Do not repeat mistakes from HIV in COVID-19 response

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For **Hargreaves et al** see **Comment** *Lancet HIV* 2020; **7:** e309–11

For **COVAX** see https://www.who.int/initiatives/act-accelerator/covax

For more on **vaccine purchasing** see *BMJ* 2020; **371:** m4750

40 years since the first cases of HIV were identified, we often reflect in these pages about the enormous advances that have been made to combat the disease. From the vantage point of 2021 there is a lot to celebrate: an unknown virus identified, characterised, and sequenced; treatments developed and refined; health systems strengthened to deliver those treatments; an HIV response that has shaped health systems and global health. However, when considered alongside the rapid response to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and COVID-19 the HIV response seems practically sluggish.

In just 1 year, the virus responsible for the pandemic that currently grips the world has been identified and characterised, treatments (albeit imperfect) have been implemented to save lives, and, crucially, at the start of 2021, several vaccines are being rolled out after astonishingly rapid development, progress through the clinical-trial process, and approval. Now, a few weeks into 2021, millions of people have received their first doses and protection against the virus will begin to drive down incidence of COVID-19 and save lives. In Israel, for example, where almost 9 million people, a quarter of the adult population, have received the Pfizer vaccine, people expect to begin to see the effects of vaccination on the epidemic soon. But as many celebrate the remarkable progress in combatting SARS-CoV-2, a concerning pattern is beginning to emerge that is all too familiar to those who have worked in HIV: inequitable distribution.

Although HIV programmes worldwide are now seeing rapid scale-up of treatment access, this was not always the case. Less than a decade ago, access to treatment was massively skewed in favour of people in high-income countries with lower burden; and even as treatment access was scaled up, while people with HIV in richer countries had access to the newest, most effective, and least harmful treatments, people in the poorest countries had patchy access, sometimes to outdated treatments. And even today, inequalities remain in access to treatment, prevention, care, and testing.

Similar imbalances are emerging at the time of writing in the early days of coronavirus vaccination. For example, whereas 25% of people with Israeli identity cards have received the Pfizer vaccine, none of 4 million Palestinians has received a dose of vaccine. Worldwide, around 45 million people have received vaccine, but so far, almost every single one has been given in high-income countries.

Speaking on the day of the 148th Executive Board meeting of WHO, Director General Dr Tedros Adhanom Ghebreyesus warned that the "world is on the brink of a catastrophic moral failure, and the price of this failure will be paid with lives and livelihoods in the world's poorest countries". As countries scramble for access to vaccines with the hope of breaking out of the cycles of epidemic flare-ups and economically damaging lockdowns and high mortality from coronavirus, vaccine prices could be pushed up as richer countries try to jump to the front of the queue. A "me-first approach would be self-defeating", said Ghebreyesus.

In April last year, James Hargreaves and colleagues wrote a Comment, *Three lessons for the COVID-19 response from pandemic HIV*, published in this journal. The first lesson was to anticipate and address inequitable responses and specifically referenced the need for fair access to vaccines. WHO's COVAX programme was set up to ensure that 2 billion of the world's poorest people will have access to vaccines by the end of 2021.

But despite clear warnings and efforts to ensure equitable access, vaccine procurement is off to a biased start. Countries such as Australia and Canada have purchased many more vaccines than their populations need, and alongside Israel, other countries such as Bahrain, the United Arab Emirates, the UK, and the USA have raced out of the gates in terms of vaccine delivery. Countries with more money have more immediate access to vaccines.

SARS-CoV-2 has taken an enormous toll on the world in the past 12 months, claiming more than 2 million lives. But, if there is a silver lining, the response and the incredible speed of development of vaccines will also likely have a lasting impact on the systems of vaccine approval that may benefit the HIV field in due course. However, it would be unforgivable not to heed the clear lessons from the HIV response and for richer nations to race ahead in vaccination while excluding the world's poorest. The international development and aid arms of governments in the richest countries must act now to ensure that no-one is left behind in coronavirus vaccine roll-out. ■ *The Lancet HIV*