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See Online for appendix

A woman who was born preterm is more likely to deliver a child preterm, and the daughter of a mother who is obese is more likely to become obese. Hence intergenerational transmission amplifies the problem.

The collaborators primarily consider solutions within a medical construct even though child rearing and education are also powerful determinants of physical and mental health.¹ Strategies that improve MNCH would uniquely benefit human potential across generations, needed now more than ever as countries grapple with the task of prioritising investment in post-COVID recovery.³ These visionary policies include, for example, tax-exempt childcare, 6 months statutory paid leave on a use-it-or-lose-it basis for each parent during a child's first year, and investment in universal secondary school education. These would reduce NCD through multiple interrelated pathways including improved newborn health, breastfeeding, family cohesion, and gender equity, and they would empower girls, reduce crippling dependencies, and help fulfil human potential.

NM is president of the UK Medical Women's Federation, immediate past-president of the UK Royal College of Paediatrics and Child Health, and president-elect of the British Medical Association. MH is past-president of the International Society for Developmental Origins of Health and Disease. The views expressed here are their own.

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Who should be prioritised for COVID-19 vaccines?

As effective vaccines and preventive medications become available for COVID-19, demand is likely to outstrip supply, so we need to develop a strategy to prioritise their use to ensure maximum public health and societal benefits. Interim advice from the Joint Committee on Vaccination and Immunisation¹ suggests that people older than 65 years of age, those in shielding groups, and health-care workers should be prioritised for vaccination. The advice lacks detail, and it is essential that a plan is developed that takes the growing body of evidence on the effect of comorbidities, occupational, and socioeconomic factors on COVID-19 severity into account.

People living in areas with the highest levels of poverty and lowest levels of educational attainment have the highest rates of hospitalisation and are 1.9 times more likely to die from COVID-19.² Physical crowding, homelessness, poor air quality, and smoke exposure are also associated with poorer outcomes.² The disproportionate impact on minority ethnic groups is clear, and these communities are also more likely to be socioeconomically deprived, live in overcrowded conditions, and hold key worker or high exposure occupations.³

Planning for a culturally competent, transparent, and effective public health campaign is needed to ensure that vaccinations and preventive treatments are taken up in those most at risk of severe disease. Responsible messaging is needed to ensure adequate uptake and avoid stigmatisation and discrimination of disproportionately affected groups. This is critical when vaccines are being developed at an unprecedented rate and trust in safety and efficacy will be key. Previous work has suggested that enthusiasm for a vaccine during a pandemic is highest

around the time that it is made available, so a well planned programme with outreach and education is needed to capitalise on this, and it is critical that a strategy is developed now.⁴

We propose a draft schema for prioritisation of vaccines and preventive medications based on our analysis of at-risk groups (appendix). This includes groups at risk of severe infection, including those with non-communicable diseases (eg, diabetes, hypertension, obesity, and cardiovascular disease) that should also be prioritised. High-risk occupational groups including those working in public facing roles, such as those in security and transport should also be included. Socioeconomic factors associated with adverse outcomes in COVID-19 should also be considered, and an effective strategy would include vaccination of those living in overcrowded conditions or in institutions such as care homes. Clinical prediction tools under development could be used to inform further risk stratification.⁵

KK is a member of the Independent Scientific Advisory Group for Emergencies subgroup on ethnicity and COVID-19, a trustee of the South Asian Health Foundation, and director of the Centre for BME Health. ZH-S and WH declare no competing interests.

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The Nobel Prize for discovery of HCV is a call to end hepatitis

This year, Michael Houghton, Harvey Alter, and Charles Rice were awarded the Nobel Prize in Physiology or Medicine for their discovery of the hepatitis C virus (HCV).¹ Equally important to recognising the rigorous methods employed by these scientists, the Nobel committee also credited this discovery with later development of diagnostic tests and curative treatments. Science is not an end but a means to achieve a greater purpose. The Nobel committee issued a challenge, "For the first time in history, the disease can now be cured, raising hopes of eradicating Hepatitis C virus from the world population".² I, together with my colleagues in the Coalition for Global Hepatitis Elimination, agree.

The discovery of HCV placed the world on the path to elimination. Within a few years, reliable tests were available to screen donated blood, reducing the risk of HCV from one in every 14 units to one in every million. Over the following decades, with improvements in blood safety and infection control, new HCV infections declined an extraordinary 90%.²

71 million people globally are already living with HCV. Deaths among those infected have sadly mounted to over 500 000 annually.^{2,3} To curb this epidemic, a safe and effective therapy was needed. In 2014, years of research culminated in the first cure for a chronic viral infection. Anyone infected with HCV is now recommended to receive treatment, saving lives and health-care costs.² Generic HCV therapies are available in more than 100 countries, costing

US\$200 or less. With these tools, simple care models were developed, and early moving governments in Egypt,⁴ Georgia,^{2,5} Rwanda,⁶ and Punjab state, India,⁷ showed how to scale up HCV testing and treatment within health systems. The recent investments in diagnostic capacity for COVID-19 further increase the feasibility of large-scale HCV testing, treatment, and elimination.

In 2016, WHO set goals for the elimination of HCV by 2030.³ However, in 2020, only one in five people infected with HCV are diagnosed, and a smaller fraction is treated and cured.^{2,3} The barrier to sufficient HCV testing and treatment is no longer on the scientific or public health side. In fact, all the pieces are in place to eliminate HCV, save one: financing.

In the coming decade, 1.5 million deaths can be averted by HCV elimination.³ Yet major philanthropic funders have not committed to this global goal. Not one. Most international support for hepatitis elimination comes from public-private partnerships with industry. Investments from global partners can catalyse development and evaluation of national programmes. HCV is curable. As shown in Egypt⁴ and Georgia,^{2,5} relatively modest external support can jumpstart larger domestic investments in hepatitis elimination. Many countries have plans for HCV prevention, testing, and treatment, and with catalytic investments they can begin to advance towards HCV elimination.

This year's Nobel Prize is a challenge to the philanthropic community. Finish the journey started by these Nobel Laureates. Rally around this Nobel Prize. Commit the financial resources and eliminate hepatitis C.

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For the Coalition for Global Hepatitis Elimination see <https://www.globalhep.org/>



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SARS-CoV-2 risk misclassification explains poor COVID-19 management

One of the most striking facts about the COVID-19 pandemic is the notable difference in approach, attitude, control measures, case incidence, and mortality rates between eastern and western hemispheres. Results of a recent analysis¹ show lessons to be learnt from the experiences of these countries and regions. The differences in approach and mortality could be explained, at least partially, if not totally, by the misclassification of the infectious agent risk.

WHO classifies microorganisms into four risk levels according to its