and address inequalities.

The sources of further information include practical tools to support the implementation of the recommendations. For example, the Scottish Human Rights Commission self-assessment toolkit contains prompt questions for each of the PANEL principles, and the Scottish National Action Plan for Human Rights (SNAP) year three report (2016) is accompanied by case studies on the right to housing, the right to health, and poverty.

Further information

- [Guide to the AAAQ Framework \(WHO\)](#)
- [Equality and Human Rights Commission advice and guidance](#)
- [Equality and Human Rights Impact Assessment](#)
- [Scottish Human Rights Commission: A self-assessment tool](#)
- [SNAP Year Three Report and Case Studies](#)
- [Health Inequalities Impact Assessment](#)

- [Putting Assets-based approaches into Practice: Identification, mobilisation and measurement of assets](#) (Glasgow Centre for Population Health)
- [The Health Literacy Place](#) (NHS Education for Scotland)
- [Scottish Framework for Trauma Informed Practice](#) (NHS Education for Scotland)
- [Trauma and Homelessness](#) (European Federation for Organisations Working with Homelessness)
- [Guide to Preventing and Addressing Social Stigma](#) (WHO)
- [Scottish Framework for Gypsy Traveller Communities](#)
- [Support for women involved in prostitution](#) (CLiCK)
- [COVID-19 and Gender Equality](#) (European Institute for Gender Equality)
- [Tools for Monitoring and Evaluation](#) (Public Health Scotland)
- [Evaluation Support Scotland](#)
- [Support for community organisations during the COVID-19 crisis](#) (Scottish Community Development Centre)
- [A Connected Scotland: our strategy for tackling social isolation and loneliness and building stronger social connections](#) (Scottish Government December 2018)
- [Six key questions to ask when making budget decisions](#) (Scottish Government 2019)

9. Concluding remarks

This document was produced by the multi-agency Inclusion Health Group of the Social and Systems Recovery from COVID-19 programme led by Public Health Scotland. The group would be interested in receiving any comments or feedback for progressing the human rights and inclusion health agenda. In particular, examples of good practice where a human-rights approach has influenced effective policy and where there may be potential for collaboration. Please get in touch by emailing healthscotland-placeandequity@nhs.net with the subject header 'FAO Inclusion Health Group'.

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