The Association of Schools of Public Health in the European Region

Addressing the long shadows of the COVID-19 pandemic's unjust, unequal, deep, widespread and enduring impacts over the next decade

Building Forwards Fairly 2022-2032:
What can we learn from COVID-19's unequal and unjust losses in Europe?
Second ASPHER Statement on the Pandemic Impacts on Health Inequalities in Disadvantaged Vulnerable Populations in the European Region

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We acknowledge that this ASPHER 2nd Statement focusses on the still emergent reports covering the 52 countries in the WHO European, that ASPHER normally has as its main remit. We wish to acknowledge that the Global picture of COVID-19 related inequalities has not been covered here and would encourage all our fellow public health networks in developing a world-wide overview.

Cover Graphic: Tobias Weitzel, ASPHER Young Professional

1. Learning from the pandemic's deep and widespread unequal and unjust losses in Europe

1.1. ASPHER's developing position during 2020-21

The COVID-19 pandemic has already led to, and will probably further lead to, a large-scale loss of life, health and well-being for the most disadvantaged vulnerable population groups – on a European scale as well as globally. It is time to draw lessons from past developments necessary to inform public health policies, practice, education and research over the next ten years and possibly beyond.

The Association of Schools of Public Health in the European Region (ASPHER) is a network of schools for public health and has a specific focus on education and research. Member schools are often also engaging in policy consultation and public health advocacy within their countries, while ASPHER is doing so together with other public health networks on the European Regional level. We focus here on reviews and some case studies from those 53 countries, while recognising that there is a need for a global impetus to address the inequalities and legacies from COVID-19 in the next decade and beyond.

This statement follows **ASPHERs first statement on COVID-19 related inequalities** in June 2020, *'COVID-19 – How and why is the pandemic exacerbating and amplifying health inequalities and vulnerabilities in Europe?*[1] Here ASPHER's second statement highlights our continuing concerns about the multiple dimensions of this pandemic's inequalities and the anticipated enduring impacts over at least the next ten years.

In ASPHER's 'Basic Terms' e-booklet on inequalities, we acknowledged key concepts such as the syndemic and underlying determinants of inequality.[2] The e-booklet is part of a 'Basic Terms' series for Schools of Public Health and is currently being updated to include important extra teaching and policy concepts, such as intersectionality and about relational determinants observed during COVID-19.

ASPHER continues to advocate for reducing global inequity of access to vaccines, [3] and to promote better ways of supporting hard to reach groups in Europe.[4] Working with our volunteer Young Professionals and others, ASPHER contributed to highlighting vulnerability and inequality during 2020 and 2021. For example, by producing reports on pandemic vulnerabilities for specific groups or settings such as prisons,[5] homeless,[6] and school children.[7]

Necessary interventions such as social distancing and case/contact isolation have protected many millions across Europe from severe illness and deaths. ASPHER acknowledged that attention and further support is also needed for those most vulnerable to wider impacts of such interventions, including their psychological and mental health impacts, as in lockdowns.[8,9] ASPHER recognises that increased violence in household and other settings has been one such major impact area, as with intimate partner violence.[10]

We will continue to teach and to advocate for comprehensive long-term approaches and interventions that recognise the immediate and shorter term interventions, while also highlighting structural and wider determinants of inequalities and vulnerability in pandemics.

We also support other broad conclusions, such as Bambra and colleagues on COVID-19 as a new syndemic.[11] *"Inequalities in COVID-19 infection and mortality rates are therefore arising as a result of a syndemic of COVID-19, inequalities in chronic diseases and the social determinants of health. The prevalence and severity of the COVID-19 pandemic is magnified because of the pre-existing epidemics of chronic disease - which are themselves socially patterned and associated with the social determinants of health."*

It is not only pre-existing chronic disease though. We are concerned about chronic inequity, with many risks for severe disease, along with inequity in access to services or best treatment outcomes, along with wider inequitable social and economic consequences of acute and chronic health conditions for patients, households or family members. The shadow of Long-Covid is covered further below.

Public health often focusses on populations by addressing differences in health risks ("vulnerability"). While population groups differ in their vulnerability, those who are disadvantaged through adverse social determinants of health often miss the resources to cope with their vulnerability. It is the group of the disadvantaged vulnerable suffering most from the pandemic crisis. Very often, they are hit by different overlaying and interacting dimensions of inequalities ("intersectionality"). A recent pre-pandemic European review in 2019 highlighted inequity and vulnerability across the WHO European Region, much of which is amenable to policy changes.[13] We can learn from countries who share their models of multiple factors at play in the pandemic's inequalities.

1.2. Country level reports - examples

Spain's initial overview regarded vulnerability as a three way mix of clinical, epidemiological and social factors.[13] *"**Social vulnerability** relates to insecurity and powerlessness experienced by certain communities and families with regard to their living conditions and their capacity to manage resources and to mobilise coping strategies. On account of their worse baseline health status, they have also a worse prognosis of the disease. The pandemic of COVID-19 and the measures adopted for its control have had an uneven socioeconomic impact on the population, which has led to escalation or generation of new social vulnerability. Furthermore, the COVID-19 health crisis has highlighted the significance of, namely, the circumstances in which people are born, live, work and age, including the health system. **These determinants are unevenly distributed** among the population, causing social inequities in health."*

Reports from **France** illustrate concerns about multiple influences in the regions,[14,15] or national levels.[16] The latter whole France overview seeks to explain multi-dimensional and cumulative mechanisms with reference to the influenza pandemic preparation model of Blumenshine et al,[17] that was an adaptation linked to Diderichsen et al concepts of multiple levels of causation,[18] (such has differential exposure, differential vulnerability and consequences, along with multiple policy entry points. Also following this model Whitehead et al commented early in the first wave May 2020.[19] *"Crises such as the pandemic are a stress test of the systems that aim to protect the worst off in society, demonstrating the shortcomings of those systems, revealing the unequal distribution of exposure, vulnerability and consequences. These crises send shock waves through society, exposing existing vulnerabilities leading into cycles of consequences, from the initial deaths from the disease to the economic and social repercussions of control measures. So far, we have only seen the first wave of impacts and the inequalities generated are likely to be amplified through subsequent waves".*

Data from **Vienna, Austria,** highlighted a range of adverse COVID-19-related outcomes by socio-economic position, with those of higher social position and greater household income having less severe outcomes.[20] Public concerns about the first two lockdowns in **Austria** indicated the extra burden on women in households as schools closed and also issues of unpaid care and lost income.[21] Overall, the negative well-being impacts of the Covid-19 lockdowns were strongest for people with a history of mental health treatment with only 30% of them receiving care during the first lockdown.[9]

In **England** the so-called North-South divide is a dominant theme in the Northern Powerhouse analysis of COVID-19 impacts, leading to calls for 'levelling up' and attention to children in the COVID-19 generation.[22] 'Building back Fairer' was a theme from Marmot review of COVID-19 and the work needed during coming years to address the pandemic impacts,[23] and to catch up on the lost years of opportunities missed from 2010-2020.[24]

Reports from **Germany**,[25] **Denmark**,[26] and **Norway,** [27,28] indicate some early attention to emerging evidence on inequalities, including on ethnicity and immigrant status, that needed further assessment. Additional insights can come from other data sources, such as digital library use by children in Denmark, with higher use on well off families,[29] probably indicating a form of digital divide there.

1.3. European Cross-country reviews – examples

EuroHealthNet's 2020 'deep dive' of seven countries' COVID-19 experiences allowed some broad themes to emerge, such as impacts on widening inequalities, mental health issues, digital divide and problems across the life course.[30] Recommendations were made to address these problems including improved and wider public health capabilities, improve living conditions and housing, better support for children and overall population skills development and stronger health and social care systems and care of the elderly.

WHO Europe's COVID-19 health inequity Review: this review by WHO European Regional Office has highlighted three phases of impact for the multiplicity of unequal adverse outcomes.[31] Some of these would be we long-term as in long-term ill health or unemployment, within potentially slow and variable economic and social recovery periods. Apart from dealing with the acute phases of the pandemic, there is a need identified for action and investment much wider than healthcare, including reaching out more effectively to those most vulnerable.

Independent Commission (Chair Monti M): Drawing light from the pandemic. A New Strategy for Health and Sustainable Development.[32] One major call is to "Take action at all levels of societies to heal the divisions exacerbated by the pandemic" including use of better and standardised information systems across Europe and inclusiveness to work with those in precarious and insecure circumstances. Greater representation of women in policy decision-making is also a highlighted priority. Their theme 'Drawing light from the pandemic' is resonant with this ASPHER 2nd inequalities statement's emphasis (below) on identifying and addressing various longer-term shadows from this pandemic.

European Observatory on Health Systems and Policies: In the wake of the pandemic; Preparing for Long COVID. [33] Among the long-term challenges are the people with persistent or 'long-covid'. Here are people who are a newly vulnerable group from these long term pandemic infection effects.

While much attention must go to the clinical inputs and local or specialist healthcare and rehabilitation, there are many wider issues for those affected to enable them to regain optimal function and a productive future. This should include attention to employment rights and policies, and ways to support self-care and informal carers. Strong registers and surveillance systems are also needed to evaluate population needs and for services evaluation.

1.4. Summary of European lessons

Drawing lessons from COVID-19 in the European region so far must include learning to develop and implement better measures to prevent the pandemic's new health inequalities across all population groups, but especially also addressing pre-existing inequities for those already suffering from socially determined and configurable inequalities. ASPHER also contends that addressing pandemic inequalities requires strong pre-pandemic action and preparedness, prompt and effective action throughout a pandemic, and later a full set of actions to help address the cumulation of exacerbated conditions and new harms.

However, health inequalities have different impacts according to the countries circumstances. To a certain degree, this can be explained by climatic, geographic and general socioeconomic factors, but largely depends on pre-existing intra-country variations between socioeconomic population groups, allocations of capabilities, health and risk behaviours, together with various kinds of welfare systems and national politics. Especially they relate to welfare state policies and politics around inequalities, and the overall country levels of equity and inclusiveness. This pre-pandemic status should be taken together with how quickly and strongly they mobilised and targeted pandemic interventions to protect the most vulnerable and their societies as a whole, to help us explain a major part of COVID-19 variations. The prior allocation of social determinants of health, as well as related dominating politics, are then translated into their economic, social and health policies for the pandemic and otherwise. These features thereby framed and intensified historical patterns or pathways for pandemic inequalities. Too often the acute phase of the pandemic has unevenly targeted those suffering deprivation and disadvantage, and those already with lower income, lower education, less favourable workplace conditions, poorer housing, and social exclusion or marginalisation.

However any post-pandemic austerity measures could further worsen health inequalities, as in the UK historical example of inequality-increasing impacts of government austerity policies from 2010 onwards, following on the 2008 economic crisis.

Moreover, there has been perhaps insufficient theoretical or political consensus about the definitions and interactions of inequities. It is up to the Public Health community to research and conceptualise inequalities in health status and their underlying or interweaving pathways, while highlighting inequitable access to services, support and resources. It is up to policy makers as well as the public to debate if the main motivations and justifications of intra-pandemic and post-pandemic policies and measures can reduce the health inequalities or inequities. The same holds for the debate about fundamental reasons for social inequalities as a dependent as well as independent variable for health inequalities. Widening such concepts and frameworks should also include impacts of global economic, commercial and trade determinants of health and the overlaps with sustainable development policies.

However, it is the Public Health academics and professionals missions to support and orientate evidence-informed debates and policies. It is part of ASPHER´s mission to back up such policies on the European level and to support the schools of public health to do so within their own countries – including the further development of Public Health core competencies on achieving equity, in line with the WHO "Essential Public Health Core Operations" (EPHOs) in our education and research.[34] We highly value the importance of EPHO4 – "Health Promotion including action to address social determinants and health inequity. There is however a case to integrate tackling social determinants and health equity more explicitly across each of the 10 EPHOs". However we believe that tackling social and wider determinants, including economic and environmental determinants, should be central to all ten EPHOs.

1.5. The Shadow concept/metaphor and why it has become important in the pandemic

While some reports may refer to the 'wake of the pandemic' waves,[33] there has also been relevant attention to several long-term impacts as 'shadow' concepts or metaphors. The challenges inherent within the shadow concept include that some important public health issues and population epidemiology may be missed, ignored, under-researched, marginalised or hidden. The implication is that, for transparency and comprehensive policies and strategies, all dimensions of the pandemic's health impacts should be fairly and evenly explored, reported and responded to in European recovery plans during the coming years. Another implication for the future public health workforce in the years ahead is to be able to take effective action and to advocate for those who are most vulnerable amid shortages of time and resources in their professional life.

A prominent use of the shadow pandemic has been in highlighting violence against women (and girls) on a global level.[35-37] ASPHER supports all efforts to understand and address intimate partner violence.[10] In the UK the rise of the shadow pandemic of domestic violence has been featured,[38] and broad partnerships are seeking to tackle it together, including an emphasis on minoritized groups and those with protected characteristics, and underlying structural inequalities.[39] Case studies of resultant effective action should be a focus for public health evidence.

Violence or abuse or neglect towards other vulnerable groups can also be seen as a growing pandemic shadow to highlight those whose severe needs, as in elder abuse,[40] or failing those with mental health problems.[41,42] There are serious concerns also about the pandemics mental health impacts on children.[43]

Since our initial ASPHER inequalities statement in June 2020, we have learned that the pandemic amplifies and exacerbates social and health inequalities in many different ways. Every country has had examples of increasing health inequalities due to the impact of COVID-19. Nevertheless, we already know positive as well as negative examples of action and ways to mitigate these profound inequalities. Collecting and sharing case studies and examples of good practice, as well as of failure, is a further important part of the mission of the ASPHER academic community.

Positive and negative examples must include measures of prevention (such as vaccination, and mask wearing protective measures) and treatment of infection, as well as various indirect impacts of the pandemic and its countermeasures, e.g. dealing with delayed healthcare, lockdown and school closures, that more severely affect the most disadvantaged vulnerable population groups.

The pandemic has many impacts, but we highlight **seven main long shadows** that we expect will last for many years. The period from 2022-2031 should be a decade of reducing pandemic inequalities and pursuing equity by **building forwards fairly**.

2. Pan-decade 2022-2031 – *What are the pandemic main seven lingering shadows to be studied and counteracted for the next ten years?*

The expression "long shadow" is used here to help us address long-term impacts, also in terms of recognising ineffective efforts, where it could be difficult to study the consequences of interventions for policy learning. For example, in the case of hidden traumas, abuse or mental health problems, that historically often went under-recognised.

Shadow 1 - Unequal direct morbidity and mortality impacts from future ups and downs of the COVID-19 pandemic.

Further waves of COVID-19 may unfold in the next months and years, as with the current Omicron variant impacts. Even if vaccine roll-out has in 2021 been mitigating overall incidence levels and reducing severe COVID-19 morbidity and mortality effects, the negative outcomes of the pandemic are still amplified for disadvantaged groups.

Shadow 2 - Unequal vaccine coverage in disadvantaged, underserved, and reluctant groups.

Vaccine coverage and rollout to vulnerable groups should be studied in detail.[44] unequal rollout and uneven vaccination coverage in Europe is delaying control of each wave. Initial lower uptake was linked to less included or less trusting population groups, adding to existing inequalities. For example, ASPHER has expressed concerns about marginalised populations in Palestine who were denied early and equitable access to vaccines,[45] as well the potential widening of social divides by pandemic interventions such as vaccine passports.[46]

Shadow 3 - *Unequal occupational exposure to those caring for people infected by SARS-CoV-2 virus and to those supporting their aftercare may lead to severe harms to key workforces.*

Such vulnerable workforces include not only health services and social care workers, including low status caring workforces, but also those carers self-employed or with precarious incomes.

Especially for these groups, there were higher COVID-19 risks of infection. There were also later consequences for care workers themselves, including caring informally for affected, colleagues and clients, that have had the potential to intensify occupational distress, burnout and post-traumatic stress disorder (PTSD).

Shadow 4 - Unequal impact of disrupted and delayed access to health and social care systems, including mental health problems and their weakened services.

Lockdowns disrupted mental health care and reduced direct interactions with those services in many countries.[8,9] The volume of new problems was also exacerbated putting additional strain on already weak support systems. Well-funded and extensive mental health promotion and care planning for the next decade is essential. For example, a variety of pandemic-related and historic challenges has been summarised in the Northern Ireland 10 Year Plan (2021-2031) that seeks to be comprehensive across the whole life course and across

systems.[47] "*There are a number of COVID-19 specific factors which will likely have an impact upon the mental wellbeing of our population during this pandemic. These include: social distancing and isolation, bereavement, unemployment, financial hardship, inability to access services, stress.*"

Shadow 5 – Unequal impacts of pandemic countermeasures – social restrictions, lockdown, more precarious income and economic downturn.

In some countries, various groups of self-employed lost income and had troubles to safeguard their future economic existence. Also in some countries, large population groups were, at least for a certain timespan, supported by the welfare state. However, in the light of pre-existing social determinants of health, those already most disadvantaged were often hit hardest (e.g. in precarious employment, in high household population density and/or with poor general living conditions). For the complete picture in each country, gender dimensions, the heterogeneous situation of different disadvantaged vulnerable groups, and patterns of intersectionality, all will need to be taken into account.

Shadow 6 – Unequal childhoods and futures – how the pandemic has set back education and development of future generations and highlights the need for urgent and long-term action plans.

For many children the pandemic had effects on their psychosocial well-being and their education as well as socialisation.

School closure and absences due to quarantine as well as long-term health effects affected educational results, while long-term educational gaps resulting in socioeconomic positions with higher health burdens threaten to extend social and health inequalities in future.

Absence from school, for various reasons, might have had positive effects for the vulnerable, but it had also negative effects, which had often more impact on the disadvantaged. Households differ in their capabilities and resources to back up educational activities at home.

Restricted space in households and stress translating in conflicts at home sometimes lead to (undetected) violence.

The Northern Ireland model of right-based approach to child mental health could be considered, not just for addressing their territory's historic legacy from factional violence, but also the pandemic impact and other contemporary challenges of child exploitation and abuse.[48]

Shadow 7: Unequal impacts from regressive policy measures, populism, scientific mistrust, and xenophobic nationalism.

Pandemic policy measures included the centralization of political power, strengthening of the executive (in federal states sometimes on the national level), restrictions of fundamental economic and social rights and critical data transparency/protection policies. At the same time, uncertainty and the need to act under uncertainty was paralleled by unjustified scientific criticism and populism, threatening evidence-informed policies and trust in democratic institutions and public health scientists, advisers and practitioners. We are concerned that poorly developed policies will increase health inequalities in some countries.

3. Building forwards fairly - *How can European societies protect themselves from future devastating health inequalities?*

ASPHER, as a public health academic learning, teaching and research community, cooperating with other networks, encourages each member school of public health to share knowledge and practice in addressing health inequalities. This implies that they address entrenched and complex policy areas.

WHO Europe has set out two broad aims that ASPHER supports:

- "targeted measures to prioritize those readily identifiable as being most vulnerable to the effects of COVID-19 and its containment measures; and
- universal measures to ensure that no one who is vulnerable is left behind and to address the increased needs of the population as a whole resulting from COVID-19 and its containment measures".

ASPHER specifies perspectives and detailed recommendations and aspirations in the sections below – with a focus on learning from good practice or innovative models.

3.1. Protecting disadvantaged vulnerable groups – learning from reviews and experiences

Disadvantaged vulnerable groups are many and heterogeneous. Missing economic, cultural or social capital goes hand in hand with restricted capabilities – either to stay healthy or to deal with acute or chronic health restrictions. Transgenerational structures impact life course opportunities and challenges. These groups often suffer from multidimensional inequalities and inequities ("intersectionality"). Often they are placed in high-risk environments while they have little choice in their places of domicile (e.g. migrant detention centres and displaced populations' in formal/informal encampments, prisoners, mental health wards or homes for the poorer elderly). Some disadvantaged vulnerable groups suffer from absolute poverty (e.g. homelessness and need basic material support). Others suffer from relative material of immaterial poverty and need different kinds of support to develop their capabilities. In case their capabilities are restricted (e.g. prisoners or people with massive mental restrictions), responsibilities and standards of good practice must be maintained.

For all of such groups the common overarching goal is to enable responsible action to prevent COVID-19 infections and to mitigate negative side effects of anti-Covid-19 protective measures. Any kind of stigmatising or blaming disadvantaged or vulnerable people should be avoided

3.2. Influencing Future Policy directions

ASPHER will continue to emphasise the wider determinants of health inequalities and promote evidence-informed equitable policies. This will include supporting policies to minimise harmful social gradients and social exclusion.

For both protecting disadvantaged vulnerable groups and broad policy directions the underlying themes include the respective development and application of Essential Public Health Operations and Public Health Core Competences. The Public Health workforce must be able to learn from policies and to accompany policy transfer from abroad and to develop internal governance structures as well as leadership skills to support policy makers in making politics and developing policies. The aim is widest possible recognition of inequalities through better health information systems (public health reporting systems including monitoring and surveillance) as well as investigation and research. The provision of data and

information must transform in professional knowledge and understanding, which enhances knowledge and understanding of policy makers, supporting policy learning and policy transfer. The lack of transparency and coordination of vulnerability data across Europe has been evident in some of ASPHER's reviews. There is scope, for instance, for public health and governmental agencies to work closely together to highlight good practices and deficiencies. A variety of organisations work with prisons and prisoners and examples of prisoner education and empowerment within the Red Cross initiatives, highlighted in ASPHER's prisons review.[5] The cross-Europe advocacy and intelligence gathering role of FEANTSA for instance was recognised in our review of homelessness approaches during the pandemic.[6]

Activities within countries must include local, regional and national levels and should be able to draw from international databases, reporting systems and experiences. European institutions and networks must add the inequity lens to their information and reporting schemes.

ASPHER will support a reinvigoration of all efforts to build comprehensive approaches to Health in All Policies (HiAP) as part of pandemic recovery. This should include evaluative benchmarking information systems, while adopting milestones for demonstrating progress, for example as in Finland review of 2018.[49]

All countries will need to systematically review their evidence from the pandemic, including on inequalities issues. There is much needed debate around further developing concepts and practices for evidence-informed, evidence-based, and evidence-led public policies, such as proposed by Belfiore[50,] and Smith [51]. ASPHER should support all public health systems in updating their policy formulation models. Tools such as Integrated Impact Assessment, for example used in Wales,[52] may be helpful.

In summary, the public health community, including ASPHER, should contribute with:

a) enhancing capacity development, including the development of leadership and governance in administering Public Health services;
b) developing and employing our tools, structures and institutions, including HiAP, to support evidence-informed policy making (e.g. in the fields of public health reporting tools including monitoring and surveillance as well as research studies);
c) reinforcing each country's public health workforces and training programmes; and
d) strengthening European cooperation within and beyond the EU.

This must also be reflected in our Public Health academic education and research into public health policy formulation.

4. Better Public Health teaching and learning - *How can we improve academic and wider understanding of inequalities?*

Public health across Europe within ASPHER and wider partnerships have shared expertise and resources to gain better understanding of good practice and innovation.

Working with our ASPHER Younger Professionals during the pandemic helps build public health workforce capacity and resilience for the future.

Academic Public health in Europe has shifted forwards during the pandemic. Students may in future be taught more with greater shared direction, pooled resources and improved digital technologies.

The pandemic has taught us more about studying workplaces and healthy workforces of all types; with populations needing better access to occupational health services, workplace support, along with secure and minimum income for healthy living. Post-pandemic, there is a need to find and develop interventions, data-sharing and understanding all workplaces, including universities, as potential pathways to prevention of infection.

Academic Public health has contributed to greater health literacy and wider community engagement on public health topics during the pandemic with improved cross-Europe data sharing and improved links with filed public health professionals.

4.1. Better Population health status - *How can we improve public health surveillance and population health sciences*?

ASPHER has collated and shared information on surveillance systems and weekly produces its own Europe-wide bulletin. This highlights the disparities between the 53 European region countries in terms of incidence rates, hospitalisation levels, mortality rates and population vaccine coverage. There is now a wide range of pandemic related reports on the ASPHER website in addition to the many non-pandemic resources.[53]

4.2. Better public health research – How can we improve the development of new knowledge regarding post-pandemic health inequalities?

ASPHER is concerned about the depth and extent of post-pandemic inequalities and the magnitude of the ensuant investigations that need to be done. A new consensus is needed about coordinated efforts with suitable models and methodologies.

ASPHER continues to support coordinated review projects linked to the European Observatory on Health Systems and Policy.

ASPHER remains concerned about hidden and enduring impacts that could be overlooked while governments hope to seek a quick return towards 'normality'. This includes our deep concern about COVID-19 infection causing some long-term medical conditions including long-COVID. Many types of follow up studies that are needed including social sciences and psychology to understand pathways to ill-health, to estimate scale of pandemic impacts and to evaluate intervention programmes.

'Longitudinal COVID' is the epidemiological approach to ensuring that all long-term population health impacts are studied over the next ten years or more. ASPHER will continue to seek support for well-funded research programmes of cohort studies and whole population studies in the period 2022-32.

ASPHER will also advocate for greater international collaboration in studying long -term pandemic impacts and their inequalities on a global scale. This will involve discussing with our networks and collaborations with other Associations of Schools of Public Health from other continents. Pre-pandemic health inequalities, vulnerabilities and inequities can be found in all regions of the world, for instance in South Africa and Southern Africa.[54,55] The pandemic has highlighted the global social disparities and inequities with respect to income, and accessibilities to basic healthcare; people who earn less, are less educated, and particularly belong to ethnic minorities, that are disproportionately affected by higher rates of morbidity and mortality from severe COVID-19 infection, including their lack of facilities in accessing necessary healthcare.[56,57] We support the recent call for improved pandemic preparedness for inequities, learning from the COVID-19 pandemic, "*The exposure of social and health inequities calls for the inclusion of health inequity considerations into pandemic preparedness and response plans, both for the potential next COVID-19 waves and for future pandemics and other emergencies".*[58]

4.3. Leadership, governance and policy consultation – How can we improve our interaction with policy makers and policy-making?

In modern society, legitimacy of political decisions should be rooted in the application of best available knowledge as well as in democratic principles. Robust data, clear and scientifically sound information, new knowledge, better understanding and enhanced professional expertise is necessary for future policy learning, policy transfer and policy consultancy.

Effective communication and productive interfaces are challenges between public health scientists and professionals on the one hand and with policy makers on the other hand. These mechanisms differ between countries and ASPHER has supported a recent European review of various national public health advisory machineries (via EHESP colleagues in France – to be published). We also advocate for greater professional awareness and building resilience against personal attacks, including internet and media based aggression (ASPHER – 'Don't Shoot the Pianist' statement to be published).

Understanding the policy process as well as policy changes and politics is part of academic and professional expertise. ASPHER supports academic and networks with other public health communities within European countries. It leads in developing some key functions in a European and worldwide context. That will include the integration of enhanced materials on inequalities and equity in our future core competencies and curricula reports.

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