and children should build on previous investments and achievements in sexual and reproductive health (SRH) in crisis settings. We fully agree. SRH is arguably the area in which most progress has been made in terms of improving humanitarian response for women, and we recognise the decades-long work and leadership of the Inter-Agency Working Group (IAWG) in driving that progress. This work includes IAWG's development of the Minimum Initial Service Package, which is indeed widely endorsed by a broad range of humanitarian actors as an essential package of priority SRH (including maternal and newborn health) activities at the onset of an emergency, although its implementation is still uneven.[1–3] We also recognise and value the online repositories of technical guidance and other resources on SRH maintained by IAWG and its members, which complement similar repositories on other topics relevant for conflict-affected women and children that are hosted elsewhere (eg, ALNAP, UN Office for the Coordination of Humanitarian Affairs, and COVID-19 Humanitarian).

Our call for a technical advisory group to support empirical work and guidance development to improve humanitarian health action for women and children in conflict settings[4,5] is essentially a call to bridge the domain-specific silos that many researchers concerned with the wellbeing of conflict-affected women and children often find themselves working in, ourselves included. Our Series highlighted the challenges of health service provision for women and children in conflict settings (many of which are common across the life course) that arise from underlying contextual factors, including violence and insecurity, mass population displacement, and the changing nature of war. We remain convinced of the value of establishing an integrated technical advisory group through which such common challenges could be more effectively addressed. Leveraging the strengths and expertise of existing groups and networks and including academic, technical, and implementing partners from conflict-affected geographies, such a technical advisory group could help coordinate and steer efforts to fill the data, evidence, and guidance gaps that persist within and, in some cases, across the full continuum of women's and children's health and nutrition in conflict settings. Such integrated coordination of these efforts would help to ensure that the complexities and special requirements of delivering evidence-informed interventions and services for women and children in conflict contexts are systematically considered and explicitly addressed. We envision this technical advisory group as being aligned with and building on the extensive knowledge and work of IAWG and other actors, and we also hope that one or more of these actors would be willing to lead this initiative.

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*Zulfiqar A Bhutta, Michelle F Gaffey, Neha S Singh, Ana Langer, Karl Blanchet
zulfiqar.bhutta@sickkids.ca

Centre for Global Child Health, Hospital for Sick Children, Toronto, ON M5G 0A4, Canada (ZAB, MFG); Health in Humanitarian Crises Centre, London School of Hygiene & Tropical Medicine, London, UK (NSS); Women and Health Initiative, Department of Global Health and Population, Harvard T H Chan School of Public Health, Boston, MA, USA (AL); The Geneva Centre of Humanitarian Studies, University of Geneva, Graduate Institute, Geneva, Switzerland (KB)

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Gendered effects of COVID-19 on young girls in regions of conflict

The Series on Women's and Children's Health in Conflict Settings provides important guidance for addressing the health of women and children in areas of poor security and instability. However, we write to call special attention to the gender inequalities in areas of armed conflict and, in particular, the effects of the COVID-19 pandemic on young, school-age girls (aged 5–18 years).

In settings of violent conflict, young girls are about 25 times more likely to be out of school than their male counterparts, and the COVID-19 pandemic appears to have exacerbated this disparity.[1] The pandemic has also had substantial indirect effects on levels of poverty and child malnutrition which appear to have fallen hardest on young girls. In some areas of civil conflict, the pandemic has increased the power of armed non-state groups that threaten girls' access to education and other public goods. Several of these groups, such as the Taliban in Afghanistan and Boko Haram in Nigeria, routinely threaten girls' education, at times even conducting acid attacks, kidnappings, and killings of young girls and their families.[2] The pandemic has also destabilised the security situation in ways that have expanded the exploitation of young girls in the sex trade and as child soldiers, as was seen in Boko Haram's

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For the **UN Office for the Coordination of Humanitarian Affairs' repository** see https://www.humanitarianresponse.info/en/documents

For the **COVID-19 Humanitarian repository** see https://www.covid19humanitarian.com/framework

use of girls as young as 7 years as suicide bombers.[3] The effects of the COVID-19 pandemic have been far-reaching, but its impact on the health and wellbeing of young girls in areas of conflict and political instability deserves focused, urgent attention.

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*Sophia N Nesamoney, *Gary L Darmstadt, Paul H Wise*
gdarmsta@stanford.edu

King Center on Global Development, Stanford University, Stanford, CA, USA (SNN); Department of Pediatrics, Stanford University School of Medicine, Stanford, CA 94305, USA (GLD, PHW)

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Time to integrate congenital CMV testing into hearing screening for newborn babies

We congratulate the GBD Hearing Loss Collaborators for highlighting the magnitude of hearing loss as an important public health problem.[1] Early detection of hearing loss in children can substantially improve their academic performance.[2] Congenital cytomegalovirus (CMV) is the most common non-genetic and the only potentially treatable cause of sensorineural hearing loss; globally, it alone accounts for approximately 20% of moderate to profound bilateral sensorineural hearing loss in children.[3]

Diagnosis of congenital CMV in the first 3 weeks of life and starting treatment with oral valganciclovir within the first month will reduce the risk of hearing loss caused by this infection.[4] In the absence of any screening programme, the great majority of newborn babies with sensorineural hearing loss related to congenital CMV are missed at birth.[5] The diagnosis is often delayed into early childhood, by which time the condition is likely to have progressed and antiviral treatment has not been shown to be effective.

We fully agree with the Article authors' assertion that urgent attention is required to improve newborn babies' hearing screening programmes. It is now time for policy makers to optimise this pathway and to begin testing for congenital CMV in those who do not pass their newborn baby hearing screen. Addressing this condition will have immediate benefits for affected infants by improving developmental outcomes and to wider society by increasing productivity and minimising the health-care burden.

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**Seilesh Kadambari, Monique Ingrid Andersson*
seilesh.kadambari@paediatrics.ox.ac.uk

Oxford Vaccine Group, Department of Paediatrics, University of Oxford, Children's Hospital, Oxford OX3 9DU, UK (SK); NIHR Oxford Biomedical Research Centre, Oxford, UK (SK); Oxford University Hospitals NHS Foundation Trust and Nuffield Division of Clinical Laboratory Sciences, Radcliffe Department of Medicine, University of Oxford, Oxford, UK (MIA)

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Data discrepancies and substandard reporting of interim data of Sputnik V phase 3 trial

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Restricted access to data hampers trust in research. Access to data underpinning study findings is imperative to check and confirm the findings claimed. It is even more serious if there are apparent errors and numerical inconsistencies in the statistics and results presented. Regrettably, this seems to be what is happening in the case of the Sputnik V phase 3 trial.[1]

Several experts[3,4] found problematic data in the published phase 1/2 results.[2] We have made multiple independent requests for access to the raw dataset, but these were never answered. Despite publicly denying some problems, formal corrections were made to the Article,[2] thus addressing some concerns.[5] Notwithstanding the previous issues and lack of transparency, the interim results from the phase 3 trial of the Sputnik V vaccine[1] again raise serious concerns.

We have a serious concern regarding the availability of the data from which the investigators draw their conclusions. The investigators state that data will not be shared before the trial is completed, and then only by approval of stakeholders, including a so-called security department. Data sharing is one of the cornerstones of research integrity; it should not be conditional and should follow the FAIR principles.

The second concern pertains to the trial protocol, as already described in an open letter by the Russian Society for Evidence-Based Medicine.[3] The Sputnik V investigators mention that three interim analyses were added to the study on Nov 5, 2020,[1] but this change was not recorded on ClinicalTrials.gov (NCT04530396). Unfortunately, the full study protocol has not been made publicly available, so the rationale behind this change or the type I error rate adjustment, if


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