

Comparison of health, economy, and educational consequences of covid-19 across and within countries¹

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ABSTRACT

This article sought to document the impact of the COVID-19 pandemic on health, economy, and education. While the overall impact of the pandemic has been tremendous, I have also described how the severity of the impact varied across countries and among social groups within societies. The international differences contrasted lower- vs higher-income countries, socialist vs capitalist societies, and nations that did or did not have governments oriented to scientific evidence and populations that trusted the government. Inter-group differences contrasted groups that differed by social economic status, race/ethnicity, and gender. In general, the pandemic reinforced existing inequalities across nations and among social groups within nations. Part of the explanation of the overall impact as well as the differences in the impact of the pandemic include decisions and behaviors of individuals, but the policies and (in)action of governments clearly also played a substantial role.

Keywords: COVID-19 pandemic, educational inequalities, health inequalities, economic inequalities.

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¹This is a revised and substantially expanded version of manuscript, Editorial Note (Dunlop and Ginsburg, 2022), which was developed in consultation with my coeditor of the special issue of the *Journal of Education in Emergencies* focused on “Education in Pandemics” (volume 8, number 3). I should note that at least four other journals organized special issues focused on education during the contemporary pandemic: *Current Issues in Comparative Education* (2022, Volume 24), *Journal of Comparative and International Higher Education* (2022, Summer), *NORRAG* (Special Issue No. 6), and *Prospects* (2020, Volume 49).

INTRODUCTION

Black et al. (2021, p. 48) state that “unsurprisingly, the effects of COVID-19 amplified ... inequalities.” In this article, I draw on a wide range of literature to describe and analyze how the COVID-19 pandemic had unequal impacts – in terms of health, economy, and education – on different countries and different groups within various countries.

To begin our discussion, I note that the “word ‘pandemic’ comes from the Greek *pan* meaning ‘all’ and *demos* ‘the people’” (Qiu et al., 2016-2017, p. 3). And the World Health Organization defines a pandemic as “an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people” (WHO, 2011; quoting Last, 2001; see also Felman and Simpson, 2020).

Furthermore, while much of the literature I draw on

here centers on the impacts of the COVID-19 pandemic (2019-??), history has been “plagued” by a long list of pandemics (Table 1). And as also shown in Table 1, COVID-19, while killing 6,390,401 people worldwide (as of 29 July 2022), has not been the worst case. That “honor” goes to the 18th Century Great Plagues, which caused 600 million deaths during a one-hundred-year period, followed by the Black Death or Bubonic Plague (1347-1351), which caused 200 million deaths, and the Spanish Flu (1918-1919), which cause 40-100 million deaths (Barry, 2005; Beach et al., 2020; Crosby, 2003; Outka, 2020; Wooliscroft, 2008).

But why do pandemics occur? There is clear evidence that many of the virus-based pandemics erupting during at least the 20th and 21st centuries emerged as a result of transmission from other animals (e.g., bats, birds,

Table 1. History of Pandemics.¹

Name	Year(s)	Deaths Globally
Antonine Plague	165-180	5 million
Plague of Justinian	541-542	30-50 million
Japanese Smallpox Epidemic	735-737	1 million
Black Death (Bubonic Plague)	1347-1351	200 million
Smallpox	1520	56 million
17 th Century Great Plagues	1600-1699	3 million
18 th Century Great Plagues	1700-1799	600 million
Cholera 6 outbreak	1817-1923	1 million
The Third Plague	1855	12 million
Yellow Fever	Late 1800s	100-150 thousand
Spanish Flu ²	1918-1919	40-100 million ³
Russian Flu	1889-1890	1 million
HIV/AIDS	1981-present	25-35 million
Asian Flu	1957-1958	1.1 million
Hong Kong Flu	1968-1970	1 million
SARS CoV-1	2002-2003	770
Swine Flu	2009-2010	200 thousand
MERS CoV (Middle East Respiratory Syndrome)	2012-present	850
Ebola	2014-2016	11.3 thousand
COVID-19 (SARS CoV-2)	2020 (thru 2 August 2022)	6,390,401

¹ Adapted from LePan (2020), Loyola University-Chicago and St. Edwards (2020), Open Society Foundation (2020), and Velikova (2020), with the COVID-19 death figure obtained from WHO (2022).

² There is debate regarding the origins of what became known as the Spanish Flu of 1918-1919. For instance, Kelly (2022a) suggests that “the breeding ground” for the pandemic was in the “army barracks in the Midwest [of the U.S.] ... World War I soldiers ... quickly spread the flu around the world. ... Spain raised the alarm, and that’s how that pandemic was mislabeled” (see also Barry, 2005; Outka, 2020). Nevertheless, Outka (2020, p. 9) observes that “some scientists now propose Asia as a possible source, and others find that the location is too difficult to determine.”

³ According to Outka (2020, pp. 10-11), the so-called Spanish Flu “was the deadliest pandemic in history in terms of numbers, though the bubonic plague killed a higher percentage of the much smaller existing population. ... [Moreover, in contrast to] “a typical flu season, ... the fatalities were also high among healthy men and women between twenty and forty years of age” (see also Barry, 2005; Griffin and Denholm, 2020).

chimpanzees) to humans (Arnold, 2018; Wallace, 2020). With regard to the coronavirus, some have theorized that it was produced and then somehow escaped from a laboratory in China (Lerner, 2022). However, I agree with Worobey et al. (2022) that the preponderance of evidence indicates that the source of the virus was animals being sold in the “wet market” in that city.

However, we need to seriously consider whether global deforestation and extraction activities have “destroy[ed] ecosystems and disrupt[ed] wildlife ... [This] can therefore be seen as part of the larger planetary ecological crisis or metabolic rift engendered by twenty-first-century capitalism” (Bellamy Foster et al., 2021b, p. 10; Bellamy Foster et al., 2021a; Fraser, 2022; Oliver, 2022; Open Society Foundation Education Program, 2020; Vidal, 2020; Wallace, 2020). Accioly and Macedo (2022, p. 1) elaborate on this point in the introduction to their book, *Education, Equality and Justice in the New Normal: Global Responses to the Pandemic*:

We deeply believe that the coronavirus pandemic and its educational and societal ramifications cannot be

comprehended through an amorphous approach that reduces the danger ... we face worldwide to biology and medical threats alone. ... [We argue that the] coronavirus became the flashpoint that unveiled how capitalism, particularly through neoliberalism and its “Godification” of the market, had been exploiting and ravaging the planet to the degree that could only lead to its eventual unsustainability (Apple, 2022).

Moreover, Chomsky and Horvat (2020, p. 44) describe the COVID-19 pandemic as stemming from “a colossal market failure” of global capitalism, exacerbated by the savage neoliberal intensification of deep socioeconomic problems. ... Between then [the SARS epidemic of fifteen years ago] and now, labs around the world could have been working on developing protection for potential coronavirus pandemics. Why didn’t they? The market signals were wrong.” And it is important to remember that disease spreads more easily among people who have other health complications, inadequate housing, and insufficient nutrition – all elements that could be reduced or avoided if the global and local economies were

organized to meet human needs. Additionally, as Taylor and Adler (2020, p. 149) observe, “many people ... perish not solely because of the virus, but because countries don’t have the resources or public health infrastructure to handle it. This isn’t a natural disaster, in that sense, but a social disaster” (Goodman and Chomsky, 2022; Kelly, 2022b). And, in the provocatively titled book, *Coronavirus Criminals and Pandemic Profiteers*, Nichols (2022a) argues why so many died and suffered during the pandemic in the U.S. and globally. The volume identifies individual and organizational culprits (e.g., Donald Trump and Pfizer) and describes: crimes, conspiracies and corruption. It rejects the claims of apologists and revisionists who would have us believe that the pandemic was the healthcare equivalent of a ‘natural disaster’ that would have gone badly no matter who was in charge. It argues that during the period from early 2020 to early 2021, choices were made, decisions were taken, and lies¹ were told that cost not a few lives, but hundreds and hundreds of thousands of lives that did not need to be lost. (Nichols, 2022a, p. 8; Bezruchka, 2022).

HEALTH IMPACT: INFECTION AND MORTALITY RATES DUE TO COVID-19

It is noteworthy that, as of August 2022, when this manuscript was being finalized, the infection and death tolls of the COVID-19 pandemic were still climbing and had already far outdistanced predictions. For example, in 2013, the AIR Worldwide Research and Modeling Group estimated the effects of a pandemic similar to the Spanish Flu occurring today “would result in 188,000—337,000 deaths in the United States alone” (Arnold, 2018, pp. 298-299). And even early on in the COVID-19 pandemic, on 31 March 2020, Dr. Anthony Fauci, the top infectious-disease expert in the country, and Dr. Deborah Birx, who was coordinating the coronavirus response at the time, projected that “the virus might kill as many as 240,000 Americans” (Bosman, 2021, p. 40), a figure that was less than half the actual number of deaths registered by 19 March 2021 (CDC, 2021a) and less than one-fourth the actual number of deaths registered by 2 August 2022 (WHO, 2022) in the United States.

In the midst of this pandemic, it is a challenge to report such statistics. First, the figures available at any point in time are subject to errors in reporting (including insufficient access to testing, limitations of some national health data systems, and outright misreporting).² Second,

¹ Peters and Besley (2021, p. 6) introduce the term, “viral politics,” which they define as “the deliberate use of misinformation, innuendo and lies for political purposes that often depend on viral media where truth is no longer considered to be an issue.”

² Jerving (2022) reports that the World Health Organization indicated that “excess deaths” from COVID-19 were likely three times higher than what governments reported. Moreover, according to Mazer (2022), the statistics on people experiencing “long COVID” are even challenging to collect and report.

the statistics are literally moving targets. For example, on 17 January 2021, approximately when I began doing the research on which this manuscript is based, the World Health Organization (WHO) reported that globally there had been 89,047,781 infection cases and 1,933,110 deaths registered. However, on 2 August 2022, when my research basically concluded, WHO reported that globally there had been 589,834,012 confirmed infection cases and 6,390,401 deaths registered. Importantly, COVID-19 hit in waves, activated by different variants, including Delta and Omicron and its many sub-variants (Al-Shami, 2021).

International differences in infection and death rates

The health impacts of COVID-19 differed significantly across countries, in large part because of the pre-pandemic situations in societies, but also because of government as well as citizens’ actions or inactions in response to the pandemic (Kelly, 2022b; Peters and Besley, 2021). For example, Cave (2022) observes that despite many similarities between the two countries,

Australia’s Covid death rate sits at one-tenth of America’s, putting the nation of 25 million people (with around 7,500 deaths) near the top of global rankings in the protection of life. ... Australia’s Covid playbook produced results because of ... a lifesaving trait that Australians displayed from the top of government to the hospital floor, and that Americans have shown they lack: trust, in science and institutions, but especially in one another (Astra and Zenovic [2022] comparing the U.S. and China).

Silva-Ayçaguer and Ponzó-Gómez (2021, pp. 68-70) provides an overview of some of the results of a study of 16 Latin American countries carried out in March 2021:

Cuba is used as a reference to calculate relative risks ... because it occupies the best position for both indicators in mid-March 2021. In terms of mortality, Uruguay follows, although with an appreciable difference: a crude mortality rate 6.2 times higher, which is still appreciably distant from the rest. In terms of morbidity [infection rate], after Cuba, there are several countries with similar rates. ... The successes of both Uruguay and Cuba in the first months of their respective epidemics ... [can be explained by the ... strengths of [their] ... health systems ... [and their] universal comprehensive healthcare coverage.³

The above-noted Latin American findings coincide with the general argument that there was a differentiation between the socialist and capitalist approaches to the virus. The socialist approach [e.g., in Cuba and Vietnam] is based on 1. Science-based government action, 2. Public sector production of essential materials, 3. Public

³ See also Perry’s (2022) discussion of “Nicaragua’s inconvenient Covid victory.”

action mobilised to facilitate social life, 4. Internationalism. In the capitalist states (such as the United States, Brazil, and India), the governments have instead operated in a hallucinatory manner, pretending that the virus is either not real or not contagious ... For-profit sector firms have failed to provide the necessary equipment, while public action has been hard to galvanise ... (Tricontinental, 2020b, pp. 7-8)⁴

Black et al. (2021), focusing on the pandemic experiences in South Africa and the United States, argue that “COVID-19 is a pandemic of racial capitalism” (p. 49).

To further explore the socialist versus capitalist system COVID-19 realities, we compare the pandemic experience of Cuba and the United States (Burdynska-Schuurman, 2022; Curcio, 2021; Powell et al., 2021). To start with, according to the World Health Organization (WHO, 2 August 2022), the U.S. recorded 2.8 times the number of cases of COVID-19 per 100,000 population than did Cuba (27,131 vs 9,781) and witnessed 4.1 times the number of COVID-19-related deaths per 100,000 population than did Cuba (308 vs 75).⁵ Urra (2020) outlines three of the factors influencing Cuba’s relative success in combatting the disease: “1) the coordinated actions of health agencies and entities working directly together to combat the disease, 2) the merging of science and medical treatment working in coordination with a deep understanding of the solution needed to fight a pandemic, [and] 3) the understanding by the population of the need to comply with measures needed to control the disease.” Additionally, Powell et al. (2021, pp. 2188-2189) report that: a unique feature of the Cuban response to COVID-19 has been its nationwide screening effort, which was enabled by the country’s strong primary health care system. ... The information was given to the ... family doctor, who ... then provided follow-up to individuals reporting respiratory symptoms. ... [Furthermore,] strategic-informative communications [on state-run television] related to COVID-19 began early in the pandemic, and health officials regularly provided ‘comprehensive stay-at-home messaging’ that kept the public up to date and encouraged a collaborative spirit.

To these elements, we need to add the differences between the United States and Cuba in the production and, perhaps more important, the distribution of COVID-19 vaccines. The U.S.’s approach was to direct government funding⁶ to private-sector companies (viz.,

Moderna, Johnson & Johnson, and Pfizer) to develop the vaccines and to administer these without charge to consumers through a network of private entities as well as some county public health organizations, beginning on 14 December 2020 (Cohen, 2020; Frank et al., 2021; Howard and Wright, 2021). In contrast, Cuba mobilized the various state-run biopharma companies to develop 5 vaccines, three of which it began to administer to the population via its extensive set of *consultorios* or doctors’ offices on 12 May 2021 (Augustin, 2022; Beaubien, 2022; Frank and Acosta, 2021; Goodman et al., 2021; Goodman and Valdés-Sosa, 2022; Hosek, 2022; Kunzman, 2021; Meredith, 2022; Powell et al., 2021; Reardon, 2021; Stancil, 2021).⁷ While the vaccination effort began months earlier in the U.S., Cuba’s later start was made up for by a much more rapid and broad-based vaccination campaign. Thus, by 22 February 2022, Cuba had fully vaccinated 88.1% of its population, including people from 2 years of age (Guerra Cabrera, 2021; Schellekens, 2022; Sheridan, 2022), while the vaccination rate in the U.S. (66.6%) and the world (62.0%) were substantially lower (WHO, 2022).

Finally, with regard to international variations in COVID-19 indicators, we should note the different orientations of the U.S. and Cuba regarding commitments to vaccinate people around the world (Chintan, 2022). The private companies in the U.S. (Kelly, 2022a), which had been funded by the government to develop and distribute the vaccines, resisted the World Trade Organization’s authorizing a waiver on patents so that other countries could produce the vaccines (Green, 2022b; Kelly, 2022a; Nichols, 2022b).⁸ However, in December 2021, USAID committed \$500 million to distribute vaccines around the world, “if it can secure funding from the U.S. Congress” (Igoe, 2022; but see Kelly and Hodges, 2022; Lazare, 2022). And USAID had previously identified – and began efforts to address – the fact that “simply getting vaccines to countries is only the beginning of the challenge,’ given that of 128 low-income and middle-income countries ‘only 30% have developed processes to train the large number of vaccinators who will be needed’” (Igoe, 2021; World Bank, 2021a). With regard to Cuba, its strategy from the

⁴ Tricontinental (2020b, p. 43) qualifies this conclusion by noting that there were “exceptions to these reactions among the capitalist states. Several states in East Asia – such as Japan and South Korea – as well as Australia and New Zealand had been prepared by the SARS outbreak of 2003, and they did not destroy their public health infrastructure in the decades that followed” (see also Waitzkin, 2021).

⁵ Covid-19 statistics obtained at WHO (2022), WHO Coronavirus (COVID-19) Dashboard (<https://covid19.who.int/table>). Population figures obtained from Worldometers.info World Population by Country (2022) (<https://www.worldometers.info/world-population/population-by-country/>).

⁶ Nichols (2022b) comments that “the notion that the ‘private sector’ achieved all this entirely on its own is ... wrong. None of its diagnostics, therapeutics, or

vaccines would exist if the U.S. and other developed countries hadn’t the government-funded research before the companies stepped in to exploit it” (see also Frank et al., 2021)

⁷ It is noteworthy that “when it became clear [that Cuba] couldn’t manage on its own,” primarily because of the impact of the U.S. blockade, solidarity “organizations in the U.S. and Europe ... launched campaigns to collect donations to buy syringes and have them shipped [to Cuba] to help narrow a deficit of as many as 25 million syringes” (Brasileiro, 2021).

⁸ As Lazare and Oamek (2022, p. 12) explain, “Big Pharma has been caught in a big lie. ... Among Big Pharma’s talking points [in opposing the waiver was ... that even if we got rid of all intellectual property rules tomorrow, global vaccine supply would not change much. ... [Nevertheless,] on Oct. 22, 2021, the *New York Times* ... identified 10 facilities in India, Brazil, Thailand, South Africa, Argentina, and Indonesia as strong candidates [with] ... existing facilities [and] human capital” (Lazare and Oamek, 2022; Maranges, 2021).

start was to develop more vaccine doses than needed to inoculate its own population, with the explicit plan to distribute its vaccines to other nations at low prices or for free (Guerra Cabrera, 2022a and 2022b; Kunzman, 2021). It began to do so to Argentina, Iran, Mexico, Nicaragua, Venezuela, and Vietnam, beginning in September 2021 (Beaubien, 2022; Kunzman, 2021; Powell et al., 2021; Stancil, 2021), and then on 24 January 2022 announced its commitment to distribute 200 million doses (Goodman and Valdés-Sosa, 2022; Kelly, 2022a; Progressive International, 2022), which will be facilitated once Cuba's vaccine production facilities are certified as meeting WHO standards (Espinosa-Pool, 2021; Fors Garzon, 2022; Garcia, 2022).

Intergroup variation in infection and death rates

Moreover, the health-related impacts of the COVID-19 pandemic have not been uniform within given societies (Black et al., 2021; Goodman and Chomsky, 2022; Katu et al., 2022; Landry, 2022; Leonhardt, 2021). This is the case with respect to both infection and death rates. For instance, within the U.S., according to the Centers for Disease Control and Prevention (CDC, 2022b): a) the rate of infection (%Cases/%Population) varied from 0.7 for Asian Non-Hispanics and 0.9 for White Non-Hispanics to 1.7 for Black Non-Hispanics, and 1.4 for American Indians/Alaska Non-Hispanics, and 1.3 for Hispanics/Latinos and b) the rate of dying from COVID-19 (%Deaths/%Population) varied from 0.6 for Asian Non-Hispanics and 1.0 for White Non-Hispanics to 1.5 for American Indians/Alaska Native Non-Hispanics, 1.1 for Black Non-Hispanics, and 0.9 for Hispanics/Latinos.

Moreover, Žižek (2020, p. 88) commented that in the U.S. "Blacks and Hispanics are much more likely to die from the virus than white Americans (Flounders, 2020; Kelly, 2022a; Nichols, 2022a; Powell et al., 2021). Furthermore, while echoing the concerns identified above about racial and ethnic group inequalities in the U.S., Rosenthal and Parra (2021) point to the more negative impact on "poor and working-class populations, and especially elderly and disabled people living in nursing homes and long-term care facilities (along with the perhaps less-documented populations of homeless people and disabled people on the verge of entering nursing homes)."

Interestingly, the race and class figures in the U.S. were likely influenced by political perspectives – and associated acceptance or resistance to recommendations for being vaccinated and wearing masks. In this regard, Leonhardt (2021) reports that "in October [2021], 25 out of every 100,000 residents of heavily Trump counties died from COVID, more than three times higher than the rate in heavily Biden counties (7.8 per 100,000). October was the fifth consecutive month that the percentage gap between the death rates in Trump counties and Biden

counties widened."

With respect to other countries, Accioly and Macedo (2022, p. 2) observe that "the coronavirus and its subsequent ravages ... have had disastrous adverse impacts on nonwhite and lower-class populations ... From Brazil to India ..., socially and economically disadvantaged ethnic groups have had a higher mortality rate due to the coronavirus contagion. ... [These groups] experience both higher rates of contagion and death and less access to quality health care and education." And focusing on South Africa, Zillo Phiri (2021, pp. 48-49) indicates that "the current COVID-19 pandemic cannot be abstracted from the materiality of racial capitalism, white supremacy, and global empire making. COVID-19 blatantly exhibited the social inequalities of South African society that have always been predicated on anti-Black racism and genocide."

ECONOMIC IMPACT OF PANDEMICS

We should note that in addition to the impacts on health, "pandemics have a range of negative social, economic and political consequences" (Qiu et al., 2016-2017, p. 5). That is, as Taylor and Adler (2020, p. 149) explain, "it is not just a health crisis, but an economic crisis, social crisis, and, above all, a political crisis." Here I will focus on the economic impact of the pandemic.

As a historical example, Beach et al. (2020) comment that "the second lesson from 1918 is that it caused an economic contraction, reducing both GDP and employment" (Evans, 2020). And Decerf et al. (2020, p. 2) sought to estimate the social and economic impact of the COVID-19 pandemic, reporting that "as of early June 2020, the pandemic (and the observed private and policy responses) has generated at least 68 million additional poverty years and 4.3 million years of life lost across 150 countries."⁹ The early-on impact was also noted by Popa (2020, p. 2): "The COVID-19 crisis could push half a billion more people into poverty globally (Oxfam 2020). Additionally, the ILO (2020) estimated that nearly 25 million jobs could be lost globally due to the coronavirus."

Findings from more recent analyses include: The impact of the pandemic on world GDP growth is massive. The COVID-19 global recession is the deepest since the end of World War II ... The global economy contracted by 3.5 percent in 2020 according to the April 2021 World Economic Outlook Report published by the IMF, a 7 percent loss relative to the 3.4 percent growth

⁹ Decerf et al. (2020, p. 1) explain that "additional years spent in poverty (PY) are conservatively estimated using growth estimates for 2020 and two different scenarios for its distributional characteristics. Using years of life as a welfare metric yields a single parameter that captures the underlying trade-off between lives and livelihoods: how many PYs have the same welfare cost as one LY. Taking an agnostic view of this parameter, estimates of LYs and PYs are compared across countries for different scenarios."

forecast back in October 2019 (Yeyati and Filippini, 2021, p. 1).

Global growth is expected to decelerate markedly in 2022, from 5.5% to 4.1% ... This reflects the continued disruption caused by COVID-19, as well as supply bottlenecks. ... [Additionally,] the slowdown in global growth from 2021 to 2022 could be sharper if the fast spread of Omicron overwhelms health systems and prompts a re-imposition of strict pandemic control measures in major economies (Quaglietti and Wheeler, 2022).

These same authors highlight differences in economic impact across countries: a) "While virtually every country covered by the IMF posted negative growth in 2020 (IMF 2020b), the downturn was more pronounced in the poorest parts of the world" (Yeyati and Filippini, 2021, p. 1) and b) "Although output and investment in advanced economies are projected to return to pre-pandemic trends next year [2023], they will remain below in emerging market and developing economies" (Quaglietti and Wheeler, 2022).

In terms of within-country inequality in economic impacts of COVID-19, "we can clearly see the ways in which the present [COVID-19] pandemic is fragmented along very familiar fault lines in terms of class and social position" (Taylor and Adler, 2020, p. 149). That is, "people are suffering but not everyone is suffering equally" (Edwards, 2021, p. 30). For example, "just as social distancing and lockdowns were being instituted and unemployment was soaring to the highest levels since the Great Depression, ... the U.S. stock market experienced its biggest increase since 1974 in the week of April 6 to 10" (Bellamy Foster et al., 2021b, p. 10). Additionally, note that "In the midst of this global health, political, economic, and social crisis, it is often women who bear the brunt of the cataclysmic shifts in daily life, from the increasing care work of children, the elderly, and the sick to skyrocketing incidences of gender-based violence, as women ... are quarantined with their abusers" (Tricontinental, 2020a, p. 6).

IMPACT ON EDUCATION

During the 1918-1919 Spanish Flu pandemic educational institutions were closed in various countries for extended periods of time (Arnold, 2018; Guimbeau et al., 2022; La Monica, 2020; Mlynaryk and Makovac, 2020; Outka, 2020; Stern et al., 2009). Similarly, when COVID-19 hit, early childhood education centers, schools, and higher education institutions were closed (Agyapong et al., 2020; Borg and Mayo, 2022; Coutinho and Côco, 2020; Education Cannot Wait et al., 2021; Education International and UNESCO, 2020; Essah et al., 2022; Hale et al., 2021; Jensen et al., 2022; Open Society Foundations Education Program, 2020; Reimers et al., 2021; Săsa, 2020; Schleicher, 2020; UNESCO et al., 2020; Wang, 2021; Wijaya et al., 2020; World Bank,

2020a and 2020c).^{10,11} As reported in a study that was updated as of 13 January 2021, "98% of countries have implemented full or partial closures due to COVID-19 ... [and there were] 199 billion closed days of school in 2020" (Grob-Zakhary et al., 2021, p. 4). In addition, a study (REDS), conducted between December 2020 to July 2021 in Burkina Faso, Denmark, Ethiopia, India, Kenya, the Russian Federation, Rwanda, Slovenia, the United Arab Emirates, Uruguay, and Uzbekistan, found that: all 11 countries ... reported at least one period of physical school closure in response to the COVID-19 pandemic, during which most schools were closed for the majority of students. The periods of school closure varied within and across countries, mostly starting in the Northern Hemisphere in the Spring of 2020, and lasting one to two months in the Russian Federation and Denmark to almost a year in the United Arab Emirates. In addition to this large variation in the duration of school closures, there were also differences in the participation of students in schooling and the modes, media, and teaching methods used in these periods (Meinck et al., 2022, p. xvii; see also Corwith and Ali, 2022).

According to more recent data released by UNESCO on International Day of Education (5 October 2021), "schools are currently open in most countries of the world (135). In a small number of countries (25), schooling has been temporarily suspended by extending the end-of-year break. Only a dozen countries have opted to close schools and pivot to fully remote rather than in-person learning since the outbreak of the Omicron variant. This is in stark contrast with the same period last year when schools were closed, and learning was fully remote in 40 countries" (UNESCO, 2022a).¹²

The strategy of distance education is also mentioned by UNESCO et al. (2020, p. 6): "As schools closed around the world to limit the spread of COVID-19, governments moved quickly to offer remote learning options, including through online platforms, television, radio and paper-based take-home packages" (Cameron et al., 2021; Crompton et al., 2021; Einhorn, 2020; Mladenova et al., 2020; UNESCO et al., 2020; Wijaya et al., 2020; Zhao, 2020).

However, Nóvoa and Alvim (2020, p. 37) note the challenges faced by government authorities, who "were dependent on platforms and content made available by private companies and were not even able to ensure

¹⁰ And such actions also contributed to hunger. Especially in countries having school feeding programs: "with classrooms closed for months because of the pandemic, millions of children are going hungry" (Flounders, August 2020, p. 9).

¹¹ Hoechner and Idris (2022) document how in northern Nigeria Qur'anic school students were seen by authorities as the source of the pandemic and as dangerous (i.e., as potential terrorists); these perceptions served to justify forced Qur'anic school clearances and student deportations.

¹² As an example, Green (2022) notes that Uganda's "22-month school closure ... [which ended in January 2022, represents] the longest pandemic-related shutdown in the world."

digital access for all students” (Elliot et al., 2022).

Evidence indicates that students were not satisfied with their remote learning experiences (e.g., see Mok et al., 2021). Moreover, the implementation of various distance education strategies created serious challenges for both teachers and parents. While in many contexts “the best answers” to the closure of schools during the pandemic “came from the teachers themselves” (Nóvoa and Alvim, 2020, p. 37; Education International and UNESCO, 2020; Lewin, 2020),¹³ we should note that teachers were challenged to reimagine and seek to continue their interactions with their students (Davis and Payan-Luna, 2022; Inal, 2022; Iyengar, 2020; Lassoued et al., 2020; Motala and Menon, 2020; Wang, 2021).¹⁴ Moreover, teachers also faced additional health and family-care responsibilities (Saini, 2022).

And for parents and other caregivers, who in normal times perform many educational roles with their children, found themselves with increased demands on their time and energy resources. With their children at home during what would have been school hours and with their children perhaps gaining access to online instruction, parents would be expected to supervise and offer assistance to their children’s cognitive and socio-emotional learning (Chabbott and Sinclair, 2020), despite not necessarily having the training to do so (Brown, 2022; UNESCO et al., 2020) and despite the increase in other family-care responsibilities. The impact of such challenges on parents is evidenced by the results of a nationally representative survey of 3,338 households administered in March and April 2020 in the U.S.: “Roughly 51% of eligible survey respondents indicated that at least one of their children was struggling with distance learning. ... [P]arents with children who struggled with distance learning experienced elevated mental health distress [i.e., anxiety, depression]” (Cassandra et al., 2021, p. 62; see also Davis et al., 2021).

Moreover, the various distance education strategies, while effective to varying degrees (e.g., Lassoued et al., 2020), certainly exacerbated the inequalities in educational access across and within countries (see also Borg and Mayo, 2022; Crompton et al., 2021; Mok et al., 2021; Zahir, 2022). For instance, with respect to international inequalities, Chabbott and Sinclair (2020, p. 7) observe that: a significant proportion of students—mainly those who were already under-resourced and at risk of under-achieving—had limited or no access to ICT.

¹³ Thus, Education International (2021) indicates that “on World Teachers’ Day, 5 October [2021], education unionists from all corners of the globe gathered to pay tribute to teachers and education support personnel lost during the COVID-19 pandemic, to honour their legacy, and to demand safe working conditions in education” (Peske, 2022).

¹⁴ Carter et al. (2022), drawing on a survey of teachers and school administrators in Rwanda in August 2020, report greater access to and use of technological devices for remote teaching by male and younger teachers as well as by teachers working in “better-resourced schools.”

... The negative impact of closures was especially severe in LMICs [lower and middle-income countries], where textbooks are often the main teaching technology and a significant proportion of students (sometimes the majority) still do not have their own copies (Abioui et al., 2020; Cameron et al., 2022; UNESCO et al., 2020.)

In relation to inequalities within nations, Schleicher, 2020, p. 1) explains:

The COVID-19 pandemic ... hit the most vulnerable hardest. ... Students from privileged backgrounds, supported by their parents ..., could find their way past closed school doors to alternative learning opportunities. Those from disadvantaged backgrounds often remained shut out when their schools shut down. This crisis has exposed the many inadequacies and inequities in our education systems – from access to the broadband and computers needed for online education, and the supportive environments needed to focus on learning, up to the misalignment between resources and needs. (Abioui et al., 2020; Arnove, 2020; Corcoran et al., 2022; Einhorn, 2020; Iyengar, 2020; Lassoued et al., 2020; Wijaya et al., 2020).

If there is a silver lining for those youth and families who have not had access to online platforms to continue their learning during the pandemic, it is that they largely escaped being targeted online by corporations that have been acquiring and selling their data. The Open Society Foundations Education Program (2020, p. 6) points to “significant concerns about data privacy and rights” (Ávila and Saranović, 2020; Lassoued et al., 2020; Operti, 2021). However, the concern is not just about corporations’ exploitation of personal data; it is also about governments’ invasion of privacy. As Zuboff and Ávila (2020, p. 235) mentions in a dialogue article discussing the book, *The Age of Surveillance Capitalism: The Fight for a Human Future at the New Frontier of Power*, “the last time ... [we witnessed] the massive expansion of the surveillance state and surveillance capitalism was 9/11 [i.e., September 11, 2001].”

As a consequence of the closure of educational institutions, despite various mitigation strategies, it has been estimated or found to lead to significant learning losses, which some suggest have the potential to affect future adults’ economic productivity and earnings (Einhorn, 2020; Kuhfeld et al., 2020a and 2020b; Soudien, 2020; UNESCO et al., 2020; World Bank, 2020a and 2020c).¹⁵ For instance, d’Orville (2020, p. 11) comments: with the spread of the virus, the education system is now facing an entirely new and massive crisis. According to UNESCO et al. (2020), more than 87% of the world’s student population—over 1.5 billion learners in 165 countries—have been affected by the temporary

¹⁵ Falisse et al. (2022) report that, in the Democratic Republic of Congo, the combination of the pandemic and the recently introduced abolition of school fees led to a worsening of parent-teacher relations and an increase in teachers exiting the profession after schools reopened.

closure of educational institutions. Not since World War II have so many countries around the world seen schools and educational institutions go into lockdown at around the same time and for the same reason. Extended school closures may not only cause loss of learning in the short term, but also diminish human capital and economic opportunities for children and youth over the long term.

And, based on a simulation conducted in the first year of the COVID-19 pandemic by the World Bank (2020c, p. 2), it was estimated that “COVID-19 could result in a loss of 0.6 years of schooling adjusted for quality, bringing down the effective years of basic schooling that children achieve during their schooling life from 7.9 years to 7.3 years.” In contrast, however, UNESCO Institute for Statistics et al. (2022, p. 11) report that based on studies in Burkina Faso, Burundi, Côte d’Ivoire, Kenya, Senegal, and Zambia, “students at the end of primary schooling have maintained learning outcomes in reading and mathematics since the onset of the pandemic, at least until mid-2021.”¹⁶

Similarly, Russo et al. (2020, p. 2) argue that “existing educational inequalities have been significantly increased through measures to contain the spread of the virus” (Borg and Mayo; Open Society Foundation Education Program, 2020; Stewart, 2021). According to the World Bank (2020a, p. 5), “the crisis was not equally distributed: the most disadvantaged children and youth[, including refugees,] had the worst access to schooling, highest dropout rates, and the largest learning deficits” (see also Boujikian et al., 2022; Cameron, 2021; Menashy and Zakharia, 2022). And we should mention that “the combination of being out of school and the loss of family livelihoods caused by the pandemic may leave girls especially vulnerable and exacerbate exclusion and inequality — particularly for persons with disabilities and other marginalized groups” (World Bank, 2020c, p. 3; UNESCO, 2022b).¹⁷

Inequality of education impacts of the pandemic has arisen not only across social groups within countries but also across countries. For instance, UNESCO and the International Association for the Evaluation of Educational Achievement report, based on the “REDS” study conducted in 11 countries (see above listing)

¹⁶ Several possible reasons are offered for this: “a) learning gains that may have otherwise been achieved since the previous assessment may have been suppressed by the pandemic; b) students already on track to achieving the MPLs [Minimum Proficiency Levels for achieving SDG 4.1.1b] may have been less impacted by the COVID-19 disruption; c) low proportion of students meeting the MPLs in historical assessments makes decline difficult to observe; d) students may already have recovered from any learning loss by the time they undertook the assessment. ... [and] families, schools, and educational systems were able to offset much of the impact of the disruption” (UNESCO Institute for Statistics et al., 2022, pp. 11-12).

¹⁷ Moreover, “the importance of reopening schools should be noted, first and foremost, not only through the lens of missed education, but in recognition of the role of schools as places of protection for other rights, including protection from gender violence and domestic abuse” (Open Society Foundations Education Program, 2020, p. 23).

between December 2020 and July 2021.

In Burkina Faso, Rwanda, Kenya, Ethiopia, and India, varying proportions of school leaders reported that their schools did not offer any teaching and learning provisions during the disruption. In the remaining six RED countries—all with higher Human Development Index measures—all schools were reported to continue to offer teaching and learning provisions during the disruption (Meinck et al., 2022, p. xvii; see also UNESCO, 2022a).

Add to this the fact that “education spending lost space in national budgets of low- and lower-middle income countries in 2021 and 2022 ... in contrast with trends observed in [upper-middle and high-income countries,] where education as a share of total government budgets was stable in 2019–2021 and 2022 [was] higher than in 2019” (World Bank Group et al., 2022, p. 2). And Stromquist (2020, p. 49) observes that “COVID-19 and the likely long economic recovery from it are worsening the already low budgets confronting many governments in developing nations.” Furthermore, Lewin (2020, pp. 19-20) predicted that “the amount of grant aid from donors will plateau and may fall, as the appetite for aid to education comes under increasing pressure from new domestic priorities and economic recession” and that lower-income and lower-middle-income countries “will suffer more than OECD countries from reductions in domestic revenue, making educational financing more difficult” (see also World Bank, 2020b).

CONCLUSION

In this article, I have drawn on an extensive body of literature describing the impact of the COVID-19 pandemic on health, the economy, and education. While the overall impact of the pandemic has been tremendous, I have also discussed how the severity of the impact varied across countries and among social groups within societies. The international differences contrasted lower- vs higher-income countries, socialist vs capitalist societies, and nations that did or did not have governments oriented to scientific evidence and populations that trusted the government. Within countries the impacts differed by social economic status, race/ethnicity, and gender (although the literature reviewed gave less attention to the latter). In general, the pandemic reinforced existing inequalities across nations and among social groups within nations.

Part of the explanation of the overall impact as well as the differences in the impact of the pandemic include decisions and behaviors of individuals, but the policies and (in)action of governments clearly also played a substantial role (Aten, 2021; Klein, 2020). For instance, Escotet (2022, p. 73) states that the dramatic, negative impact of COVID-19 on education and learning was due to “inappropriate education systems” as well as “globally fragile health structures and human services.” And

Neelon et al. (2021) conclude that the higher rates of cases and deaths in the second half of 2020 in U.S. states led by Republican governors (compared with those led by Democratic governors) “may reflect policy differences that could have facilitated the spread of the virus.”

However, I would also stress how economic inequalities – internationally and across social groups within societies – facilitated the unequal health and education experiences stemming from the COVID-19 pandemic. In this regard, it is worth quoting the words of Pope Francis (2021), included in a letter he wrote to the World Bank and the International Monetary Fund in advance of their spring 2021 civil society meetings: “The notion of recovery cannot be content to a return to an unequal and unsustainable model of economic and social life, where a tiny minority of the world’s population owns half of its wealth. ... A spirit of global solidarity also demands at the least a significant reduction in the debt burden of the poorest nations, which has been exacerbated by the pandemic.”

Arundhati Roy (2020) observes that “historically, pandemics have forced humans to break with the past and imagine their world anew. This [Coronavirus] one is no different. It is a portal, a gateway between one world and the next” (Arrove, 2020, p. 43). With regard to the future within the health sector, one should note that “the COVID-19 pandemic erased decades of progress in the fight against life-threatening antibiotic-resistant bacteria, also known as ‘superbugs,’” which the World Health Organization identifies as “one of the 10 greatest public health threats to humanity” (Gillis, 2022). And Hotez (2021) stressed the need for “vaccine diplomacy” in order to prevent – or, at least, minimize the impact of – future pandemics. Furthermore, the staff of the *World Politics Review* (2022) make an important point that “the novel coronavirus ... revealed the flaws in a global health architecture headed by the World Health Organization ... but [noted that] the WHO has also been intentionally hobbled by member states in how aggressively it can react to public health crises out of concerns over sovereignty.” The challenges faced by the global (and various nations’) health architecture became apparent even before COVID-19 had receded from focus; cases of Monkeypox, which had been endemic in various African countries for years, began to proliferate in Europe and the U.S. in May 2022, leading the World Health Organization to declare another health emergency – in addition to COVID-19 and Polio (Axe, 2022; United Nations, 2022a and 2022b).¹⁸ Moreover, even as Monkeypox was spreading around the world, although “the majority of WHO member states were in favor of a legally binding instrument ... on pandemic prevention,

preparedness, and response,” there were differences in which of the two WHO Constitution articles should be used for that purpose (19 or 21) (Ravelo, 2022).

With regard to the education sector, I agree with Castle et al. (2021, p. 78) that “COVID-19 highlights the importance of strengthening the resilience of education systems in developed and developing countries alike.” Such efforts in terms of policy and practice should consider that “in response to [the COVID-19 pandemic], many stakeholders collaborated to create novel ways of sustaining education at times when this was very challenging. ... There is much to be learned from studying these [thirty-one] innovations, particularly when it comes to supporting the necessary transformation of schools and school systems around the world” (Reimers and Operti, 2021, p. 39, see also International Commission on the Futures of Education, 2020; Reimers et al., 2021).¹⁹ At the same time, we need to recognize that “the pandemic has made visible the entanglement of social, economic, and planetary crises, creating an opening for a critical reconceptualization of education. ... This position acknowledges that our [human-centered] ways of thinking and doing created conditions for the pandemic, the climate crisis and widespread social, racial, and economic injustice, and recognizes these habitual toxic ways of thinking and doing are disseminated through education” (Molloy Murphy, 2021, p. 130). Similarly, in line with Giroux and Filippakou (2022), I believe that we need to move beyond what they call “pandemic pedagogy”—“a pedagogical virus that erodes the modes of agency, values, and civic institutions central to a robust democracy” (p. 37) and which “functions ... to shape human agency, desire, and modes of identification ... in the logic of consumerism while privileging a hyper form of masculinity and legitimating a friend/enemy distinction” (p. 35; Accioly and Macedo, 2022).

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¹⁸ According to the WHO Health Emergency Dashboard (<https://extranet.who.int/publicemergency/#>), 23,351 cases and 8 deaths from Monkeypox were listed as of 2 August 2022.

¹⁹ Reimers and Operti (2021) group the 31 innovations in terms of the areas they supported: a) student-centered learning, b) deeper learning, c) socioemotional development and well-being, d) teacher and principal professional development, and e) family engagement.

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