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people in low-income countries have received at least one dose.⁶ In addition to efforts to increase vaccine affordability and access globally, it is important to ensure that COVID-19 vaccination and research are inclusive. For many low-income countries with high seroprevalence after infection, the focus must be maintained on rapidly giving the first and second doses of COVID-19 vaccine to boost immunity gained from primary infection, endorsing the WHO targets to vaccinate 40% of the global population by the end of 2021 and 70% by mid-2022.¹²

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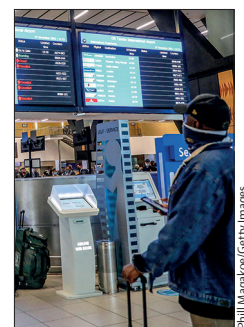
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The political theatre of the UK's travel ban on South Africa

On Dec 24, 2020, the UK's Prime Minister Boris Johnson announced an immediate travel ban on all flights to South Africa after the detection of SARS-CoV-2 beta variant by South African scientists.¹ The resulting travel restriction was lifted 291 days later. On Nov 25, 2021, South African scientists reported a new SARS-CoV-2 variant, B.1.1.529, that was subsequently designated omicron. Although the omicron variant has mutations that could make it less susceptible to neutralising antibody activity and possibly as transmissible as or more transmissible than the delta variant,² such concerns have yet to be determined by in-vitro and in-vivo evidence. Furthermore, it is also relevant to consider that although antibody activity induced by the ChAdOx1 nCoV-19 vaccine (AZD1222) had nominal neutralising activity against the beta variant and failed to protect against mild to moderate COVID-19 due to the beta variant, the vaccine still reduced risk of severe COVID-19 due to beta or gamma variants by 80%.^{3,4}

2 days after the identification of omicron, the UK Government promptly reapplied a travel ban on travel from South Africa and some other African countries.⁵ Several other countries, such as Israel and the USA, swiftly followed suit with travel bans from countries in sub-Saharan Africa, citing this action as a precautionary measure.⁶ This unwarranted action has generated intense anger and frustration. Travel restrictions are unlikely to be able to stop the spread of coronaviruses unless countries are able to completely seal their borders to travellers from all nations. Predictably, soon after the UK travel ban announcement, cases of the omicron variant were reported in Europe,⁷ the UK, North America, and, as of Dec 2, 2021, 25 countries in total.^{8–10} Paradoxically, the most concerning SARS-CoV-2 variants for a highly vaccinated population would likely arise in a high transmission environment where there are high levels of vaccine coverage, such as the UK, France, or Italy, to name but a few.^{11,12}

New Zealand has comprehensively restricted COVID-19 numbers but only through its geographical



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location, totally sealing off of travel, and implementing aggressive hotspot management and strict lockdowns.¹³ Elsewhere, despite selective travel bans, successive SARS-CoV-2 variants of concern have spread widely. Just 8 months after its discovery, the beta variant was present in 141 countries, including the UK.¹⁴ As of Dec 1, 2021, the delta variant dominates globally.¹⁵

By their nature, SARS-CoV-2 variants are several steps ahead of the international travel curve. Once community transmission of an airborne virus is occurring, travel restrictions have little effect,¹⁶ before travel bans can be imposed a variant identified in country A has most likely already spread to country B and, thereafter, globally. 2 days after South Africa's announcement, omicron was sequenced from an unvaccinated traveller returning to Belgium from Egypt via Turkey who became symptomatic 11 days later.⁷ She had no ties with or exposure to anyone from southern Africa.⁷ Omicron has probably already spread globally. Countries with robust surveillance and genomics capability will be able to identify cases early; others will not. The folly of restricting travel to a handful of countries at best might only buy some time before the virus variant is eventually imported.

In 2002, the Chinese Government was criticised for withholding information on SARS.¹⁷ In November, 2021, South African scientists rapidly and transparently shared the findings of mutation and genomic sequences of the latest SARS-CoV-2 variant. Rather than applaud their generosity and openness, travel bans have had the opposite effect and could be damaging to the health response, economy, and freedom of movement. This situation puts countries such as South Africa in a difficult position, and potentially threatens future willingness to share information and weakens global solidarity. Once again, South Africa and other southern African countries have been stigmatised and will pay a heavy economic and societal price for sharing information. This experience is also likely to have a detrimental impact on the behaviour of other countries going forward.

South Africa has been proactive in its contribution to the world's COVID-19 response by sharing news of the new variant, but other countries have not fully supported an equitable COVID-19 response in low-income and middle-income countries. For example, of the promised 100 million COVID-19 vaccine doses to be donated to COVAX by the UK, as of Dec 2, 2021, only 11.5% have been

forthcoming.¹⁸ We believe governments need to attend to their failings rather than penalise other countries unnecessarily.

The latest travel ban has devastated family holiday plans and an industry. South Africa's tourist industry contributes about ZAR82 billion (£3.77 billion) annually to the fiscus, by far the largest proportion coming from UK tourists.¹⁹ Tourism and allied industries account for an estimated 1.5 million jobs and livelihoods in South Africa. 1 day after the UK's travel red-listing of South Africa occurred, the Federated Hospitality Association of Southern Africa and the Southern Africa Tourism Services Association did a survey of association members serving international markets. An average of 2506 cancellations had occurred among 603 respondents from tourist bookings they held over the next 4 months, representing 1.5 million cancellations in the first 48 h after the travel ban began, and 390 respondents reported ZAR940 million of lost revenue, an average of ZAR2.4 million each (Rosa N, Southern Africa Tourism Services Association, personal communication).

We call on the UK and other governments to reverse their damaging travel bans and follow the advice of WHO and the International Health Regulations in keeping international borders open.²⁰ Instituting public health measures to identify and manage cases of the omicron variant would be a far better investment. The UK in particular is damaging the economy of South Africa by its actions. Countless families in many countries have once again had their plans dashed by the decisions of politicians who want to be seen to be doing something rather than focusing on what they should be doing—meaningfully supporting global COVID-19 vaccination efforts.

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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 services³ 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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