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Such drastic measures would lead to stigmatising young people by labelling them as having mental health conditions. Psychiatry must never be used as a social control, oppressive, or punitive measure.

The belief that coercive psychiatric measures can be used to correct young adults with differing personal, social, cultural, religious, or political views to align them with the propaganda of ruling regimes has long been outdated.³ Political abuse of psychiatry is not a new phenomenon. The former Soviet Union, Russia, Cuba, and China—among other countries—have a history of abusing psychiatry for political reasons.⁴ Even in democratic countries, psychiatry has occasionally been used to pathologise civil rights movements, such as African-American freedom seekers being labelled as having drapetomania.³

Abuse of psychiatry for political and religious reasons could have long-lasting negative consequences for psychiatry as a profession as well as damaging society's trust in a medical speciality that is expected to be based on evidence and science. Psychiatry has been scrutinised more than any other medical speciality by human rights activists for posing social control over people.⁵ With insufficient knowledge of the pathophysiology of most psychiatric conditions, poor access to curative measures, and the restrictive nature of involuntary admissions and coercive treatments, psychiatry will remain in the spotlight. Although many of these issues might not be addressed adequately in the foreseeable future, all mental health professionals should responsively take a strong stance against the political abuse of psychiatry by any government.

We declare no competing interests.

Maryam Jay, *Artin A Mahdanian, Emytis Tavakoli, Dainius Puras
artin.mahdanian@mail.mcgill.ca

Western Sydney Local Health District, Sydney, NSW, Australia (MJ); McGill University, Montreal, QC H3A 1W9, Canada (AAM); Ontario Sores Center for Mental Health Sciences, Whitby, ON, Canada (ET); Vilnius University, Vilnius, Lithuania (DP)

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Integrated respiratory surveillance after the COVID-19 pandemic

We welcome Thedi Ziegler and colleagues' Comment on the WHO Global Influenza Surveillance and Response System and believe its proposals could strengthen global sentinel surveillance.¹

We respond to this Comment from the Oxford-Royal College of General Practitioners (RCGP) Research and Surveillance Centre (RSC), one of Europe's oldest sentinel networks.² The RSC is a collaboration between the University of Oxford, RCGP, and the UK Health Security Agency. The UK Health Security Agency's respiratory virus reference laboratory has provided data to the Global Influenza Surveillance and Response System and its predecessors since 1950. The RSC has grown substantially throughout the pandemic and, therefore, we are well placed to comment on the strategic and operational implications of the proposals.³

We support the principle of year-round integrated respiratory

surveillance and the broadening of laboratory testing to other respiratory viruses. Furthermore, we agree that measuring disease severity will support effective public health decision making. However, we should not overlook the importance of quality clinical data reporting and sufficient representative sampling to evaluate performance of diverse influenza and COVID-19 vaccine types across primary and secondary care networks. Additionally, longitudinal data enable prompt detection of changes in disease incidence, and routine surveillance with serology can also provide insights into heterogeneous population immunity.⁴

The RSC's rapid expansion and improved digital maturity through the pandemic have shown that surveillance systems can be a test bed for innovation.³ The integration of data from near-patient diagnostics into the RSC surveillance system's dataset and the evaluation of interventions (eg, antiviral therapies and new vaccines) are examples of such innovation.⁵ Growth, however, comes at a cost, and if improvements are to be sustained and built upon, necessary investment in personnel and resources is essential.

MZ is the chair of the International Society for influenza and other Respiratory Virus Diseases (ISIRV), a charitable organisation. MZ is a member of the government advisory groups Scientific Advisory Group for Emergencies, New and Emerging Respiratory Virus Threats Advisory Group, and the Joint Committee on Vaccination and Immunisation. Through his university, SdeL has received vaccination-related grants from AstraZeneca, GlaxoSmithKline, Sanofi, Seqirus, and Takeda. SdeL has been member of advisory boards for AstraZeneca, Sanofi, and Seqirus. We declare no competing interests.

William Elson, Maria Zambon,
*Simon de Lusignan
simon.delusignan@phc.ox.ac.uk

Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford OX2 6EE, UK (WE, SdeL); Reference Microbiology, UK Health Security Agency, London, UK (MZ)

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Weaponisation of water

We read Sharmila Devi's World Report¹ on the cholera outbreak in Syria and would like to emphasise how the weaponisation of water, sanitation, and hygiene (WASH) has affected the emergence of preventable communicable disease outbreaks. This weaponisation includes deliberate interference with WASH, and the use of WASH as a military tool, a tool of cooperation, or a tool of domination and legitimacy.² Water infrastructure is often indirectly damaged due to secondary reverberating effects of attacks on urban infrastructure.³ For example, the Alouk water station in the Al-Hasakeh governorate in Syria, which serves 460 000 people directly and another half a million indirectly via truck transport, has faced numerous deliberate disruptions as a result of Turkish occupation.⁴ In northwest Syria, substantial water infrastructure damage occurred in July, 2019, when eight facilities in the Al-Ma'ra district were attacked by Syrian Government forces, leaving a quarter of a million people without water.⁵

Such attacks, alongside the over exploitation of ground water, climate change, drought, and environmental contamination related to the conflict,

have contributed to a dire WASH situation across Syria.⁵ Contamination of water in the Euphrates, a river used to irrigate crops, is believed to be the origin of this current cholera outbreak.

Water is protected under International Humanitarian Law; however, there is little accountability for attacks that threaten a population's access to it. The WHO Surveillance System for Attacks on Health Care was introduced in December, 2017. Although this system is not perfect, it is a step towards documentation and accountability.⁶ Given the changing nature of increasingly urbanised conflicts, a similar mechanism is needed to document and deter attacks on civil infrastructure. Without such intervention, attacks and resulting preventable communicable disease outbreaks will continue to affect vulnerable populations.

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**Aula Abbbara, Naser Almhawish, Ibrahim Aladnan, Redwan Alobaid, Nabil Karah*

a.abbbara15@ic.ac.uk

Department of Infection, Imperial College, St Marys Hospital, London W2 1NY, UK (AA); Syria Public Health Network, London, UK (AA); Assistance Coordination Unit, Gaziantep, Turkey (NA, RA); Environmental Protection Agency of Syria, Gaziantep, Turkey (IA); Umeå University, Umeå, Sweden (NK)

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Ebola outbreak in Uganda: patient values and preferences

The Ebola virus outbreak in Mubende district, Uganda, in September, 2022, was caused by Sudan virus. It was expected that with an effective government response this outbreak would be quickly under control.¹ Nevertheless, seven suspected patients reportedly left their hospital quarantines on Sept 26, ahead of their scheduled release.² One of these individuals ran to seek a traditional healer. Additionally, his family wanted a traditional ritual to be carried out before a potential burial.³ It has been argued that understanding and respecting local cultural practices and placing trust in communities is essential for Ebola control.⁴ For better quarantine and treatment, decision making should be made on the basis of sufficient information sharing between the health-care providers and patients.

To process the informed decision making, the benefits and risks need to be communicated and the patients' values and preferences considered. As quarantine is an effective public health measure, it should be perceived as beneficial to the patient as well. Health-care providers should accurately explain the positives of quarantining in a way that the patient can easily understand, such as the possibility of early treatment and protection of their family. Next, the patient's concerns, stigma, financial burden, fear of infection, etc, should be discussed. Finally, together they should explore treatment strategies to meet the patient's values and preferences as much as possible, including clergy in