Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Comprehensive and incisive evaluations, although essential, might unintentionally signal that it is time to move on, paradoxically abetting processes of forgetting. The risk is that moving on will worsen ongoing deficiencies in care, response, and advocacy for people who continue to be affected by or clinically vulnerable to COVID-19. Institutions, including governments, global health agencies, and donors, must be able to plan for and respond to new global health emergencies while still supporting their past priorities.[4] Otherwise, these institutions risk further failing the people they intend to serve.

I declare no competing interests.

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The importance of accountability in tackling future pandemics

In Richard Horton's Offline,[1] he raises two issues that can undermine the future success of the pandemic agreement being negotiated by the Intergovernmental Negotiating Body: WHO's resistance to an independent high-level council outside its governance structure and the absence of meaningful accountability in large-scale WHO initiatives.

Why must a pandemic convention be housed outside WHO? Ministers of health (who comprise the World Health Assembly, the decision-making body of WHO) simply do not have the power to drive the whole of society, whole of government approach needed to prevent, prepare for, and respond to pandemics. A broader approach is needed because pandemics are not just a health issue but a problem that affects all layers of the economy and society. Moreover, a high-level council comprising heads of state and government must be outside of WHO because heads of state cannot report to their own ministers of health.

A body that is independent from WHO, such as the Global Health Threats Council envisioned by Helen Clark and Ellen Johnson Sirleaf, is also needed for compliance because WHO, as a technical adviser to countries, should not be placed in a position to evaluate and hold countries accountable for their obligations. Furthermore, because the absence of accountability and enforcement threatens the success of international treaties,[2,3] an accountability framework with incentives and disincentives for compliance is necessary for a pandemic convention to achieve its desired effect.[4] Details of this framework must be agreed upon in advance to be binding for countries and not left for discussion until after the pandemic agreement is signed, as has been proposed in the Zero Draft.[5] Failing to keep countries accountable for their obligations under the agreement would place the world at greater risk for another pandemic.

We declare no competing interests.

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Moving towards a precision approach for prevention of severe COVID-19

Replication of results in science is always reassuring, so we were pleased to see that Utkarsh Agrawal and colleagues,[1] using data from all regions of the UK, identified nearly identical risk factors as we did for severe COVID-19 despite vaccination among a nationwide cohort of US veterans.[2] An advantage of our study was the analysis of multiple subgroups, which allowed estimation of absolute risks on the basis of age and specific details about immune-compromised status. Advantages of the study by Agrawal and colleagues include the use of a variable that summarises the number of severe comorbidities at the patient level, a study population with large numbers of patients who had received booster vaccines, and a subanalysis limited to patients who had received boosters—which showed similar relative risks to what had been observed in analysis of the entire vaccinated population.

Data increasingly support the hypothesis that there are so-called

vaccine complete responders, who most likely do not require frequent re-dosing; partial responders, who would benefit from re-dosing; and limited or non-responders, for whom we desperately need alternative prevention options, such as effective pre-exposure or post-exposure prophylaxis.[3] Monoclonal antibody strategies have been shown to be ephemeral, and more advances are needed in this space.[4] The large UK dataset used by Agrawal and colleagues might be useful for identifying these vaccine response phenotypes, through subanalyses stratified simultaneously by age and the number of comorbidities, with separate analyses for boosted or unboosted patients. Findings could be used to inform practice regarding vaccine distribution campaigns, targeting those who are likely to derive substantial clinical benefit from additional vaccine doses.

WB-E and PAM were both site investigators for a clinical trial of remdesivir, which was sponsored by Gilead Sciences.

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1 Agrawal U, Bedston S, McCowan C, et al. Severe COVID-19 outcomes after full vaccination of primary schedule and initial boosters: pooled analysis of national prospective cohort studies of 30 million individuals in England, Northern Ireland, Scotland, and Wales. *Lancet* 2022; **400:** 1305–20.

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Authors' reply

We welcome the Correspondence from Westyn Branch-Elliman and Paul A Monach in which they hypothesise that there are some individuals who, after completion of their primary COVID-19 vaccination course, do not need frequent vaccine re-dosing; others who might benefit from periodic re-dosing; and others who could, irrespective of the number of doses given, respond poorly to vaccines.[1]

Specifically, we support their suggestion of potential follow-up analyses of UK datasets[2] of severe COVID-19 outcomes after full vaccination and initial booster vaccines to investigate this hypothesis. An approach to tackle these analyses could be to develop a risk prediction model for severe COVID-19 outcomes (ie, COVID-19 hospitalisation or death), similar to the QCOVID model at the request of the UK's Chief Medical Officers.[3] This prediction model could help identify individuals at both very low risk and high risk of a severe COVID-19 outcome. With such a model, we could then explore if the individuals in the high-risk group are likely to benefit from either frequent vaccine re-dosing or the growing array of COVID-19 therapeutics. We are currently in the process of conducting a UK-wide analysis to investigate the factors associated with increased risk of severe COVID-19 outcomes among individuals in the UK who received a vaccine as part of the 2022 COVID-19 autumn booster campaign and who might also have received treatments with monoclonal antibodies or antivirals.[4]

There is also the opportunity to use the Scotland-wide Early Pandemic Evaluation and Enhanced Surveillance of COVID-19 (EAVE II) platform, which is uniquely placed within the UK, because towards the end of 2022 it had linked serology data to the existing electronic health record and vaccination data, to enable identification of serological responses to vaccination.[5]

AS and CR are members of the Scottish Government Chief Medical Officer's COVID-19 Advisory Group. AS is a member of the Scottish Government's Standing Committee on Pandemic Preparedness, the UK Government's New and Emerging Respiratory Virus Threats Advisory Group (known as NERVTAG) Risk Stratification Subgroup, the UK Department of Health and Social Care's COVID-19 Therapeutics Modelling Group, and was a member of AstraZeneca's COVID-19 strategic thrombocytopenia taskforce. All of AS's roles are unfunded. CR is a member of the Scientific Pandemic Influenza Group on Modelling, Medicines and Healthcare products Regulatory Agency Vaccine Benefit and Risk Working Group. UA declares no competing interests.

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Gender inclusivity in India's National Family Health Survey

India's National Family Health Surveys (NFHSs), the most recent of which was done in 2019–21 (NFHS-5),[1] have provided rich insights into women's wellbeing and agency and the progress made in enabling women to claim their rights. The NFHSs have allowed policy makers, programme implementers, and researchers to track over time women's nutritional status, access to institutional delivery services, educational status, and agency—namely, participation in household decision making, freedom of movement, control over resources,