

to be left to uncoordinated separate studies by individual investigators or vaccine developers. South Africa, at the forefront of dealing with the challenge of its vaccine roll-out during the spread of a predominant 501Y.V2 variant, has to make vaccine decisions without adequate efficacy data. A correlate of protection for mild and severe SARS-CoV-2 infection will go a long way to providing an evidence base for these decisions and overcome the obstacles that new variants are placing on the vision of global SARS-CoV-2 control with the widespread implementation of effective immunisation.



SSAK is the co-chair of the South African Ministerial Advisory Committee for COVID-19.

Salim S Abdool Karim
salim.abdoolkarim@caprisa.org

Centre for the AIDS Programme of Research in South Africa, Durban 4013, South Africa; Department of Epidemiology, Columbia University, New York, USA

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Gender, race, and health workers in the COVID-19 pandemic

The Editors¹ correctly highlighted the situation the health workforce is in, and how it is facing “serious harms to their physical and mental wellbeing while trying to deliver quality care” during the COVID-19 pandemic. Considering the health workforce as a homogeneous group misses the reality of who is affected within this group and the necessary solutions.

70% of the global health workforce are women, a number that increases to 90% with social care workers. Sex-aggregated case data collated by the UN show that more than 70% of COVID-19 infections in health-care workers in the USA, Italy, and Spain are in women. In our work on health professionals’ gender and race at the front line of the COVID-19 pandemic, we found that this rate is partly because of the absence of necessary resources provided to these health-care workers: women, and Black women in particular, have less access to personal protective equipment (PPE) and training. Female health-care workers worldwide are also facing the downstream effects of their work, including mental health issues,² increased physical violence, alternative arrangements for their families so as to not expose them to risk, and physical exhaustion.

Gender-neutral policy making inherently neglects the needs of women.³ Thus, it is imperative to ensure that all considerations of health-care workers are disaggregated by gender and race to understand the differential effect between different members of the workforce. In doing so, targeted interventions can ensure that PPE is distributed fairly, that proper mental health programmes are created, and that these efforts are gender mainstreamed to ensure that they reach those most vulnerable to suffering these effects.

We declare no competing interests.

Gabriela Lotta, *Michelle Fernandez, Denise Pimenta, Clare Wenham
michelle.vfernandez@gmail.com

Fundação Getúlio Vargas, São Paulo, Brazil (GL); University of Brasília, Brasília 70904-970, Brazil (MF); Fundação Oswaldo Cruz, Belo Horizonte, Brazil (DP); London School of Economic and Political Science, London, UK (CW)

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Lokugamage AU, Wong SHM, Robinson NMA, Pathberiya SDC. *Transformational learning to decolonise global health*. *Lancet* 2021; **397**: 968–69—In this Correspondence, the published work the authors refer to in their first sentence has been corrected to a Comment. This correction has been made to the online version as of April 1, 2021.

For UN sex-aggregated case data see <https://data.unwomen.org/resources/covid-19-emerging-gender-data-and-why-it-matters>

For more on gender and race on the front line see <https://www.genderandcovid-19.org/resources/covid-19-pandemic-and-health-professionals-gender-and-race-on-the-front-line/>