We declare no competing interests.

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COVID-19 combination prevention requires attention to structural drivers

Richard Horton draws parallels between the colliding pandemics of COVID-19 and HIV, observing that both "exploit and accentuate inequalities".[1] He and others[2] advocate that responses to COVID-19 learn from HIV combination prevention approaches. However, it is key that in doing so, prevention measures go beyond the behavioural interventions they call for, to include interventions that are structural and systemic in nature.

The HIV movement demanded action on social, economic, political, and legal factors that undermine people adopting effective prevention measures. The aim was to create enabling environments that liberate people, particularly vulnerable groups, to exercise agency to practise healthy behaviours. These efforts ranged from targeting international patent laws and monopolies that put the price of treatment out of reach of people living with HIV; taking steps to decriminalise sex work, drug use, and LGBTI people; ending violence against women, girls, and key populations; and challenging stigma and discrimination, which remains one of the most substantial barriers to an effective HIV response. We advocated for cash transfer programmes to lessen vulnerability to HIV risk and demanded innovative financing to increase AIDS budgets.

A rights-based combination prevention approach that addresses the structural drivers of inequality of risk and inequity of responses is as crucial to COVID-19 as it remains for HIV. We call for measures that include: a people's vaccine;[3] a moratorium on debt repayments and progressive taxation to enable a mass roll-out of social protection, food, and income support programmes; removal of punitive laws that block access to health and social services; and civil society expertise and meaningful representation in COVID-19 governance and accountability structures[4] as key components of COVID-19 combination prevention.

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Silvennoinen R, Heckman CA. A candid view of CANDOR. Lancet *2020;* **396:** *147–48*—In this Comment, the seventh sentence of the second paragraph should read "These also occurred more frequently in intermediate fit patients and in patients aged at least 65 years." This correction has been made to the online version as of Aug 13, 2020.

Dimopoulos M, Quach H, Mateos M-V, et al. Carfilzomib, dexamethasone, and daratumumab versus carfilzomib and dexamethasone for patients with relapsed or refractory multiple myeloma (CANDOR): results from a randomised, multicentre, open-label, phase 3 study. Lancet *2020;* **396:** *186–97*—In this Article in table 1, the number of patients receiving at least two previous lines of therapy was 84 (55%). In the Results section on p 194, the number of patients of 65 years and above who had a fatal adverse event was 22. These corrections have been made to the online version as of Aug 13, 2020.

Bar-Zeev N, Moss WJ. Encouraging results from phase 1/2 COVID-19 vaccine trials. Lancet *2020;* **396:** *448–49*—This Comment should have been published under a CC BY Open Access licence. This correction has been made to the online version as of Aug 13, 2020, and the printed version is correct.

Folegatti PM, Ewer KJ, Aley PK, et al. Safety and immunogenicity of the ChAdOx1 nCoV-19 vaccine against SARS-CoV-2: a preliminary report of a phase 1/2, single-blind, randomised controlled trial. Lancet *2020;* **396:** *467–78*—In this Article, the percentage of participants with antibodies detectable at a lower level has been corrected to 18% in the last paragraph of the Results. Additionally, the appendix has been corrected. These corrections have been made to the online version as of Aug 13, 2020, and the printed version is correct.