to follow rules and guidelines, both generally and during the COVID-19 pandemic,[4,5] which is fundamental to the control of infection and mortality. There had already been a gradual decrease in public adherence to guidelines before the publicity about Cummings' actions on May 22, but the difference in this decline between England and Wales and Scotland grew in the 3 weeks following (May 22–June 11, 2020; appendix pp 7, 8).

Although, as of June 17, 2020, more than a month has passed since the Cummings events, data show there has been no recovery in confidence in the government, with confidence in England remaining low and gaps between confidence in England and confidence in devolved nations growing (appendix p 8). Trust in government decisions and actions relating to the management of COVID-19 is a major challenge worldwide, and these data show the negative and lasting consequences that political decisions can have for public trust and the risks to behaviours.

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Donation and transplantation activity in the UK during the COVID-19 lockdown

As of May 14, 2020, over 11 000 patients with COVID-19 in the UK were admitted to intensive care units (ICUs), with a median length of stay of 9 days.[1] The COVID-19 pandemic had the immediate effect of severely reducing living and deceased organ donation and transplantation activity, as happened in other countries.[2] On March 23, 2020, the same day that the UK Government announced lockdown restrictions, National Health Service (NHS) Blood and Transplant altered the age acceptance criteria for deceased donors to protect ICU bed capacity and maximise use of organs available for transplantation.[3] The maximum age for donation after brain death was reduced from 85 years to 60 years (increased to age 75 years after April 7, 2020) and the maximum age for donation after circulatory death from 80 years to 50 years. These changes would, in ordinary times, be expected to reduce actual donor numbers by approximately 47%.[3] All potential donors are required to have a negative severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) nucleic acid test nose and throat swab and endotracheal aspirate.[4] Many specialist nurses in organ donation were redeployed to various roles in ICUs and other COVID-19 related projects. Transplant priority was given for patients on the super urgent liver and heart transplantations lists.

We compared donor and transplantation activity during the COVID-19 lockdown period March 23 to May 10, 2020, with the same time in 2019 (appendix p 1). Compared with 2019, the number of deceased donors decreased by 66% and the number of deceased donor transplants decreased by 68%, larger decreases than we estimated.[3] The number of referrals of potential donors decreased by 39%. These decreases might be because ICU physicians did not refer those not meeting the new criteria for donors but might also reflect a reduction in the potential donor pool, with a reduction in trauma and other emergency department admissions of over 50% seen in the UK during lockdown.[5] Families continued to support donation with a 74% consent rate despite the restrictions on them visiting hospital (appendix p 1).

See **Online** for appendix

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Abdominal organ transplants, particularly kidneys, were substantially reduced during UK lockdown compared with the same period in 2019, but heart transplants, although reduced, were not as affected, and accounted for 9% of all transplants rather than 5% as in 2019. 79% of organ donors were donors after brain death in 2020 compared with 59% in 2019 (appendix p 1); however, donors after circulatory death continued to contribute to transplantation, including two successful heart transplants.

The relaxation of lockdown coincides with the first steps in donation and transplantation recovery. The upper age limit for donation after circulatory death has been increased to 60 years, three suspended renal programmes have re-opened, and many specialist nurses in organ donation have returned to their usual roles. If we must live with COVID-19 in the future, data on the morbidity and mortality due to SARS-CoV-2 infection in transplant recipients and those awaiting transplantation are needed.

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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.