The Sydney Statement is one of the first framing documents on the principles for guiding global health security. Framing matters because the funding pool for development assistance for health is finite and has plateaued over the past decade.[2,3] Investments in global health security to prevent future catastrophes are subject to competing health priorities, such as scaling up the "most essential interventions" against ongoing epidemics of preventable morbidity and mortality in mothers, infants, and children in the Global South.[4] Development assistance for health that prioritises global health security could overwhelm or detract attention from multiple competing health priorities.[3]

Any overarching statement on global health security requires structured, inclusive, and incisive debate from all stakeholders, particularly from the Global South, such as the deliberations proposed for identifying synergies across related initiatives by the *Lancet* Commission.[5] The purpose and nature of global health security is too important to be established through asynchronous online contributions and normalised through social media. In the interests of pursuing everyone's health, there should not be a premature closure of the debate.

We declare no competing interests.

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The responsibility and potential of public health

In 2019, the Editors proposed that the challenges to halting the Ebola outbreak in the DR Congo are "principally a political problem" and no longer within the scope of public health.[1]

This assertion problematically compartmentalises the social and political drivers of health outside the purview and responsibility of the medical community, and it implies that simply pursuing conventional public health approaches is a good enough response, even if such approaches are insufficiently effective because of social and political factors.

We disagree and think that the obligation of public health must be to achieve healthful outcomes, even if that entails navigating messy politics and daunting social challenges or reformulating delivery strategies to overcome related barriers.

Such actions are how progress was made against HIV. Even after the advent of antiretrovirals, HIV was thought to be untreatable in sub-Saharan Africa and countries like Haiti because of the implementation-related challenges posed by poverty.[2] This perception was debunked when health actors made these structural barriers central to their mandate and developed novel ways to deliver care despite such factors.[3]

A similar approach must be taken to combat this Ebola outbreak. It is not enough to pursue conventional approaches and look elsewhere when those approaches are confounded by the security and political challenges of eastern DR Congo. We are not advocating health actors to directly solve the political hurdles or take up arms to create security. However, health actors should work with other sectoral actors to address these challenges while working to adapt existing strategies and create new ones that are more effective in this context.

We declare no competing interests.

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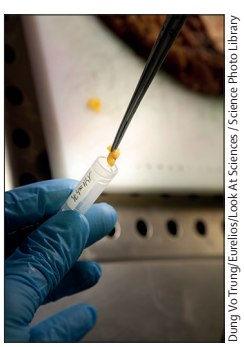
Careful governance of African biobanks



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In a World Report,[1] 54gene (a start-up genomics company) was featured as the first pan-African biobank that plans to collect 40 000 biospecimens from ten hospitals in Nigeria by the end of 2019. The World Report[1] has subsequently been reproduced in the media.[2] In a world where media reports are dominated by fake news, clarification of African biobank initiatives is imperative. These initiatives have been active for years and have delivered tangible interventions that affect Africans who donate biospecimens for research and empower the researchers who are resident in Africa.

54gene claims to be the first pan-African biobank, but both accredited and non-accredited pan-African biobanks have been around for as long as there has been genetic research in Africa by Africans. Initiatives such as H3Africa for genetics research in Africa, B3Africa for biobank data sharing between Africa and Europe, and the Global Emerging Pathogens Treatment Consortium for biosecurity have contributed substantially towards the formalisation of biospecimen and governance structures for data by African scientists who engage

For more on **H3Africa** see www.h3africa.org

For more on **B3Africa** see www.b3africa.org

For more on the **Global Emerging Pathogens Treatment Consortium** see getafrica.org

with international counterparts. These efforts have translated into evolving policies and guidelines for establishing regional African biobanks and guidelines for the sharing of biospecimens and data.[3]

As a result of the west African Ebola outbreak that brought the economy of many countries to a standstill and resulted in thousands of fatalities, the regional authorities have reacted aggressively to address the seemingly policy-free zone that Africa seems to represent with respect to human biological samples and data, which multiple opportunists have taken advantage of. This reaction was reflected by the mass movement of samples and data out of the region without appropriate diligence and governance.[4,5] Government-to-government collaborations have led to a review of the policies and shortage of necessary structures to bank and disseminate samples of pathogens, especially during public health emergencies of international concern. These collaborations have also resulted in the development of two biobank (also called biocontainment) facilities in Lagos, Nigeria, and Freetown, Sierra Leone, with elaborate community engagement and governance structures.

The UN Security Council Committee, on resolution 1540 in collaboration with the African Union, is advancing the urgent need for countries in Africa to undergo legislative review that will curtail biopiracy especially with respect to samples that could be used or deployed for nefarious objectives. This process is resulting in substantial domestic review processes of national laws to address the rapid changes in science and technology and the domestication of policies and guidelines to manage the movement of biological samples, as well as diminishing the biorisk potential associated with the plethora of conflict hot spots in Africa.

Members of communities who are donors of biological samples (including those who intend to donate the 40 000 samples earmarked by 54gene in Nigerian state hospitals) are essential stakeholders in health research. It is imperative that every academic initiative and public or private partnership that establishes itself in the biobanking space does so while recognising the rules of engagement around collection and sharing of biological samples and data for the purpose of improving human health. Failure to do so can cause irreparable damage to meaningful community engagement.[6] We remain gravely concerned that 54gene is "in talks with stakeholders in six other African countries where it is planning to set up biobanks".[1]

We urge 54gene to reflect on South Africa's experience 4 years ago when a health insurer announced genetic testing for its members at a competitive price in partnership with an American company.[7] This proposition, at that time, exposed South Africa's regulatory framework on the use, storage, and export of biological samples. In turn, Nigeria needs to reflect on its regulatory framework governing the export of biological material and associated data and ensure that measures are in place to safeguard the rights of Nigerian citizens who opt to donate their genetic material for the public good.

Good governance with respect to biological samples and their associated data requires complex discussions around community engagement, public learning and understanding of science, ethical principles of informed consent, storage of samples into antiquity, secondary use, return of results, and commercialisation. We wonder if 54gene considered the work done in Africa on these topics, especially if they feel that they are pioneering this space in Africa.

AC has a trademark on the name of an open-source software that is pending. In addition, both AC and AA are active African researchers in the field of biobanking and biobank informatics and have published in this space too, which has informed their views in this Correspondence.

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Refugees, asylum seekers, and immigrants in clinical trials

In 2017, the National Institutes of Health (NIH) highlighted that current federal regulations should include protections for vulnerable populations (ie, pregnant women, fetuses, neonates, prisoners, and children). The issue of inclusivity specifically for under-represented populations is being debated in government. In 338 phase 3 and phase 4 NIH-funded, actively recruiting studies registered with ClinicalTrials.gov, explicit exclusion was found for pregnant women, lactating women, children, older people, individuals with intellectual or developmental disabilities, and for those with physical disabilities.[1]

I suggest extending the definition of under-represented populations to include refugees, asylum seekers,