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.

George Orwell coined the term "doublethink".

Doublethink can mislead even experienced public-health practitioners. An example is the term "post-eradication immunization policy" for poliomyelitis.[2] It describes preventive strategies, such as routine immunisation with inactivated polio vaccine in low-income and middle-income countries, which will have to be implemented once the eradication of poliomyelitis has been achieved.[3] "Eradication", as defined by WHO, is the "achievement of a status whereby no further cases of a disease occur anywhere, and continued control measures are unnecessary".[4] By definition, in a post-eradication scenario, there will be no further need for any strategy against either poliomyelitis or poliovirus. In short, there is no such thing as a "post-eradication immunization policy".

The term misleads lay people and professionals alike by implying that the polio eradication initiative will soon come to a successful ending—an interpretation in line with the needs of donor agencies.[1] The implicit concession that there is a need for continued control measures, however, confirms the very opposite, namely that we are still far from achieving polio eradication. In an attempt to solve this contradiction, a redefinition of the meaning of eradication has even been suggested: "the extinction of a pathogen in the human population worldwide, though not. . . necessarily followed by the cessation of all control measures such as vaccination".[5]

Confusing and unclear language of this kind should be avoided in a scientific approach to public health.

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Registering clinical trials

Sir—I share the view of Timothy Evans and colleagues (May 1, p 1413)[1] that much research is wasted because some important studies are not published. Evans and co-workers are also concerned that researchers in developing countries whose first language is not English might experience difficulty publishing in international indexed journals. However, the notion that WHO leading universal registration of studies in developing countries will allow equitable access to the results of relevant research might not happen in practice.

Like many international agencies, including the International Monetary Fund, World Bank, and the World Trade Organization, WHO has been hijacked by the alliance of dominant classes[2] in dictating its policies and practices. One example was the failure of the WHO Global Outbreak Alert and Response Network (GOARN)[3] in responding to the severe acute respiratory syndrome (SARS) outbreak in China.

SARS is a timely reminder of the growing threat to humanity from infectious disease. WHO set up GOARN to maintain global-health security, but it was frustrated by the influence of dominant nations; in this instance, China managed to delay everything that WHO aimed to do. Moreover, since the 23 million people of Taiwan are excluded from WHO, there is a serious gap in the GOARN network.

Outside WHO, my friends and colleagues in Taiwan are compromised in matters of global-health policy discussions, technical connections, and disease control and prevention. Scholars in Taiwan are inhibited in developing public-health policy and promoting good practice owing to lack of support. They were barred from attending the WHO influenza symposium in March—an example that contradicts the spirit behind universal access to health-related knowledge for health improvement.

For the universal registration of controlled trials to succeed, I agree with Vicente Navarro[2] that WHO should be faithful to its constitution and charters, which state that health is one of the fundamental human rights of every human being, and that it should stop ostracising the people of Taiwan.

Many parliamentarians from the UK, the USA, Canada, Australia, and the European Parliament, together with the British Medical Association and the World Medical Association, have recognised the dangers and pitfalls of allowing China to hold WHO ransom in matters of global health.

The Lancet Editorial[4] echoed the difficulty of China's weak commitments to international human-rights agreements. I hope that the initiative of universal sharing of health-related knowledge for health improvement will allow WHO to turn a new page and succeed in their essential role.

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Global human resources crisis

Sir—We agree with Vasant Narasimhan and colleagues (May 1, p 1469)[1] that in many developing countries, international players have substantial influence over the agenda-setting and policy-making with respect to human resources for health. The joint poverty-reduction strategy paper and debt initiative for heavily indebted poor countries (PRSP-HIPC) is a prime example of an interface between international actors and national decision-makers with real clout. Unfortunately, human resources for health often do not even figure on its agenda. A review of the PRSP in six selected African countries by the UK's Department for International Development Health Systems Resource Centre indeed shows that, at best, the human resources crisis is merely acknowledged, and that an in-depth analysis of the issue and how it relates to civil service conditions is conspicuously absent in most papers.[2]

Cynics might say that these findings simply confirm the worrying tendency among both national and international policy-makers to skirt the very problems that will undermine any attempt to improve health and social services, let alone poverty reduction