

EDITORIAL

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The many revelations of and about inequality data in the context of COVID-19: introducing a special issue on COVID-19 and inequality

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COVID-19 has starkly revealed the depth and breadth of health inequities within and across nations. According to the World Health Organization's (WHO's) Coronavirus dashboard, as of 18th December 2022, about 648 million COVID-19 cases have been reported, with over 6.6 million deaths, and 13 billion doses of vaccines have been delivered... but how even has the distribution of these values been, across and within nations, and within population subgroups? Are data available to be able to monitor this?

COVID-19 was a health emergency that triggered a statistical crisis. At a time when information was most needed, many traditional statistical sources dried up, because containment measures during the pandemic dramatically impeded data collection. In May 2020, 96% of National Statistical Offices (NSOs) reported that face-to-face data collection had ceased [1]. During 2020–2021, the years scheduled for the global decennial population and housing census, 68% of NSOs had to postpone their work [1]. These crises were not evenly spread - high income countries were less affected, as they enjoyed

better data infrastructure and more modern data collection systems.

This special issue gathers and presents inequalities in the context of COVID-19, with an emphasis on the analyses, tools, and initiatives of the World Health Organization. This plays an important role, we felt, in revealing, and beginning to address, the core equity issues that COVID 19 has brought to the fore.

Contributions in this special issue include three research papers that draw on global data to describe the nature of inequalities in COVID-19 prevention, testing, and vaccination. Kirkby *et al.* [2] studied education-related inequalities in COVID-19 prevention and testing across 90 countries, showing varying trends across low and lower-middle-income countries compared to high-income countries. Flores and colleagues [3] explored age-related inequalities related to COVID-19 testing, finding that younger populations faced greater financial hardship attributable to testing. Further, Nabaggala *et al.* [4] sought to understand the nature of COVID-19 vaccination coverage among healthcare workers, who were targeted as a priority group in most countries, compared to the general population. They found that vaccine availability and prioritization affected healthcare worker vaccination coverage relative to the general population, following varying geographic patterns.

In addition to research papers using global data, we also focused on the tools used for gathering and analysing data to monitor COVID-19, including inequalities experienced within and between countries during the

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pandemic. This includes Allan et al.'s database manuscript, which describes WHO's COVID-19 surveillance database with emphasis on the collection and presentation of disaggregated data [5]. Kirkby et al., in their software paper, present the latest version of the WHO Health Equity Assessment Toolkit (HEAT and HEAT Plus), a software application that facilitates the assessment of inequalities and the computation of summary measures, including examples of how this software has been used to monitor inequalities during the COVID-19 pandemic [6].

This special issue has also raised a clarion call for renewed and redoubled commitments, partnerships, and compacts in service of inclusion of persons with disabilities as part of health emergency responses such as COVID-19, as well as action on the social determinants of health. Pearce and colleagues [7] describe the unique challenges persons with disabilities faced regarding exposure, risk of severe disease, and heightened barriers to service utilization, COVID-19-related and otherwise. Globally issued guidelines often fail to reflect the diversity of circumstances that persons with disabilities face and how these may be redressed through ensuring availability of data and participation from these communities. The paper by Solar, Valentine and colleagues [8] presents a WHO special initiative that has sought to theorise on how action on social determinants of health may move forward, focusing on building models for change, building networks for collaboration and building capacity to think and act across sectors. There is a long way to go to make a transformative change that brings about health equity on the ground, but the commitment and threads of collaboration have emerged.

Placed together, these contributions offer a few broader insights:

First, COVID-19 has shown us the possibility of generating data for global health monitoring in a reasonably granular, disaggregated, and timely manner, often by harnessing technology. This allows for the assessment of inequalities over shorter and longer periods. The one consideration here is that disaggregated data on relevant indicators may not be available or consistent across countries and periods. This points towards the need to create not just core common sets of health indicators but also a set of common disaggregations that should be prioritized in all data systems and research studies. As our issue suggests, it is crucial, in addition, to consider the needs of particular sub-populations. Examples include persons with disabilities, the elderly, and health workers. This could address the global dearth of disaggregated data globally.

Moreover, in contexts where there may be technological constraints, this ought not to stand in the way of

regularly collecting and analysing disaggregated data. Strengthening capacity, offering support, and providing adequate resources for national agencies involved with data collection and curation should be given priority, with an emphasis on countries that are lagging. There must also be room for identifying additional axes of vulnerability or disadvantage that may have arisen during the COVID-19 pandemic (such as carers and health workers).

One other area of emerging importance for inequality is access to, and representation in, data. With the oligopolistic concentration of technology platforms, many data are being made artificially excludable, leading many to argue that growing inequalities in access to data and information are creating a new inequality frontier between the data haves and have-nots. Meanwhile, the digital-divide has created a data-divide, where those without access to technology or broadband are not represented in many digital datasets.

Further, understanding inequalities using quantitative analyses is necessary but insufficient to address inequities. Areas of inquiry, including in pandemic settings, should include more contextually driven, qualitative analyses of community experiences, patient pathways, governance achievements, challenges and insights, as well as forms of collaboration and competition that affect the distribution of resources, disadvantage, and disease within and across nations.

To conclude, the urgency of action on inequities concerning pandemics is apparent. This will have to be supported by inequality monitoring with regular and in-depth analysis of inequalities across the care spectrum, using both quantitative and qualitative studies on how inequities manifest and also what approaches offer promise in redressing them.

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