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Governments and international institutions should urgently attend to the unjust disparities that COVID-19 is exposing and causing

Information of authors:

- ***Corresponding autor: Luis Alberto Martinez Juarez MPH***
  London School Hygiene and Tropical Medicine, Mexican Society of Public Health;
  Address: Keppel St, Bloomsbury, London, WC1E 7HT, UK
  Email: luis.martts@gmail.com

- *Ana Cristina Sedas MBBS*
  Harvard Medical School
  Address: 641 Huntington Ave, Boston, MA 02115, USA

- *Miriam Orcutt MSc,*
  Senior Research Fellow, Institute for Global Health, University College London;
  Address: Keppel St, Bloomsbury, London, WC1E 7HT, UK

- *Raj Bhopal, DSc(Hon),*
  Emeritus Professor of Public Health, Usher Institute, University of Edinburgh
  Address: Usher Institute, Medical School, University of Edinburgh, Teviot Place, Edinburgh EH8 9AG, UK

During the COVID-19 pandemic, world leaders should pay more attention to those populations living in the poorest conditions, such as the homeless, those in prisons, poor ethnic & racial minorities, and millions of distressed migrants and refugees in unsanitary camps, settlements, shelters or detention centres. These vulnerable groups are most likely to suffer the consequences of inadequate and inequitable access to testing, treatment and medical care[1]. Socio-economic circumstances determine the distribution of health conditions in populations and the severity of outcomes.

Poverty drives unjust disparities (inequalities, or more accurately, inequities). However, social and health inequalities are not limited to economic hardship – as we are witnessing worldwide during the COVID-19 pandemic -politics plays a key role on who is affected most. The success of our global response to this pandemic will rely on the responses of the weakest health systems. Sadly, health care remains a luxury for many low-income populations.

The World Health Organization (WHO) consistently states that accurate and timely information for all communities is fundamental for successful public health intervention[2]. Yet, misinformation together with lack of culturally and linguistically adapted health promotion and information is apparent, including divisive, politicized public health discourse[3]. Furthermore, the world continues to neglect previous lessons from Public Health Emergencies of International Concern (PHEIC) such as Influenza H1N1 pandemic in 2009, the Ebola outbreak in West-Africa in 2014, and the Zika 2015 pandemic[4]. The critical lessons are that the only way of successfully mitigating the disease is by actively reaching out so ´leaving no one behind´. Social, economic and health inequalities experienced by impoverished communities are certain to be exacerbated as COVID-19 affects the already weak health systems, jeopardizing their emergency and preparedness plans.

Mostly, marginalised populations living with a low-income, or in poverty in high-income countries, have shorter life expectancy[5], and more surprisingly a high and rapidly rising burden of chronic respiratory disorders, cardiovascular diseases and diabetes mellitus, three of the most common co-morbidities found to increase COVID-19 mortality [6]. Those living in lower socioeconomic strata have additional hazards such as increased, prolonged and continuous exposure to contagious diseases (including COVID-19) associated with overcrowded working and living conditions, as well as slower, weaker and insufficient health system responses. These structural factors, in addition to political and institutional bias, increase the risk of acquiring infection, staying ill for a longer period of time, and increased COVID-19 mortality.

Impoverished communities struggle with both the health of their people and the short-and-long-term impact on their local economies. Many families depend on a daily income and can neither maintain nor achieve social distancing given the nature of their housing and workplace. Therefore, recommendations applied in China, much of Europe and North America might not be feasible and certainly will not be sustainable. Even in high-income countries people from the lower socio-economic strata, are more likely to suffer the unintended consequences of city or nationwide shutdowns, especially for those with informal employment or absent employee benefits.

Already, we have learned important lessons from Asian and European countries where COVID-19 left a mark. However, this pandemic is taking its toll in African, Oceanian and Latin American countries, some of them only recovering from severe damage to their health system, recent and historical socio-economic challenges. Moreover, combating COVID-19 in addition to HIV, tuberculosis, malaria or malnutrition will overburden already strained health care systems without international aid. Multidimensional poverty analysis could help us pinpoint which countries have the least opportunity to respond according to WHO standards, and focus global health and related institutions in supporting the mobilization of humanitarian resources to allow the needed public health interventions, health care and social welfare.

This is the time for all sectors from the global governance of health to act. Multiple statements by international organisations and academic groups have been made about the importance of including migrants & refugees and ethnic & racial minority groups in the Covid-19 response[7–10], including calls for suspension of any policies that may exclude these. Comprehensive, ongoing analysis of the economic and health impacts of COVID-19, and guidance on how to mitigate these, involving governmental, international and community-based organisations, is required to achieve effective, evidence-based truly inclusive responses. Without international cooperation and global unity, this might not be possible.

COVID-19 does discriminate, in affecting the poorest populations maximally. Therefore, our actions should be inclusive and prioritise such populations. Without any exception, citizens and non-citizens alike. In turn, every person has a role and responsibility in utilising their expertise in helping governments, relevant institutions and health services in combating this pandemic.

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Declaration of competing interest:

Drs. Martinez, Sedas, Orcutt, and Bhopal have no conflicts of interest.