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Monitoring inequalities is a key part of the efforts to end AIDS, tuberculosis, and malaria

HIV/AIDS, tuberculosis, and malaria kill more than 2 million people every year1–3 and cause a disproportionate burden on the world’s most disadvantaged people. WHO recognises the urgency of tackling inequalities and redoubling efforts to prevent and control these diseases during the COVID-19 pandemic and looking ahead to post-pandemic recovery. The uneven progress to date in addressing inequalities in HIV/AIDS, tuberculosis, and malaria is a complex issue and requires strengthening of people-centred primary health care and universal health coverage, as well as multisectoral actions on the social determinants of health. One element that can help advance this agenda is to institutionalise and strengthen inequality monitoring as part of these efforts. An up-to-date analysis of inequalities in HIV, tuberculosis, and malaria can help inform equity-oriented approaches to tackle these diseases.

A new report from WHO and The Global Fund to Fight AIDS, Tuberculosis and Malaria, State of Inequality: HIV, Tuberculosis and Malaria,4 to which we contributed or helped develop, was launched on Dec 9, 2021. This is the first monitoring report to systematically assess the global state of inequalities in these diseases. This analysis, which used global data for 32 health indicators and five inequality dimensions, highlights the extent and magnitude of inequalities in the past 10 years (2011–20) compared with the previous decade (2001–10). Four major findings from this report are relevant to the global health community.

First, the report reveals major deficiencies in the availability of disaggregated data suitable for the monitoring of inequalities in HIV, tuberculosis, and malaria. The limited scope in terms of the number of countries, health indicators, and inequality dimensions available for inclusion in the analysis underscores the urgent need for more, better, and timely disaggregated data.

Second, the report shows there are widespread inequalities across many aspects of HIV, tuberculosis, and malaria, where data are available, including...
HIV testing, social protection for families affected by tuberculosis, and care seeking for children with malaria symptoms. National improvements in disease burden, intervention coverage, and disease prevention continue to leave the poorest, least educated, and rural populations behind. In many countries, inequalities have not narrowed over the past decade. Further research, including context-specific and in-depth qualitative and quantitative analyses, is needed to understand why these inequalities persist, what drives them, and how interventions can be designed to effectively reduce inequalities that are unfair and remediable.

Third, the report identifies examples where inequalities are small and interventions have successfully prioritised groups with the greatest need through targeted campaigns to achieve faster improvements among disadvantaged subgroups. For instance, several countries reported higher coverage of malaria prevention indicators related to insecticide-treated bednets among the poor, least educated, and rural subgroups, where the malaria burden is concentrated, compared with the richer, more educated, and urban subgroups. The encouraging examples described in the report contain important lessons for developing and scaling equity-oriented approaches to accelerate improvements among disadvantaged populations.

Fourth, the report quantifies possibilities for improving national averages by eliminating inequalities. For example, by ensuring that all pregnant women in a country have the same level of HIV testing as pregnant women in the richest 20% of the country, the current overall level of testing (weighted average across 46 countries with data) would increase from 40% to 64%. By eliminating economic-related inequalities in care seeking for children younger than 5 years with fever—an indicator related to malaria testing and treatment—there would be a 26% improvement in the weighted average across 28 countries. Reducing and eliminating unfair inequalities requires sustained and targeted action to expand access to health services, together with cross-cutting action on the social, economic, political, environmental, cultural, and commercial determinants of health.

More should be done to monitor inequalities in HIV, tuberculosis, and malaria as a means to deliver equity-oriented actions. The 74th World Health Assembly in May, 2021, recognised the need to establish, strengthen, and maintain sources of disaggregated data to assess inequities in health, and called on WHO to redouble efforts to measure, assess, and address the social determinants of health and health inequities. Alongside investments in data availability, timeliness, and quality, inequality analyses and reporting should be done at regional, country, and subnational levels. This entails building capacity for frequent inequality monitoring. WHO has an expanding collection of tools to support capacity building for health inequality monitoring, analysis, and reporting.

Inequalities in HIV, tuberculosis, and malaria are barriers to ending these diseases. To generate accountability mechanisms for equity and bring attention to priority population groups, inequality indicators and targets should be further prioritised and integrated in the core national and global monitoring frameworks for HIV, tuberculosis, and malaria programmes and policy strategies. For example, global immunisation programmes have shown how this is possible, tracking equity indicators as part of their monitoring frameworks. The State of Inequality report series, including accompanying interactive data visualisation, shows how comprehensive inequality monitoring can be conducted across health topics, and where more data are needed for expanded analyses.

The COVID-19 pandemic has been a setback to HIV, tuberculosis, and malaria programmes, stalling past progress. While monitoring alone will not end epidemics, strengthened inequality monitoring, together with other forms of evidence, are needed for equity-oriented responses to increase service coverage, prevent and reduce the burden of these diseases, and help efforts towards achieving the Sustainable Development Goals.

We are all employed by WHO. ARH, NB, KK, AS, and CVF led the development of the State of Inequality: HIV, Tuberculosis and Malaria report and SMF reviewed drafts of the report. WHO received funding from The Global Fund to Fight AIDS, Tuberculosis and Malaria for the development of the report. We declare no other competing interests. The cover of the report used in this Comment is reproduced from WHO, State of inequality: HIV, tuberculosis and malaria, Geneva: World Health Organization, 2021. Copyright © 2021. World Health Organization.

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The COVID-19 pandemic has brought new challenges for those working in public health to design, deliver, commission, and evaluate public health services. The impacts of the COVID-19 pandemic have amplified many of the inequalities that are pervasive in our communities.\(^1,2\)

COVID-19 has brought new challenges for those working in public health to design, deliver, commission, or evaluate public health services. The impacts of the COVID-19 pandemic have amplified many of the inequalities that are pervasive in our communities.\(^3,4\) However, in the pandemic’s long shadow, the public health community can re-lay the foundations for a fairer society that focuses not only on health outcomes, but also on wellbeing, equity, inclusiveness, and sustainability.

In this tenth anniversary year of the public health conference, we intend to provide a focus on the achievements, strengths, and exceptional talent of public health science over the past 10 years in the UK and Ireland. We therefore welcome submissions from all disciplines that affect public health, and we particularly seek interdisciplinary abstracts that look forward at how best to rebuild and strengthen our public health systems to improve health and wellbeing and reduce health inequalities after COVID-19 in an evidence-based way, whether such evidence is drawn directly from pandemic learning or from broader contexts. We welcome perspectives from those working across all sectors and disciplines, including but not limited to the UK National Health Service, local authorities and commissioned services, charities and advocacy organisations, universities, and government bodies.

The conference will consist of oral paper presentations, chaired poster sessions, and keynote speeches. Submissions are now open for oral and poster presentations. Abstracts can be submitted under any of the three core themes: creativity in public health science; new methodological approaches to public health science; or impact and implementation of public health systems to improve health and wellbeing. Abstracts should be a maximum of 300 words, be written in English, and contain no references, tables, or figures. Submissions should include the following sections: background (including context and aim); methods; findings; and interpretation. Please also include a non-declaratory title (including a study descriptor—eg, retrospective cohort study, randomised controlled trial); names, titles, highest

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