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.

An appeal to world leaders: health care for Ethiopians in Tigray

More than 1 year into the current tragedy in Ethiopia,[1] the situation at Ayder Comprehensive Specialised Hospital, a major teaching institution in Mekele in Tigray, is dire.[2] In wars there are always many wrongs, often on both sides, but the worst is to deny food and medical care to innocent civilians—anywhere. As such, we, along with signatories of this Correspondence, appeal to the world's medical community to demand protection of hospitals such as Ayder from attack, and furthermore we plead for assistance in ensuring the provision of food, equipment, and medications to care for the civilian population of Tigray.

As staff, and as colleagues who have worked in, visited, and collaborated with staff or are familiar with Ayder Hospital, we know the lengths to which its dedicated team has gone to provide humane, high-standard care in the past 14 years. Now, the hospital has been forced to cancel basic surgeries. The availability of essential medications has, as estimated by the Ayder Hospital,[2] plummeted from almost 80% 1 year ago to less than 20%, and laboratory tests have dropped from 94% to less than 50%. Patients are dying from a simple lack of a reliable oxygen supply. Due to the blockade of Tigray, spare parts for all medical machinery are not just in short supply—they are non-existent. Neurosurgeons are operating without the benefit of imaging, depending on clinical skills only—a situation reminiscent of the 19th century. In Ayder Hospital, which only recently could boast of its achievements in providing haemodialysis to those in need,[3] patients with renal failure are dying before the eyes of attending staff due to the lack of basic supplies. Hospital staff have gone unpaid for most of 2021; and for those who still have some savings, the banks are closed. It is becoming impossible to feed the staff and their children.

In short—a medical catastrophe is unfolding, in the background of war, famine, and a humanitarian tragedy. We demand that the relevant bodies, the UN, the African Union, WHO and, above all, the Ethiopian Government stand by the health workers and the patients in Mekele. It is heartbreaking to see that those with the capacity to help do nothing, merely muttering that they are gravely concerned. We write this on Christmas Day in Ethiopia. We pray for deliverance for Mekele's sick and helpless patients.

We declare no competing interests. Signatories are listed in the appendix.

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How to fix democracy to fix health care

Globally, we are seeing a side-effect of COVID-19: political violence.[1] This effect usually shows itself in three steps: denial of scientific evidence, judgement of the intentions of political decision makers as a conspiracy, and civil disobedience and street violence.

This dynamic embodies violence on an intellectual, institutional, and physical level. Intellectual violence tends to break the trust between the scientific world and public opinion, institutional violence aims to divide politics from society, and physical violence shatters civil coexistence. In other words, it is the best strategy to destroy the idea of basic democracy, as recalled by Josiah Ober.[2]

It is fair to ask why this trend is developing in the democracies of high-income countries. However, it seems important to us to comment on these data with the following three hypotheses, keeping in mind the 2017 World Economic Forum report:[3] the crisis of the democratic system in high-income countries already existed before the COVID-19 pandemic; political anti-establishment manifests a contempt for politics that arises from ethical scepticism (politics according to Aristotle was in fact the highest form of ethics[4]); and post-truth political debate makes information too fluid and unreliable, leaving room for fake news.[5]

If these hypotheses are correct, then the therapy should be independent of the pandemic crisis and based on trust in scientific evidence that is capable of proposing knowledge, ethics, and politics regarding human ecology. This multidisciplinary approach requires as broad an anthropological agreement as possible that recognises human ecology as a source for policy decisions. Ober's vision of democracy is welcome when it refers to the need to respect personal autonomy, natural rights, and social justice.[2] But if we want to overcome this anthropological crisis, we should elucidate what we mean by human, natural, justice, and the place of humans in society. To define these terms requires going beyond procedural thinking to recover critical and systemic thinking, which requires a deep and hard anti-disciplinary effort. The systematic


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See **Online** for appendix

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approach will increase confidence in science and medicine, improve societal compliance, and promote good governance in global health.

We declare no competing interests.

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Inclusivity starts with language

Why does the phrase "bodies with vaginas"[1] grace the cover of an issue of *The Lancet* when it was likely to alienate a great many women? Although I was born with a vagina, I do not believe reducing my person to one of my organs seems appropriate, anymore than I would be happy to be called a body with caecum. Furthermore, I suspect my brother would not wish to be called a body with ductus deferens. In medical practice, patients ought to be referred to as whole people, not bodies with diverticulitis, or sickle cell in room three.

Although the intent of the wording might have been noble, language that risks deeply offending the majority cannot be considered inclusive.[2] Thus, due to the fact this phrase can be interpreted as dehumanising, rather than the issue serving as a call to arms to rectify the historical neglect of women's health needs, *The Lancet* risks giving the impression that it is participating in the long-standing legacy of medical discrimination against the female sex. A rethink or at least discussion of this language would seem warranted.

I declare no competing interests.

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1 Davis S. Periods on display. *Lancet* 2021; **398:** 1124–25.
2 Dahlen S. Do we need the word 'woman' in healthcare? *Postgrad Med J* 2021; **97**: 483–84.

Language can be divisive. This has become acutely palpable in the academic community. Although some identify strongly with a conventional idea of gender equity, others take a broader approach, focusing on principles of inclusivity of all bodies and genders. There is much to be gained from taking an aerial perspective, one that considers the value of all views, as well as the potential damage and missed opportunities that arise from not respecting or valuing difference.

It has offended many, but by modern standards *The Lancet* took an inclusive approach in promoting Sophia Davis' Perspective on Periods on Display.[1] It is worth reflecting that of all major journals, *The Lancet* is leading by example when it comes to raising awareness and debate on issues of women's health, gender, and gender equity.[2–5]

It is time for the academic community to put difference aside and come together for a more productive approach to talking about gender and how gender relates to health. One way to do so would be to improve consistency in the use of language by agreeing to a standardised approach on language that can be routinely incorporated into research and the peer review process.

Without coming together or showing willingness to be open to diverse perspectives, much is at risk. At most risk is the future of the many aspiring leaders who feel stuck in the middle. Their progress is dependent on open and inclusive leadership, and both are essential to moving the field forward.

I declare no competing interests.

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As a Collective, we are expressing our deep concern over the language used in the Perspective on Periods on Display[1] and the colonial implications from the position in which the concerns were addressed.

Over the past two decades, the menstrual health movement has made progressive policy changes, and improved menstrual health for all individuals that menstruate.[2,3] In the Perspective, Sophia Davis led with an example from the UK, when in fact this movement emerged from low-income and middle-income countries.[4] We ask that authors are encouraged to adopt the decolonising global health movement, particularly when discussing menstrual health, which has become saturated by voices from high-income countries.

Not all women menstruate, and not all individuals that menstruate are women. While we advocate for health care for transmen and non-binary individuals, we must not forget that there are additional challenges that being a woman or a girl can have on menstrual health, particularly in low-income and middle-income countries. If we place menstruation within the wider context of gender equality, it is