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.

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compensation to the victims of Nazi medical atrocities.

Apart from a specific public plea for forgiveness addressed to physicians in Israel in 2015, no evidence exists (eg, on the GMA’s homepage or elsewhere in the media) to suggest that other victim groups, such as victims of forced sterilisations and so-called euthanasia (or their family members), the victims of forced medical research, and the victims of forced migration beyond Israel have been addressed by the GMA. Finally, it is difficult to accept Jütte’s claim of independence from the GMA, as he has been a member of the GMA Scientific Advisory Board since 1994. Jütte has spoken as a representative of this institution on many occasions (eg, at a GMA-hosted reception of US physicians in 2011) and has received direct and full funding from the GMA for two of the above-mentioned publications (in 1997 and 2011). Thus, in view of his official role and the funding he has received from the GMA for his publications, Jütte appears to have a conflict of interest when speaking about the Nazi past of the German medical profession and about the post-war dealings of the GMA with the related issues.

In view of the evidence presented above, Jütte’s allegations are unfounded and outrageous. Furthermore, it is highly regrettable that Hyde has made no attempts to evaluate the fundamentally contradicting claims represented in the World Report and that he neglected to use the evidence available to him to qualify and potentially refute the baseless allegations of the GMA’s Scientific Advisory Board member.

We declare no competing interests.

*Volker Roelcke, Sabine Hildebrandt, William E Seidelman
volker.roelcke@histor.med.uni-giessen.de
Institute of the History of Medicine, Giessen University, D-35392 Giessen, Germany (VR); Boston Children’s Hospital, Harvard Medical School, Boston, MA, USA (SH); Department of Family and Community Medicine, Temerty Faculty of Medicine, University of Toronto, ON, Canada (WES)

1. Hyde R. The slow road to atonement. Lancet 2021; 398: 105–08.
2. Roelcke V Between professional honor and self-reflection: the German Medical Association’s reluctance to address medical atrocities during the national socialist era, ca. 1985–2012. In: Roelcke V, Topp S, Lepicard E, eds. Silence, scapegoats, self-reflection: the shadow of Nazi medical crimes on medicine and bioethics. Göttingen: Vandenhoeck & Ruprecht Unipress, 2014: 243–78.
3. Seidelman W. Requiescat sine pace: recollections and reflections on the World Medical Association, the case of Prof. Dr. Hans Joachim Sewering and the murder of Babette Frowis. In: Roelcke V, Topp S, Lepicard E, eds. Silence, scapegoats, self-reflection: the shadow of Nazi medical crimes on medicine and bioethics. Göttingen: Vandenhoeck & Ruprecht Unipress, 2014: 281–300.
4. Jachertz N. 4 Fragen an Prof. Dr. med. Jong Dietrich Hoppe, Präsident der Bundesärztekammer. Deutsches Ärzteblatt 2008; 105: 2699.
5. German Medical Assembly. The Nuremberg Declaration of the 2012 German Medical Assembly. May, 2012. https://www.bundesaerztekammer.de/fileadmin/user_upload/downloads/Nuremberg_Declaration_EN.pdf (accessed Aug 31, 2021).

When suspicion replaces evidence in public health

The UK Government’s decision not to recognise people as vaccinated if they received COVID-19 vaccines in most of Latin America, Africa, and south Asia received widespread condemnation.¹ Many commentators have rightly called out this discriminatory policy, which unfairly targets people from low-income countries. However, as a group of scholars from the medical humanities and social sciences, we are particularly concerned that the way in which the government makes decisions about which countries are exempt from quarantine once fully vaccinated dispenses with evidence-based policy making.²

The policy recalls an earlier moment in global public health. At the height of the British Empire, quarantine effectively served to prevent citizens from low-income and middle-income countries entering high-income countries on the basis of the assumption that people from these countries were vectors of contagion. Both then, with quarantine islands, and now, with quarantine hotels, these policies rely on and exacerbate the role of suspicion in policing public health, especially regarding vaccines that are manufactured in countries other than the UK.³

The consequences of suspicion, and not evidence, driving policy are serious. This UK policy is irrational because many of these low-income and middle-income countries administered the same vaccines that the UK Government distributed to its own population. In some instances, the UK Government donated these vaccines. Although efforts to vaccinate the world against COVID-19 are picking up pace, there is still a lot of vaccine hesitancy. As the head of Africa Centres for Disease Control and Prevention noted, policies that exclude some vaccinated people could increase vaccine hesitancy from people who believe that vaccines are useless.⁴ ChAdOx1 nCoV-19 (AZD1222), which more than 50% of the UK population has been vaccinated with, accounts for most of the vaccines the UK have now labelled as unacceptable for travellers from some other countries. The rationale for not accepting the vaccine is unclear and speaks to a long history of suspicion-based public health policing in global health, as emphasised by the What’s at Stake in the Fake research project. It took WHO and other global health leaders decades to recover from undermining public confidence in low-cost generic drugs, which enabled low-income populations to access basic medicines. Do we want to repeat this cycle with vaccines, at what might be the start of an increase in pandemics due to increased urbanisation, globalisation, and climate change?

For more on the What’s at Stake in the Fake research project see https://warwick.ac.uk/fac Arts/history/research/projects/ fake

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*Sarah Hodges, Julia Homberger, Ushehuedu Kafokurinani, Shalini Rudra, Christopher Sairs, Nishriha Thakur, Sharifah Sekalala
s.hodges@warwick.ac.uk

Department of History (SH), UK, SR, CS, NT) and School of Law (SS), University of Warwick, Coventry CV4 7AL, UK; School of Social and Cultural Anthropology, University of the Witwatersrand, Johannesburg, South Africa (JH)

1 Odihambo R. UK Covid vaccine rules cause hesitancy—Africa health boss. Sept 23, 2021. https://www.bbc.co.uk/news/world-africa-53866356?at_medium=RSSat_campaign=KARANGA (accessed Sept 24, 2022).

2 Hodges S, Garnett E. The ghost in the data: evidence gaps and the problem of fake drugs in global health research. Glob Public Health 2020; 15:1103–18.

3 Bashford A. Quarantine: global and local histories. London: Palgrave, 2016.

4 Press Trust of India. Africa CDC slams UK’s decision to subject some fully vaccinated travellers to quarantine upon arrival. Sept 23, 2021. https://www.devdiscourse.com/article/health/3714749-africa-cdc-slams-uk-s-decision-to-subject-some-fully-vaccinated-travellers-to-quarantine-upon-arrival (accessed Oct 8, 2021).

Unclear conclusions on SARS-CoV-2 elimination versus mitigation

I read with great interest Miguel Oliu-Barton and colleagues’ Comment1 on the health outcomes of elimination versus mitigation strategies against SARS-CoV-2. I would be interested to know more about the categorisation of countries into these two strategies. Five countries (all of which were islands or peninsulas) were categorised as opting for elimination, whereas 32 countries (most of which border other countries) were categorised as opting for mitigation. Where do these categories come from? Were they explicitly stated in the policy documents of these countries? The other data sources are explicit, but this source is unclear despite being central to the analyses.

From my own unsystematic observations, Norway, for example, has adopted a much stricter policy than have countries such as Austria or Sweden; perhaps closer to an elimination strategy than to a mitigation strategy, if countries’ strategies were placed on a continuum. I have rarely, if ever, seen the goals of elimination versus mitigation explicitly stated in the national news. It would be interesting to see the analyses for each individual country, perhaps along a continuum of elimination versus mitigation strategies, and for other potential predictors such as location or borders with other countries.

The analysis exciting and thought-provoking. Although the global community wishes for this pandemic to end, Oliu-Barton and colleagues clearly show why it might be wise to be prepared for a long-lasting process.

I declare no competing interests.

Christian Gold
chgo@norceresearch.no

NORCE Health, NORCE Norwegian Research Centre AS, SØR-Bergen, Norway, Department of Clinical and Health Psychology, University of Vienna, Vienna, Austria

1 Oliu-Barton M, Pradelski BSR, Aghion P, et al. SARS-CoV-2 elimination, not mitigation, creates best outcomes for health, the economy, and civil liberties. Lancet 2021; 397:2234–36.

Authors’ reply

We thank Christian Gold for his interest and thoughtful Correspondence. Country strategies to control SARS-CoV-2 vary across many parameters but can be crudely grouped into countries that aim for elimination (ie, maximum action to control SARS-CoV-2 and stop community transmission as quickly as possible) or mitigation (ie, action increased in a stepwise, targeted way to reduce cases so as not to overwhelm health-care systems).1 Our classification is based on a qualitative analysis of policy documents, communication by government officials and advisers (eg, through press releases or other public communication), and lockdown dates and their severity with respect to case and mortality reports. Lockdown dates and severity give a good proxy on the overall response that a country showed to the pandemic, including behavioural changes that are possibly not directly linked to restrictions or policy interventions. Two authors jointly reviewed the policy documents and data, classifying each country into one of the two categories. Consensus for any disagreement was reached through discussion and final agreement from the whole author group. The classification of a country’s pandemic response into one of two categories is by virtue imperfect, particularly as responses change over time (eg, we considered only the first 12 months of the COVID-19 pandemic) and also vary within countries (eg, many countries used a zoning approach, adopting public health measures dependent on the epidemiological situation of each city, state, or region).2 Notably, Japan used local interventions as early as March, 2020, aiming to eliminate virus clusters by spatially targeted interventions.3

Gold suggests that a country-by-country analysis could strengthen our findings. For brevity, in the appendix we present annual data for a selection of countries that took markedly different approaches throughout the first year of the pandemic and have different geographical and political situations: Australia, New Zealand, and Vietnam (ie, classified as following an elimination aim) and Brazil, the UK, and the USA (ie, classified as following a mitigation aim). Focusing on annual data allows us to include non-Organisation for Economic Co-operation and Development countries, unlike in our original analysis,1 and consider cumulative deaths associated with COVID-19 in 2020, year-on-year growth change in gross domestic product in 2020 compared with in 2019, and the mean stringency index throughout 2020. The stringency index was