

The samples, although not fully generalisable to the UK population on account of sex and socioeconomic bias, were similar in both periods, allowing comparison. We had insufficient data to estimate the odds of long COVID in unvaccinated individuals and did not estimate effects in children. Finally, to enable swift reporting, the period of assessment of omicron cases was slightly shorter than for the delta variant, and assessment of longer durations of long COVID (eg, >12 weeks) was not possible.

Overall, we found a reduction in odds of long COVID with the omicron variant versus the delta variant of 0.24–0.50 depending on age and time since vaccination. However, the absolute number of people experiencing long COVID at a given time depends on the shape and amplitude of the pandemic curve. For example, given the high numbers of people infected with omicron in the UK from December, 2021, to February, 2022, our data are consistent with the UK Office for National Statistics, who estimated that the numbers of people experiencing long COVID actually increased from 1.3 million in January, 2022, to 1.7 million in March, 2022.⁴ Considering the UK omicron peak of more than 350 000 new symptomatic COVID-19 cases per day estimated on March 26, 2022, by the ZOE app model and 4% of cases being long COVID, future numbers with long COVID will inevitably rise.

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Hunting down the cause of acute hepatitis in children

As of May 16, 2022, the UK has seen 197 cases of non-A–E acute hepatitis in children younger than 16 years, 11 of whom have needed liver transplantation; no deaths have been reported thus far.¹

Epidemiological and laboratory investigations have suggested that adenovirus subtype 41F has been identified in most cases where tested (72%). It is important to note that there has been a rapid four-fold increase in adenovirus infection since November, 2021, compared with the pre-pandemic and pandemic period. This increase, alongside the lack of exposure of young children to common childhood viral infections during the pandemic, suggests that there has been a change in the host response or atypical susceptibility to a novel variant of this common virus. However, histopathology of explanted livers and liver biopsies show a non-specific pattern of mild hepatocellular

injury to hepatic necrosis, but no evidence of adenovirus in hepatocytes. This injury could be secondary to an aberrant immune response from the resident immune system of the liver, a phenomenon observed in children with acute liver failure of unknown cause.² A more detailed characterisation of the immune infiltrate of the liver and host immunity could identify children with immune dysregulation, who could respond to immunosuppression, thereby avoiding liver transplantation.

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Gender equality and climate action: lessons from evidence on SRHR

Following the successful *Lancet* webinar on gender and sustainability, the *Lancet* Editorial¹ on planetary health serves as an important reminder of how essential it is to address gender inequalities for ensuring a healthy planet. In addition to areas for action that the webinar and subsequent Editorial have highlighted, there is an urgent need to identify and exchange evidence-based transferable lessons across sectors.

On the same day as the *Lancet* webinar, the UN University International Institute for Global Health (UNU-IIGH), Asian-Pacific Resource and Research Centre for Women, and UNICEF co-hosted an event at the 66th Commission on the Status of Women to discuss transferrable



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lessons for advancing gender equality in climate change responses based on evidence from the field of sexual and reproductive health and rights (SRHR). With perhaps the most extensive history of attention to gender equality in the health field, the SRHR evidence base provides extensive transferrable learnings to advance gender equality in terms of what to do, what not to do, and what to do differently. Drawing from the UNU-IIGH team's ongoing analysis of systematic reviews and programme implementation in SRHR, the event highlighted five actionable lessons that are equally relevant for climate change responses.

First, and perhaps most fundamentally, address both sex differences and gender inequalities. For instance, the implications of water shortages can be especially acute for women because of hygiene needs related to menstruation, pregnancy, or maternity, but also because the burden of cooking, cleaning, and fetching water falls largely on women.

Second, focus on important things rather than everything. Evidence on SRHR programmes suggests that comprehensive interventions often end up being boutique (eg, small-scale, specialised, and time and expertise intensive), difficult to implement, and rarely gain commensurate financial commitments or infrastructure to scale up. Targeted approaches have been more successful when done correctly as evident from the effect of cash transfers and subsidies on outcomes, such as child marriage or maternal health.

Third, change systems, services, and individuals and communities. Gender-focused SRHR programmes have focused more on shifting behaviours and norms among individuals and communities, with less focus on advancing gender-equitable health systems. It is imperative to consider how this imbalance can be prevented in climate change responses.

Fourth, measure success in a consistent and meaningful way. Progress on gender equality in the SRHR

field has been difficult to assess because of a broad range of unprioritised and unconsolidated success measures. The climate change field can avoid this pitfall by establishing a shortlist of the most essential measures on gender-related progress it wants to achieve. Concurrently, it is as important to track unintended negative consequences and pushback against gender equality as it is to track progress.

Fifth, engage with women as consumers, producers, and innovators rather than just as beneficiaries. In engaging with women mostly as beneficiaries of family planning, maternal health, HIV/AIDS, or similar interventions, SRHR gender efforts have yet to catalyse women's broader role in health to reshape the field itself. It would be a shame for climate change efforts to similarly underutilise the proactive dynamic for transformation inherent in 50% of humanity.

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1 The Lancet. Planetary health for the ages. *Lancet* 2022; **399**: 1279.

Where are the children and adolescents?

Despite publishing a key WHO–UNICEF–*Lancet* Commission¹ that made the case for putting children and adolescents at the centre of our thinking, an Editorial commemorating World Health Day 2022 did not mention children or adolescents.²

The global COVID-19 pandemic response has highlighted the routine neglect of the voices of children and adolescents. Children and adolescents were never (or rarely) part of the public health response. Instead, we took control, circumscribed their lives in quite authoritarian ways, halted

their education, limited their play and engagement with peers, and demanded they make these sacrifices for the control of a virus that posed a small risk to them. These actions were taken in the name of protecting others. Of course, bearing a cost for others is an important and noble thing, but when we want somebody to pay a steep price, getting their buy-in is essential.

Where were youth representatives on governmental advice bodies? Where were the voices of youth activists that could advocate for keeping schools open? Arguing, as the Editorial does, for a focus on the root causes of inequity, extending sources of evidence, and forging new coalitions is of course important, but offers nothing novel and the forgetting of children and adolescents is indefensible.² We are in the midst of a climate catastrophe, and we must stop paying lip service to putting children and adolescents at the centre of our plans for the future of this planet.¹

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Supporting cancer survivors in LMICs

The Editors discuss unmet needs of the growing population of cancer survivors.¹ Cancer survival rates in many low-income and middle-income countries (LMICs) have seen a rise in the past two decades.² Amid the increasing number of people surviving cancer, cancer control efforts in these settings are nonetheless largely focused on improving early detection and access to cancer treatment, with very little emphasis on provision of structured supportive care and survivorship care.