Original Research

The experiences of socially vulnerable groups in England during the COVID-19 pandemic: A rapid health needs assessment

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A B S T R A C T

Objectives: This rapid health needs assessment was undertaken to urgently identify the needs of socially vulnerable groups arising during the first wave of cases of the COVID-19 pandemic in England. The objective was to develop recommendations for policy makers and stakeholders to mitigate adverse impacts on socially vulnerable groups throughout the COVID-19 response and recovery period.
Study design: Rapid health needs assessment.
Methods: The needs assessment employed qualitative methods to systematically collect data about the knowledge and views of key informants through semi-structured interviews and focus groups. Participants were either topic experts providing services to socially vulnerable groups who routinely face barriers to healthcare access or experts by experience. Participants included people experiencing homelessness, sex workers, people from Gypsy, Roma and Traveller communities and people facing challenges due to their immigration status. Data was collected over a week period in April/May 2020 and followed by thematic analysis to examine interview transcripts.
Results: Forty-two participants were included in the study, half of whom were experts by experience. Challenges with accessing and following COVID-19 information and government guidance were described as affecting all groups, due to exclusion from digital technology, translated resources, tailored support and adequate housing. Altered delivery of healthcare services, such as the closure of outreach and drop-in services, remote consultations, and online patient registration, were noted by interviewees as worsening existing barriers to accessing healthcare. Being charged for NHS care remained a key fear for migrants. All groups' access to income, education and social support were reported as being impacted by service closures and job losses, putting them at higher risk of destitution. Isolation, loneliness and deteriorating mental health were frequently reported.
Conclusions: This assessment has highlighted the disproportionate impact of the COVID-19 pandemic on socially vulnerable groups and demonstrated a plethora of unmet needs. As the effects of COVID-19 continue, it is imperative that the needs of these groups are urgently and explicitly addressed and prioritised. This is essential to promote engagement with test and trace services, enable isolation adherence, and achieve high vaccine uptake in socially vulnerable populations.

1. Introduction

The COVID-19 pandemic has had a devastating impact on lives globally yet it is clear that countries, regions and communities have experienced these impacts unequally [1]. In January 2021, the UK had the highest number of recorded deaths per capita in the world, and the public health impacts of the pandemic on people living in the UK are projected to be significant for many years to come [2,3].

Early in the pandemic the UK based humanitarian organisation Doctors of the World (DOTW) became concerned that the COVID-19 virus and measures taken to control it would have a disproportionate impact on the health and wellbeing of the socially vulnerable populations it served. DOTW, part of the 'Medecins du Monde' international

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Abbreviations

CVS	Community and Voluntary service
DOTW	Doctors of the World
NGO	Non-governmental organisation
NHS	National Health Service
RNA	Rapid Needs Assessment

network, works to empower excluded people to access healthcare. DOTW suspected that the pre-existing socioeconomic and health inequalities faced by excluded populations increased their vulnerability to indirect physical and mental harms associated with the pandemic, and predicted that adverse health outcomes would be exacerbated by their reduced access to and utilisation of healthcare services.

In this paper the term 'social vulnerabilities' is used to describe characteristics that increase a person's risk of a hazard due to social and environmental factors, including race, immigration status, access to basic services including healthcare, and living and working conditions [4]. A significant number of people experience social vulnerabilities; for example, 280,000 people were recorded as experiencing homelessness in England in 2019 and 46,055 people sought UK asylum in 2019 alone [5,6]. Many people experience multiple layers of social vulnerability and may identify as belonging to more than one vulnerable group. As the pandemic has evolved, data on the impact of COVID-19 on people experiencing social vulnerabilities demonstrated a disproportionate burden of morbidity and mortality, with evidence that experiencing deprivation, belonging to a Black, Asian or Minority Ethnic group and being a migrant increases the risk of being exposed to, being infected with and dying from COVID-19. [7–9].

This rapid health needs assessment (RNA) was undertaken to fill a critical evidence gap and rapidly identify the needs of socially vulnerable groups arising from the COVID-19 pandemic in England. The aim of the RNA was to develop recommendations for policy makers and stakeholders to mitigate against the adverse impact of the pandemic on socially vulnerable groups throughout the COVID-19 response and recovery period [10].

2. Methods

A rapid health needs assessment was conducted, a systematic method for identifying unmet health and healthcare needs of a population [11]. The study population was people who experienced social vulnerability and routinely faced barriers to accessing healthcare in England. The study population was distilled into a list of selected groups for assessment inclusion, displayed in Table 1, with recognition that the list was not exhaustive nor mutually exclusive. Epidemiological data on COVID-19 and socially vulnerable groups was sparse at the commencement of the RNA therefore a corporate approach to needs assessment was adopted, in which the knowledge and views of informants was systematically collected [12]. The study team utilised qualitative methodology to describe and explore the perspectives of key informants. Throughout the RNA all DOTW research ethics standards and procedures were observed.

Two categories of participants were identified: topic experts defined as those providing services to socially vulnerable groups in England during the pandemic and people who identified as belonging to one of the identified socially vulnerable groups, referred to within this paper as 'experts by experience'. Purposive sampling was used to ensure participant representation across a wide range of socially vulnerable groups. DOTW drew on its knowledge of the health inclusion sector to identify key voluntary, community and statutory organisations who work with at least one of the RNA's identified groups. Organisations were emailed an invitation to participate in the RNA, positive responders are listed in Table 1. Volunteers and staff within these organisations identified experts by experience from their service-user population for potential study participation. Potential participants were assessed for inclusion and recruited by the study team.

The inclusion criteria stated participants were required to be based in England, aged 18 years or older, and able to provide informed consent. Participants were excluded if they were unavailable during the three-week data collection period commencing on 16th April 2020, during the first national lockdown. Detailed verbal and written information regarding the RNA was provided to potential participants. Participation was entirely voluntary. No incentives were offered but after data collection, experts by experience who had participated received a £30 supermarket voucher in acknowledgement of their time.

Table 1
Target groups, number of participants who were experts by experience from each target group, and participating organisations who worked with and provided information about these target groups.

Target groups included in the assessment	Number of participating experts by experience from the target group	Participating organisations who provided information about the target group
Recently resettled or newly recognised refugees	2	Refugee Action
People seeking asylum (including unaccompanied asylum seeking children)	3 (no children)	Refugee Women Connect
		Say it Loud Club
Refused asylum seekers and other undocumented migrants	1	Bevan Healthcare
		Doctors of the World UK
		British Red Cross
		Maternity Action
People recently released from immigration detention	0	Bail for immigration Detainees
		Detention Action
People affected by, or survivors of trafficking or modern slavery	1	Unseen
		Voices of Domestic Workers
People experiencing homelessness	8	Homeless Health Exchange
		Pathway
		Doctors of the World UK
		British Red Cross
		Bevan Healthcare
Gypsy, Roma and Traveller (GRT) Communities	3	Friends, Families and Travellers
		Leeds GATE
		National Federation of Gypsy Liaison Groups
		Southwark Travellers Action Group
Sex workers	3	Basis Yorkshire
		English Collective of Prostitutes
		X: Talk: The Breakfast Club
People recently released from prison	0	Through The Gate

The three public health specialists in the study team independently collected data via remotely conducted semi-structured interviews and focus groups, each lasting 45–80 min. Verbal informed consent was obtained for all participants and documented at the time of interview. An interview guide informed by a rapid policy review was developed by the study team. The guide explored themes identified from the literature and the emerging experiential evidence from DOTW frontline staff members on how the pandemic had impacted the RNA populations' health, wellbeing and life circumstances. Where consent was given, interviews were audio recorded.

The study team used an iterative approach to data collection, meeting regularly to discuss emergent themes to inform ongoing interviews. Data collection continued until saturation of novel themes was achieved. Thematic analysis of the responses was undertaken manually. The team familiarised themselves with every transcript, then progressed to coding and identifying sub-themes within an assigned subset of transcripts. The team met daily to ensure consistency in analysis, discuss discrepancies and build consensus on major themes.

3. Results

3.1. Participants

A total of 42 study participants were included in the study. 50% (n = 21) of the participants were experts by experience, of whom 13 (62%) were female and 15 (71%) were from Black, Asian and other minority ethnic groups. The remaining participants (n = 21) were stakeholders from 21 different organisations directly working to provide services to people from the target groups.

Table 1 displays the target groups included in the assessment, the number of experts by experience from each target group, and organisations working with those target groups that participated. Some experts by experience were members of multiple groups but have been classified in Table 1 according to the main experiences they discussed. Some organisations served more than one target group.

4. Themes

Findings from the RNA are captured in three broad themes below: barriers to accessing and following guidance, barriers to accessing healthcare, and broader impacts on people's lives.

4.1. Theme 1: Barriers to accessing and following guidance

Participants from all groups described difficulties with finding out about the rapidly changing COVID-19 national government guidance and following its recommendations.

4.1.1. Digital exclusion

Participants from across all target groups and ages reported that lack of or limited access to the internet and technology was a significant barrier to accessing official COVID-19 guidance and information, which was being published and regularly updated online.

The most common reason for digital exclusion identified from the interviews was not having the resources to obtain mobile data or wireless internet. A staff member from Doctors of the World commented:

> "The first thing that happened was that these support groups closed, and people lost their access to data. This has become a more urgent need than food."

Several participants raised lack of access to internet compatible devices as an issue, particularly relevant to those living in destitution and people held in immigration detention. Even with access to a device, some lacked the necessary digital skills to access information online.

4.1.2. Language and literacy barriers

Participants stated that it was difficult for people without English language or literacy skills to access the latest guidance due to delays and omissions in publishing guidance in other languages and easy-read, audio or video versions. One member of the Gypsy, Roma and Traveller community commented:

> "Lots of people feel that without … [communications provided by local community organisations] we would feel forgotten. Many people can't read or write or go online."

4.1.3. Problems with dissemination of guidance

Participants explained how suspended provision of face-to-face services within the community and voluntary services (CVS) sector made the dissemination of guidance through these trusted channels difficult, as evidenced in the previous quote.

The interviews highlighted that targeted guidance on changes to immigration reporting, were not communicated through appropriate channels, leaving many asylum seekers anxious, confused or undertaking unnecessary journeys to report to the Home Office.

4.1.4. Non-inclusive guidance

Many people reported feeling 'left out' and frustrated at the lack of practical applicability of the guidance to their life circumstances. Participants felt there had been a failure to recognise that social vulnerabilities make staying at home, self-isolation, and physical distancing challenging. One asylum seeker noted:

> "As asylum seekers the first thing we felt was left out by the government … being a leader of a country facing coronavirus, it's not just about thinking about citizens and residents, it's about all human beings that live in the UK."

4.1.5. Problems with accommodation

Participants from several groups, such as asylum seekers living in shared accommodation, described that limited control over their own living situations restricted their ability to follow guidance. Many interviewees noted that overcrowded accommodation, communal kitchen or ablution facilities made it hard to socially distance, maintain desired hygiene standards, or to self-isolate. Reportedly, several domestic workers faced unemployment and homelessness if they did not comply with their employers' expectations to live and work in conditions that did not align with the guidance.

People experiencing homelessness and some members of Gypsy, Roma and Traveller communities struggled to access sufficient water and sanitation facilities to comply with hand washing and cleaning guidance, contributing to a sense of loss of control.

A participant from the National Federation of Gypsy Liaison Groups described:

> "How can you self-isolate in a small trailer? And you may be sharing toilet facilities. You can have 18 families accessing one toilet on transit sites. And even the structure of some sites, especially transit sites, things are close together."

Furthermore, it was reported that those without a fixed abode or with irregular immigration status had difficulties accessing government support with shielding and self-isolation.

4.1.6. Poverty

Many interviewees identified that the need to earn money to meet basic needs, or the need to manage an addiction, prohibited some people from staying at home, shielding or isolating. This was particularly the case for those that were ineligible for government financial support, some of whom continued to earn money through sex work or begging, despite the risks this posed. Others needed to break 'stay home' orders because storing food or shopping online were not possible due to space constraints, financial challenges or digital exclusion. One newly recognised refugee stated:

> *"If we have to self-isolate there is no way of us getting food. They pay us weekly, it's not like a bulk money. The money we have is hardly enough to eat for the whole week. And there is no way we can take help from any other person. I haven't had credit on my phone for 4–5 days. No calls are possible if you run out of credit."*

4.2. Theme 2: Barriers to accessing healthcare

4.2.1. GP registration

Participants found pre-existing difficulties with GP registration were exacerbated during the lockdown, reporting many GP surgeries closing to new registrations and some deregistering patients temporarily housed outside practice catchment areas. Consequences reported by participants included delayed access to healthcare and medication, heightened anxiety and disruption of continuity of care. A person experiencing homelessness who had to register with a new GP shared his experience:

> *"The transfer of all your files is a real pain in the ass … they say they've sent it but they haven't sent it, the new practice doesn't load it into their system, so to keep up with all your medications you have to fight all over again, you have to go through your history and it can be very tiring and aggravating. And to learn the ins and outs of a new surgery it can be very anxiety building."*

4.2.2. Fear and distrust

Participants across all groups identified fear and distrust to be deterrents to accessing mainstream healthcare services. Several participants explained that distrust originated from previous negative experiences of healthcare and marginalisation. One British Romani Gypsy said of people in her community experiencing COVID-19 symptoms:

> *"They would have to be on their deathbeds before they would go to a GP."*

Those working with migrant groups described the NHS as a place of fear for people who are subject to the Governments 'hostile environment' policies and NHS Overseas Visitor Charging. Although diagnosis and treatment for COVID-19 is exempt from charges, participants reported this exemption was not well known and offered insufficient reassurance. Concerns were raised about what may happen if someone sought care for presumed COVID-19, only to be diagnosed and charged for another condition. Due to data sharing between the NHS and the Home Office, participants feared unpaid NHS bills arising from such situations would result in serious actions by immigration officials such as detention and deportation. This was summarised by an NGO case-coordinator:

> *"They are concerned they will be charged by the NHS … they would avoid unless they were really very poorly".*

4.2.3. Reduced health service provision

The interview revealed that suspension or reduction of walk-in services, mobile clinics and outreach services from trusted providers meant that many people did not know where to go for healthcare. This led to delays in care with reported adverse health outcomes, as one General Practitioner exemplified with a case of a person experiencing homelessness:

> *"For a few weeks during the process of COVID he didn't know where he could go and get it* [leg wound suture removal] *sorted … The stitches were a real mess, they were embedded, they were hard to get out, it was infected."*

Suspension of services offering supported access to mainstream health service and transport barriers were described as additional practical barriers to accessing healthcare.

4.2.4. Remote services

Many participants reported challenges to accessing remote health services because they had no access to a phone, mobile credit or internet or because of language barriers:

> *"We don't have enough credit to call the GP and sometimes the call can take really long."* Asylum-seeker

People with COVID-19 symptoms were being directed to 111 for advice, but participants highlighted that making that call required access to a phone, language proficiency, confidence and trust in the provider, which were all potential problems for many of the study populations.

Conversely, some healthcare professionals interviewed suggested that they had had increased engagement with some people experiencing homelessness, some of whom preferred telephone consultations. It was suggested this was because phone calls removed barriers such as transport issues, timekeeping, and embarrassment regarding personal hygiene:

> *"Rough sleepers comment on feelings of embarrassment about their appearance or their hygiene, and they don't want to sit in waiting rooms with 10 other people."* DOTW General Practitioner

4.2.5. COVID-19 symptom identification

Participants reflected that reduced access to information about COVID-19 meant people from socially vulnerable populations were less likely to know what symptoms to look out for or when to seek help. Interviewees explained that for people with poor baseline health it can be difficult to identify COVID-19 symptoms. Examples provided were that coughs are common amongst homeless populations, street sex workers and drug users, and heroin withdrawal symptoms can have a COVID-like presentation.

In addition, some participants explained that some people have been misidentifying COVID-19 symptoms as other infections because they do not believe in the existence of the virus.

> *"We have had a couple of cases of people who we were convinced had coronavirus and they just didn't want to know … Some women were still decrying: 'it's just fake news … it's a hoax … I've just got a cold … '."* NGO worker supporting women in the sex industry

4.3. Theme 3: Broader impacts on people's lives

4.3.1. Changes in statutory service provision

Closures or remote delivery of statutory and CVS services were reported by interviewees to have a disproportionate impact on socially vulnerable groups, who often heavily rely on these services for social or financial support. Participants were concerned about the devastating

impact of school closures on the learning of children from these groups; many of whom were unable to access online resources or had less assistance with home learning, due to the limited English language or literacy skills of their caregivers. One concerned mother from the Gypsy, Roma and Traveller community explained:

> "*We have no access to the internet. When they go back to school they will have forgotten everything.*"

4.3.2. Groups at risk of destitution or homelessness

Organisations providing care to people experiencing homelessness or destitution described that many people had lost their employment during the pandemic, especially those whose employment was short-term, informal or irregular. People who had previously been financially self-sufficient now needed to access destitution support. One NGO worker explained:

> "*Now the highest number of people we see, they are not our usual service users, but people who now have lost employment …. they have lost their means of support, and have become homeless. They have been washed out*"

Interviewees noted that informal accommodation arrangements had become more precarious because of the pandemic. Some people became street homeless due to limitations on household mixing or because of community fears regarding the virus. A DOTW staff member explained:

> "*He always had somewhere to sleep and always had something to eat as people were inviting him to their home. He developed a cough, and no one would take him in after that. So now he has become street homeless, never having been street homeless before.*"

4.3.3. Reduced community support

Participants reported concerns about the wider financial impact of the many job losses in the Gypsy, Roma & Traveller communities during the pandemic, because earners commonly share their wages to support others.

A similar concern was expressed by a DOTW staff member working with migrant groups:

> "*We're seeing a real impact on undocumented individuals and families with no recourse to public funds … community support and informal work has completely dried up.*"

4.3.4. Impact on mental health

The commonest reported health impact of the pandemic by participants was on mental health. Self-reported and observed mental health deterioration of people from these groups was noted, particularly due to restricted access to usual services, activities and communities. Pre-existing trauma and mental health difficulties were described as being exacerbated by the lockdown and isolation, for example in survivors of modern slavery and trafficking. Delayed asylum applications, employment loss and reduced access to usual support groups were all reported to have triggered anxiety and low mood. Many felt that these groups were experiencing loneliness and isolation to a greater extent than the general population, due to being less able to access their social networks digitally and facing new barriers, such as cancellation of immigration centre visitations. One person with new refugee status described their experience:

> "*Before the coronavirus I was a bit suicidal so I make sure I go out every day … But now you can't do anything … Access to internet* [would help] …. *Just something that keeps you busy and your mind occupied … And*

most of this comes through the internet. And I don't have the budget for that."

5. Discussion

The results of this RNA highlight the disproportionate health, social and financial impacts of the COVID-19 pandemic on people experiencing social vulnerabilities. These findings, combined with other emerging literature, suggest that the national response to the pandemic has failed to address their needs and it is likely that they face disproportionate risks of morbidity and mortality from the pandemic due to pre-existing inequalities [8,9,13–17].

Exclusion from digital technology, translated resources, tailored support and adequate housing, in addition to needing to access basic essentials, led to significant difficulties with groups accessing and following government guidance to reduce risk of COVID-19 exposure and transmission. This has been corroborated by reports that sex workers, migrant groups and Gypsy, Roma and Traveller communities are facing significant barriers in knowing about and following COVID-19 guidance [15,18,19]. Without access to appropriate, accessible and timely guidance and the support to follow it, socially vulnerable groups have likely been less able to protect themselves and others from the effects of the virus. COVID-19 vaccination and booster programs need to take these findings into account to prevent further health, social, employment or educational inequalities developing. For socially vulnerable groups, vaccine information needs to be timely, translated, tailored and accessible, and distribution methods should be creative, proactive, and not dependent on access to digital technology.

Changes in the delivery of healthcare services exacerbated existing barriers to accessing healthcare, a finding consistent with reports from Medact and Groundswell [13,19]. Outreach and drop-in services were closed, consultations were conducted remotely, and primary care registration hurdles increased. The fear of being charged for NHS care remained among migrant groups despite the COVID-19 exemption, corroborated by Medact survey data that highlights the low levels of awareness about the exemption [19]. Socially vulnerable groups who face these complex access barriers to healthcare, on a background of existing comorbidities, may be at greater risk of poorer health outcomes and increased risk of dying from COVID-19. [9] As the pandemic continues, and primary care services consider the longevity of virtual appointments, it is vital that socially vulnerable groups who face barriers related to technology, language, literacy and mistrust are not excluded from proposed healthcare delivery systems.

Many people from socially vulnerable groups do not have sufficient financial or social resources to safeguard themselves and therefore have been disproportionately affected by control measures. Service closures and job losses have reduced socially vulnerable groups' access to income, education and social support. The RNA finding that these groups are at high risk of destitution, particularly due to their unequal access to government financial support as a result of visa limitations, informal employment and digital exclusion, is corroborated by other reports [13, 20–22]. The relationship between such socioeconomic factors and ill health is undisputed.

Loneliness and a deterioration in mental health were commonly reported in this RNA. Other studies have shown a significant increase in mental health problems in the general population during the pandemic [23,24]. The most affected groups include people that had worse mental health pre-pandemic, had lower household income, were unemployed or had lost their usual coping mechanisms, such as social networks [25]. These drivers of worsening mental health are particularly prevalent in socially vulnerable groups. The reduced access to mental health service provision during the pandemic is likely to further exacerbate the impact

on mental health with potential long-lasting effects [26].

6. Strengths and limitations

While the devolved nations in the UK operated under different COVID-19 policies, all were subject to a national lockdown making it likely that many of the RNA findings were generalizable across the UK. Furthermore, this RNA's qualitative approach enabled a holistic assessment that revealed the complex interactions between people's life circumstances and the likely direct and indirect health impacts of COVID-19. It offers a unique perspective by directly capturing the seldom heard voices of people experiencing social vulnerabilities.

To date, comparable studies have focused on the needs of one specific group. The inclusion of multiple types of vulnerability in this assessment demonstrates that intervening in certain key areas (such as digital exclusion) could have benefits for a broad range of people.

during the pandemic to counteract the ongoing effects of destitution has been absent or insufficient for the populations included in the RNA. Efforts to remedy these failings are essential to promote engagement with test and trace services, enable isolation adherence, and achieve high vaccine uptake in socially vulnerable populations. We recommend that the actions presented in Box 1 are undertaken as a matter of urgency. A more detailed set of recommendations can be found in the original DOTW RNA report [10].

Going forward, much greater inclusivity is required to mitigate the impacts of COVID-19 identified in this RNA and rebuild a more equitable and healthy society. These lessons from the first wave of COVID-19 cases must also be incorporated into future preparedness plans so that the health needs of socially vulnerable groups are given the necessary importance and attention from the beginning of any future crises that arise.

Box 1: Urgent actions

- Rapidly develop guidance and information that can be understood by all people, including those with English language and literacy barriers. Translations of vital public facing information must be timely and kept up to date as the pandemic evolves.
- Information and guidance must be more inclusive and relevant to those living in challenging and vulnerable circumstances.
- Information should be made accessible to people experiencing digital exclusion by implementing alternative targeted dissemination strategies which effectively utilise the CVS and other trusted networks and channels.
- Address digital exclusion to facilitate access to information and remote services. This includes the provision of free mobile internet data or wireless internet within accommodation for socially vulnerable groups.
- Maintain provision within General Practice for face-to-face consultations for socially vulnerable groups, irrespective of their clinical presentation.
- Immediately suspend hostile environment policies that prevent access to public services for migrants in vulnerable circumstances. Ensure there are robust provisions for including socially vulnerable groups in the COVID-19 vaccination roll out.
- Prioritise, support, and resource ongoing face to face provision of health and wellbeing services at outreach and drop in facilities for socially vulnerable groups.
- Strengthen destitution prevention and support for people in vulnerable circumstances or at risk during the pandemic, including widening access to government financial support to include people in need who are currently ineligible.
- Seek to prevent widening health inequalities in future policy and practice decision-making e.g. during the COVID-19 vaccine roll-out. Actively identify and address the evolving information, health and social needs of socially vulnerable groups throughout the pandemic and be proactive in developing timely supportive interventions.

However due to the rapid methodology used, the RNA did not include all possible groups experiencing vulnerable circumstances in England and children were excluded from participation. Due to the limited sample size the RNA is unlikely to have captured all relevant experiences of participating groups. Selection bias could have influenced the results as all experts by experience were connected to a supporting organisation, had access to a telephone for interviewing and spoke English, therefore participants may not have been representative of the broader group.

While remote interviews allowed the study team to reach participants from across the country it may also have acted as a barrier to building rapport and conveying empathy, both important for enabling the participant to be open in sharing a detailed account of the experiences under study.

7. Conclusion

This RNA has highlighted the disproportionate impact of the COVID-19 pandemic on socially vulnerable groups and demonstrated a plethora of unmet needs. In the context of continued evolution of the pandemic, ongoing social restrictions and COVID-19 vaccination roll-out, it is imperative that the needs of these groups are explicitly identified, addressed and appropriately prioritised. Many people continue to be excluded from access to basic healthcare and accommodated in conditions that increase their risk of COVID-19 exposure. Financial support

Author statements

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Data statement

To protect the identity of the rapid health needs assessment

participants and cases referred to within the interviews, full transcripts remain confidential and unavailable to share.

Declaration of competing interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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