Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Health, University of KwaZulu-Natal, Durban, South Africa (MMo); Office of the President, South African Medical Research Council, Tygerberg, South Africa (GG); Right to Care, Tshwane, South Africa (LB); Faculty of Health Sciences, University of Stellenbosch, Cape Town, South Africa (LB); Centre for the AIDS Programme of Research in South Africa, University of KwaZulu-Natal, Durban, South Africa (TdO); KwaZulu-Natal Research Innovation and Sequencing Platform, College of Health Sciences, University of KwaZulu-Natal, Durban, South Africa (TdO); African Medical Research Council Vaccines and Infectious Diseases Analytics Research Unit, Faculty of Health Science, University of the Witwatersrand, Johannesburg, South Africa (SAM)

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Global HIV efforts need to focus on key populations in LMICs

COVID-19 deaths had exceeded 5 million globally on Nov 22, 2021.[1] As the world struggles to contain COVID-19, the HIV pandemic of more than 37 million people living with HIV (PLHIV) continues.[2] Like their counterparts in high-income countries, most PLHIV in low-income and middle-income (LMICs) braced for lockdowns that reduced their access to HIV care and services[3] and the possibility that resources for HIV could be redirected towards combating COVID-19. As we pause to commemorate World AIDS Day on Dec 1, 2021, it is important to call for continued political and financial commitment and renewed support for initiatives that strive towards ending the HIV/AIDS epidemic through equitable access to prevention and treatment and inclusivity in the HIV/AIDS response.

Until the COVID-19 pandemic, HIV had preoccupied the minds of the global health community for almost four decades. Immense progress had been achieved with the support of the US President's Emergency Plan for AIDS Relief (PEPFAR) and other funding initiatives. Some LMICs had nearly achieved the UNAIDS 90-90-90 targets for 2020, but targets were not met globally.[2–4] LMICs are now focusing on the UNAIDS people-centred 2025 targets, while gearing for the UNAIDS 95-95-95 targets for 2030, especially among youth.[4]

However, the impacts of the COVID-19 pandemic and a shift in focus and resources have interrupted HIV-related health services, including HIV testing and provision of antiretroviral treatment in many settings.[5,6] Furthermore, COVID-19 disproportionately affects already disadvantaged people, highlighting existing health disparities that have characterised the HIV epidemic.[6,7] Consequently, the most stigmatised, marginalised, and disadvantaged populations, such as


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young women and youths (aged 15–24 years), men who have sex with men, transgender people, people who inject drugs, and commercial sex workers, have suffered disproportionately from the COVID-19 pandemic and its impacts on the HIV/AIDS response.[7,8] Thus, there is an urgent need to revitalise strategies to reaccelerate the HIV/AIDS response in the context of COVID-19. The same rigour and commitment that has been evident in the COVID-19 response should be adopted in refocusing global attention on addressing HIV/AIDS, especially among key populations. We set out some key priorities in advancing this agenda.

There is a need to address the structural, social, and political factors that affect key populations by investing in programmes and policies that address underlying causes of discrimination against LGBTQI people and restrictive laws that criminalise marginalised groups, such as sex workers and drug users, which also undermine their access to health services. Another priority is to combat gender-based and intimate partner violence and promote gender equality, which is key to reducing vulnerability to HIV among women and girls.

Given declining international and domestic funding for HIV over the past few years[9] and further plummeting in 2020 because of COVID-19, there is a need for more targeted resource allocation to increase and maximise financial and human resources. Focusing HIV resources on the populations most affected by HIV can achieve greater impact more cost-effectively. In South Africa, a comprehensive set of packages including the She Conquers campaign and the PEPFAR funded Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) partnership that targeted adolescent girls and young women resulted in a decline in HIV incidence in this population overall between 2012 and 2017.[10] Tailored focus on other key populations is also important. This includes the development and scaling up of national and local harm reduction policies and programmes and using online communication channels, including peer-led community outreach and services to reach marginalised populations.

There is a need to strengthen strategies and guidance to mitigate the impacts of COVID-19 on HIV prevention and treatment. PLHIV and populations at risk of HIV infection need to be at the centre of the response in planning, service delivery, and community monitoring and evaluation. Lessons from tuberculosis and HIV integration could be used to maximise prevention, screening, and testing through integrating messaging and screening and testing algorithms, as has been done with COVID-19.[11]

Expanding the role of social media and digital technologies in the HIV/AIDS response will enhance access to information, prevention, and treatment to effectively reach, engage, and retain young people in HIV services.[12] Social media, as used in the fight against misinformation and disinformation about COVID-19 and vaccines,[3] can be used to dispel myths about HIV transmission and prevention.

Lessons learnt from the rapid development of COVID-19 vaccines will benefit the possible development of HIV vaccines. Equity is crucial in this effort, just as it is imperative to ensure equitable access to COVID-19 vaccines in LMICs. Without substantial support less than 10% of African countries will fully vaccinate 40% of their populations by the end of 2021.[13]

Identifying the gaps in the UNAIDS targets can help improve efforts to reach key populations. For example, the 2021 UNAIDS update showed that substantial numbers of children living with HIV are undiagnosed and not on antiretroviral therapy and less than 50% of children living with HIV globally have suppressed viral loads.[14] AIDS-related deaths in adolescents have shown a slow decline and fewer men access testing and treatment.[14] Therefore, there is a need for concerted efforts to put children, adolescents, and men on HIV treatment.

There is also a need to expand the development of differentiated service delivery for marginalised and key populations that is adaptive, client-centred, and that makes HIV services more accessible and responsive to reflect the preferences of different PLHIV groups while minimising burdens on the health system.[12] Greater efforts are needed to strengthen effective community-based peer HIV intervention strategies to help engage disenfranchised communities that are not usually represented in mainstream health care.[15] Community-derived and participatory approaches can improve responsiveness to the HIV prevention needs of key populations.[16]

Integrating biomedical and sociobehavioural approaches is crucial in responding to the ongoing and future effects of COVID-19 on HIV. Interdisciplinary and collaborative research can help mitigate the impacts of COVID-19 and efforts to reduce disparities in HIV funding

and response. It is imperative for LMICs to rekindle the progress that had been made before COVID-19 by investing in the delivery of evidence-based interventions and services for key populations and redoubling efforts to ensure equitable access to HIV testing and treatment for all PLHIV. This will require sustained support and investment from national governments and the global community as we recalibrate the HIV/AIDS response in the context of SARS-CoV-2 endemicity.

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Universal health coverage must become a best buy for women

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Universal health coverage (UHC), the dominant approach to health system strengthening, is grounded in equity and guaranteeing health for all.[1] Yet, UHC is partly built on a flawed and unjust human resource model: whether complacently or complicitly, in concept and in practice, all health systems normalise and perpetuate underpaid and unpaid health work, exploiting women.

A key conceptual framework for women and health show a variety of ways by which women interact with health systems as both consumers and as producers of care,[2] revealing a paradox: the UHC agenda seeks to advance the health of women,[2] but it relies on gender-exploitative labour (panel). Service delivery models that use undervalued care work are affordable only in the short run as they limit educational attainment and promote practices detrimental to the health and productivity of care workers, most of them women. Therefore, this paradox poses a risk to the fundamental goals of UHC and undermines the workforce that is a building block of health systems.[7]

Health benefit packages are key elements used for planning, health system strengthening, quality assurance, and priority setting for UHC.[8,9] These packages are comprised of interventions deemed cost-effective, and seek to guarantee access to health care, especially for the poor. As such, they underpin the equity-focused approach of UHC such as progressive universalism.[9,10] However, the standard economic evaluation methods used to design these packages fail to account for and appropriately value paid and unpaid health care.[11] Despite growing recognition that undervalued labour, such as essential services and care work, is precarious, unsustainable, and unjust,[12] this