HIFA EHS-COVID-19 DISCUSSION LONG EDIT (251-401 messages)

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HIFA is collaborating with WHO to promote sharing and learning of experience and expertise around the maintenance of essential health services during and after the pandemic, in a spirit of solidarity and co-development. Below is the structured long edit version of the discussion from message number 251 to 401, which includes selected content from the 2nd Thematic Discussion as described **here.**

Also provided is a list of citations (resources that HIFA members have pointed us to) and a list of profiles of contributors.

The full compilation version of messages 251-401 is available **here.**

Outputs from previous messages 1-250 are available on the HIFA website is available **here** and a corresponding Action Brief is published on the WHO Health services Learning Hub (HLH) **website.**

General comments on messages 251-401

There was substantive discussion on all six topics except for vulnerable populations. The editorial comments at the end of each topic 1-6 indicate the key points and suggest areas for further exploration.

There was substantial discussion on additional topics, as indicated by sections 7-11.

Metrics: From 31 March 2021 to 12 June 2021 there were 150 messages from 33 participants in 16 countries (Bangladesh, Cameroon, Croatia, Egypt, Ethiopia, India, Iraq, Kenya, Lebanon, Nigeria, South Africa, South Sudan, Spain, Switzerland, UK, USA).

1. Reproductive Health

Q1. How has COVID-19 affected the delivery of essential REPRODUCTIVE health services in your health facility or country?

Dr. Sanchika Gupta (India) During emergency situations, Reproductive Health (RH) services took a back seat and the entire focus of the system was on managing the COVID-19. It affected the ongoing Reproductive Healthcare projects by different agencies/organizations. The gap between end user and service provision widened or the accessibility and availability for RH services was reduced.

Joseph Ana (Nigeria) Since the on-going thematic discussion started on HIFA forum, I have struggled to compartmentalize or separate the effects of COVID-19 pandemic on the basis of 'maternal and reproductive care', or 'child care', or any other forthcoming grouping(s). This is because frankly the health system of Nigeria has been poor for so long, and has resisted various attempts at transforming it, before the COVID-19 pandemic that it had to have only one direction of effect no matter how relatively mild the effect: bad effect and consequences on existing health conditions. Since COVID-19 landed in the country in 2020, the effect has been terrible and terrifying on lives and livelihoods and for the health system the effect is cross-cutting due to the weak structure, processes and poor outcome from all the segments of the system: maternal, reproductive, neonatal, child and others.

Neil Pakenham-Walsh (UK) The true impact of COVID-19 on maternal and new-born health is yet to be seen. Current failure to access antenatal and other services will inevitably translate to worse out-comes.

Senkyire Ephraim Kumi (Ghana) Essential reproductive health services (ERHSs) had reduced access to care during the early outbreak period as compared to pre-COVID-19 period. However, there is an increase in access due to observations of COVID-19 safety protocols

Q2. What has been the impact of health service disruptions on the REPRODUCTIVE health and well-being of people in your health facility or country?

Neil Pakenham-Walsh (UK) The authors[1] note 'deaths were concentrated in institutions from less developed regions, implying that when comprehensive ICU services are not fully available, COVID-19 in pregnancy can be lethal.'

Senkyire Ephraim Kumi (Ghana) Access to emergency contraceptives, increase in DBV, fear to visit health facilities, increase in home delivery leading unskilled birth attendants.

Q3. What have you, your health facility or country done to maintain essential REPRODUCTIVE health services?

Kristine Yakhama (Kenya) I am trying at least every twice in a week conducting community dialogue mass communication COVID-19 and nutrition giving folic supplements, encouraging mothers to plant

and eat spinach.

Ruth Davidge (South Africa) I suggest the following inclusions regarding safe maternity care during COVID-19:

- COVID positive pregnant mothers should be admitted and cared for in obstetric and not COVID-19 wards (We have had maternal deaths in mothers admitted to COVID wards who were not appropriately monitored)
- All obstetric departments (including labour, delivery and postnatal) should have capacity to isolate and provide oxygen and respiratory support for COVID positive women.
- Provision must be made to safely continue breast feeding/ breast milk provision, KMC and parental lodging/visiting for all sick and small new-born.

Senkyire Ephraim Kumi (Ghana) Ensuring safety protocols are observed; provision of PPEs; reduction in service time; follow up increase (revisitation).

Editorial Comment: Reproductive Health

Metrics: 6 contributors in 6 countries (Ghana, India, Kenya, Nigeria, South Africa, UK)
What we learned: Overall impact - Severe disruption in reproductive & maternal health; poor access to antenatal services; lack of ICU facilities causing lethal effect during COVID-19 associated pregnancy; increase in home delivery by unskilled birth attendants.
Contributors recommended efficient use of mass communication strategies; encouraging folic supplement uptake for pregnant women; COVID positive pregnant mothers should be admitted in obstetric and not COVID-19 wards; ensure oxygen and respiratory support for all COVID positive women in obstetric departments; ensure safety protocols for breast-feeding, provision of PPEs and increase in follow up.
What we have yet to learn: Perspectives from diverse background is required to understand the scale and impact of COVID-19 on reproductive healthcare services globally. Steps taken by various governments to ensure efficient access to reproductive health services.

2. Child Health

Q1. How has COVID-19 affected the delivery of essential CHILD health services in your health facility or country?

Arti Maria (India) We are witnessing this horrible phase of COVID 2021, the clinical characteristics of this wave are distinctly different from last year's wave...I can say for new-borns for sure...

- New-born disease is not a rarity any longer. I would say it's not uncommon.
- The MISC involvement has been seen.
- Clinical presentation has been with fever, Respiratory distress, NEC, seizures, encephalitis like in the picture, etc.
- Only previous WHO guidelines are available that recommend skin to skin at birth, exclusive breastfeeding and bedding in of a baby (+ or -) with his/ her COVID + mom 24x7 as far as possible.

- Currently I am not sure whether this would be the best approach to room in a baby who may be negative in the same COVID ward where other positive patients are kept as there are no other options but to cope like this!!

Dr. Sanchika Gupta (India) COVID-19 pandemic has taken a toll on child healthcare services. It may be immunization, hospital care services, public healthcare programs, etc. all are affected. The fear of contagion is widespread and parents/ caregivers don't want any risk when it comes to children. The children are usually locked/ forced to be inside homes with reduced chances of interaction with their friends/ social circles. No physical schools and online teaching are currently practised. Reduced physical activity and increased online/ internet activity. Isn't it going to affect their eyesight, psychological status, communication skills, prone to online abuses, etc. in the long run? When it comes to child health every single interaction is important!!

Beatrice Ezenwa (Lagos) From our clinical observations, the COVID-19 may have impacted our newborns not by causing the infection but by changing the health-seeking behaviour. During the peak of the pandemic, institutional deliveries declined, ill babies were not readily brought to hospitals.[6] Those that managed to present were severely ill or have sustained severe complications before presenting. For example, more cases of babies with acute bilirubin encephalopathy were seen compared with those without ABE. Some of these complications may have resulted from the difficulty to access health care facilities during the lockdown as movement and transportation were restricted. Also, the fear of contracting the disease in hospitals, resource diversion, and closure of facilities that comprised access to essential health services may have all contributed to the decline.

The present pandemic has exposed a lot of deficiencies in our health system. Our educational and social systems were not spared. Individuals, communities and governments have to rethink, go back to the drawing board and critically reappraise our healthcare system and other systems and come up with a workable plan on how to mitigate pandemics and other disasters without compromising healthcare for all.

Molla Godif (Ethiopia) We all know that the major risk factor for Neonatal sepsis is Hospital-acquired infection and therefore the impact of COVID-19 on neonatal and child health has a more positive effect due to the significant improvement of HH Practise including the access to Handwashing facilities.

Q2. What has been the impact of health service disruptions on the CHILD health and wellbeing of people in your health facility or country?

Molla Godif (Ethiopia) COVID-19 Might have contributed negatively to neonatal Health especially at the beginning of the pandemic when there is high fear to visit Healthcare facilities and as a result, safe delivery was to some extent compromised.

Q3. What have you, your health facility or country done to maintain essential CHILD health services?

Kristine Yakhama (Kenya) I am zonal leader Kakamega MNCH Alliance. I work at Shinyalu Model health facility it is a level 3 health facility. Mothers are attending ANC and taking children for immunization physical distancing, hand washing and wearing mask are key in the facility they have limit for attendance to avoid overcrowding.

Editorial Comment: Child Health

Metrics: 5 contributors in 4 countries (Ethiopia, India, Kenya, Lagos)
What we learned: **Overall impact –** Disruption of child healthcare services; rise in neonatal diseases; lack of updated guidelines to address child health during COVID-19; rise in online activities than physical activities affecting eyesight, psychological status, communication skills and online abuses; decline in the institutional deliveries and immunisation. **Positive impact of COVID-19** - Decline in hospital acquired neonatal sepsis due to increased hand hygiene practices by healthcare professionals. **Contributors recommended** reappraisal of the entire healthcare system to mitigate pandemics and other disasters without compromising healthcare services for all.
What we have yet to learn: Effective measures and steps taken by various healthcare system to ensure efficient access to child healthcare services. Impact of COVID-19 on child healthcare services across various settings and regions.

3. Mental Health

Q1. How has COVID-19 affected the delivery of essential MENTAL health services in your health facility or country?

Didier Demassosso (Cameroon) The COVID-19 pandemic when it started in March 2020 in Cameroon took many by surprise. No one really understood what was happening. This surprise was in Itself potentially traumatic. The acme of panic, fear of the unknown, fear of dying and confusion started when the lockdown measures by the Prime minister on the 18th of March was started.

I think it is this lockdown which had and still has an important impact on the general population. It had and has changed routine habits and behaviour important for mental health and wellbeing. Moreover, in the second phase of the pandemic when confinement and quarantine had to be done, many had and still experience psychological distress.

The fear was so intense in the population that the mental health department of the ministry of public health had to constantly reassure the population. I even was approached by a journalist to talk about the psychological impact of COVID-19 and what can be done to reduce it. Fear then was so intense in the population. The COVID-19 pandemic has impacted on the behaviour, attitudes and habits of the population, the health professionals, a specific population have also been affected, and the perception, representation of the health system by the population seriously affected as well. Time and research will tell to which significant extent. However, it is clear that this impact is very perceptible in the social interactions and language at all levels. As one walks in the streets, sees and listens. For example, touching behaviour is affected seriously. African-Cameroonians are very fond of touching one another when they interact. Burial rituals have also been affected seriously.

All these are stressors, maladaptive behaviours which have built up since March 2020 and impacting silently on the population's mental health.

Dr. Sanchika Gupta (India) In April 2021, there was a new wave of COVID-19 in India which was described as highly virulent. Untimely deaths of family members/ relatives/ friends/ colleagues had led to the feeling that everything is finished. Single earning member of the family has lost its battle to the virus or a single child of the family is gone or the entire family is no more or parents' death due to COVID-19 have left their children alone in the world. Hearing these stories created a dull, doom and dark atmosphere and loss of faith in individual power.

Health workers of all categories (doctors, nurses, pharmacist, laboratory staff, paramedical staff, ambulance services, sanitation workers, medical supply chain professionals etc.) all were overburdened with work and their duty schedules. Fear of contagion and spread among their family members was rampant. Non COVID-19 issues include frustration and anger for their inability to treat or cure the patient, or say the patient is not responding to any treatment. Remuneration issues like less salary/ no salary for months has created a struggle to bear their own and family expenses. Sleepless nights, inner struggle and keeping the momentum to fight the invisible was not easy to handle.

Adding the voices of medical professional students whose exams were delayed or they are solely depending on online classes. Their career struggles are still unheard. Frontline workers include persons who are involved in helping last rites of the deceased in the crematoriums, cemetery or others have one single Question 'how many deaths will we see?' Imagining their situation gives goosebumps!

Noha S Hassan (Egypt) Mental health all over the world has been negatively affected in response to events related to this pandemic, and among the highly affected are the health care providers; me included (as a medical doctor).

Already health care providers suffer from conditions related to stress and long working hours like chronic fatigue syndrome and burnout syndrome. However, this pandemic has taken such conditions to a whole new level! Although health care providers have been on the front line of pandemic response, they are not only risking their own lives but the lives of their close and beloved ones as well. However, and despite this huge role, they suffered from stigma. Some health care providers were having a really hard time in hiring a service provider like a babysitter, maid or others for fear of infection, especially in the early days of the pandemic. In some countries; the deceased from the health team were even facing some burial issues, also from fear of infection. Although reported incidents of such stigma have diminished after a while, they didn't vanish.

Goran Zangana (Iraq) COVID-19 resulted in significant mental health pressures on doctors and activists in Iraq and its Kurdistan Region of Iraq (KRI). I am reporting in this submission on the plight of a colleague who is practicing medicine in Halabja province. Dr Baxan Talabani, a general practitioner working in Halabja province, was arrested by the security forces on May 31st, 2021. Dr Baxan's 'crime'

was that she exposed a number of gross irregularities and corruption related to the COVID-19 response. She used social media to post videos and other evidence of expired medicines, charging extra fees illegally and other irregularities. The feared security force of Asyaish (security in Kurdish) attacked Dr Baxan that evening. Her ailing mother and student sister were terrorised by the force. Her two young children were traumatised.

The directorate of health in Halabja, sued Dr Baxan using 'an mobile phone abuse' law. She spent three days in a security force prison with terrorists and other criminals. After her release on bail, Dr Talabani received many death threats. She had to move to another city to protect her life and the life of her family.

Halabja is a city that was attacked by chemical weapons in 1988 by the Saddam Hussain regime killing 5,000 people in minutes. The city is still traumatised by that attack and in grave need for medical and public health services. This horrible story shows that colleagues are facing significant challenges not only related to the trauma of seeing large numbers of patients for long hours, but also corruption and irregularities in the health system is also creating other challenges.

Dr Baxan was not silenced by those threats and intimidations. Overnight, Dr Talabani became a national figure. All of the major news media in the region hosted and interviewed her. We hope that Dr Talabani's activism will contribute to a better health system in Iraq. However, such activism is not without significant toll on the mental and physical wellbeing of colleagues like Baxan. International support and solidarity with Baxan will help ease some of the unimaginable burden that she is so courageously shouldering on behalf of all of us.

Q2. What has been the impact of health service disruptions on the MENTAL health and wellbeing of people in your health facility or country?

Didier Demassosso (Cameroon) It should be noted that hospital settings during the COVID-19 pandemic in Cameroon have now got a different social representation and perception than before it. People feared and still do fear going to the hospital to seek for health care services relating to COVID 19 management. Perhaps it has extended to other services. One of the reasons stems from death associated with COVID-19 in the hospital and its impact on the mourning, bereavement and burial processes of people. Moreover, fear and distrust of the health system has increased during the COVID-19.

The inability to see and bury their loved ones who died in the hospital as a result of COVID-19 has been for many particularly very traumatic. I remember I received a lady during a clinical session who was hypertensive and whose hypertensive scores had increased during the grief, mourning and bereavement processes of her sister-in-law, wife to her junior brother who died by COVID-19. Well, when I met her, she had not even started the work of grief. It is the clinical sessions she received that induced it. Being from a region of Cameroon very faithful to rituals of the dead, the absence of the corpse because the hospital where her sister-in-law died, had to bury it soonest. The absence of the corpse plunged her into generalized anxiety disorder, depression and trauma. She also recounted

being traumatized by how the hospital handled the corpse and the whole situation of having to mourn and grief without the corpse.

It is important to talk of the health professional population working in hospitals. In the early onset of the pandemic. Those health professionals who were diagnosed positive for COVID-19 were stigmatized. I met one nurse whom while I was having psychotherapies with, disclosed she had had COVID-19 and how her hospital stigmatized her. She told me how painfully she experienced the diagnosis of COVID-19 in the hospital she was working in. She told me it was traumatic how the hospital she was working in (both the administration and her colleagues) handled her situation. I strongly believe that during the COVID-19 the mental health of many health workers has declined. COVID-19 as an additional stressor, coupled with the poor working conditions, extreme workloads has certainly aggravated the mental health of the health workers.

Dr. Sanchika Gupta (India) There are instances of discontinuation of treatment for existing patients. This led to increased severity of symptoms in the existing patients. Due to non-availability of services prospective care seekers had found it difficult to cope up with the mental health ailments resulting in grave consequences. There have been incidents of suicides during lockdown or jumping from the top floor of hospital buildings after being diagnosed with COVID-19. The positive case diagnosis creates fear and anxiety in the individual and they start thinking that I am gone and finished. Many times, they consider COVID-19 to be a death sentence.

Rural settings and hard to reach areas are still not able to become part of the system. Online consultations/ sessions are only available for those who have the power of technology. I observed one positive side of COVID-19 and mental health that it had brought to the surface and discussed on the table about health priorities of mental well-being. Even the general public are losing the reluctance to talk about it. I see a change!

Q3. What have you, your health facility or country done to maintain essential MENTAL health services?

Didier Demassosso (Cameroon) We cannot and should not talk of essential health services during the COVID-19 pandemic if mental health care services are not mentioned. As we know it is because there is no health without mental health. Moreover, the COVID-19 has created a global mental health crisis which was revealed in a UN policy brief in 2020. Furthermore, the 74th World Health Assembly which started today 24th May 2021 is for the first time addressing mental health responses. Even if it is because of the COVID-19, it is a victory to all mental health advocates as myself.

In Cameroon, the COVID-19 was an opportunity to develop Cameroon's larval but growing mental health system. In a paper published in The Lancet Psychiatry in October 2020 titled: How mental health care is changing in Cameroon because of the COVID-19 pandemic. The innovative approach put into place by the ministry of public health's mental health department which consisted of enabling mental health care services (counselling, psychoeducation, psychotherapies and pharmacotherapies) to operate at each level of COVID-19 response proved to be very effective. The establishment

of a national psychological support unit providing remote psychological assistance toll free calls at 1511 through two local mobile operators improved the outreach of mental healthcare services.

One day I was in discussions in an online community of practice. A man who had COVID-19 was sharing his distress about what he experienced during his illness and management. On requesting from him to talk with him privately having perceived distress in his expressions, he opened up to me and told me he was put in quarantine and had recovered from COVID-19. He told me how the psychological support he received by the volunteer psychologists of the Public Health Operation Centre (PHEOC) of the ministry of public health was so useful to reduce the stress and fear he had during the quarantine period. This fear was still present when I assessed him whereas he was tested negative. Notably the fear of getting re-contaminated and dying and leaving his young family.

During the COVID-19 pandemic in Cameroon, local NGOs such as Unipsy et Bien-etre with the support of UNFPA provided mental health healthcare services to pregnant and breastfeeding women. "A partnership has also been established between the German Agency for International Cooperation and iDocta Africa in Cameroon to provide remote medical and psychological support to vulnerable communities including older people and those with comorbidities".

In Cameroon, Mental healthcare services were provided by both the private and public sectors during the early phases of the COVID-19. It is clear that these interventions were tailored only or more for persons with COVID-19 or suspected to be in contact with a person with COVID-19. What about persons living with common to severe mental health disorders? What about persons living with a physical disability or mental disability? What about persons in other vulnerable groups? How did mental health professionals live the COVID-19 pandemic? Mental Healthcare Information For All and Mental Health Care For All for Everyone and Everywhere is possible! Yet for this to occur concrete Investment in mental health is highly imperative.

Editorial Comment: Mental Health

Metrics: 4 contributors in 4 countries (Cameroon, Egypt, India, Iraq)
What we learned: **Impact on General Population –** Overall mental health is affected, resulting in panic, fear of the unknown, fear of dying, confusion and fear of contagion; disruptions in healthcare services made prospective care seekers difficult to cope up with their mental health ailments; increase incidents of suicide cases; burial rituals have been affected making it difficult for people to mourn and express their grief; gaps/loopholes exposed in the healthcare system and in the governance. **Impact on Healthcare Workers/Frontline Workers -** Overburdened with work; fear of contagion and spread among their family members was rampant; frustration and anger for their inability to treat or cure the patient; less/no salary; long working hours; burnout syndrome; deceased from the health team were denied burial due to fear of infection; healthcare student's trainings were hampered; increased stigma associated with HCWs/FLWs. **Positive impact of COVID-19 –** Increased mental health awareness; more open discussion about mental health needs across communities. **Contributors recommended** more investment in mental health services; integrating mental health services at each level of COVID-19 response (like Cameroon); use of online counselling and the key role of NGOs and other key stakeholders.
What we have yet to learn: How COVID-19 affected other vulnerable groups; better-informed policies to tackle current and future needs for mental health services.

4. Surgery and Emergency Care

Q1. How has COVID-19 affected the delivery of essential health services for SURGERY AND EMERGENCY CARE in your health facility or country?

Balkrishna Kurvey (India) Fatality rate is also high. In such national tragedy some people are behaving inhumanely and black marketing of Remdesivir and O2. Number of such people is negligible but it affects the morale of people. Similarly, some COVID-19 Hospitals are charging exorbitantly, though the government has fixed the rate/charges but they do not adhere to the rule. Such hospital is very few but due to their action medical doctor community is defame, many my medical and non-medical friends are asking such question. Hope in developed countries this is not the situation but in some developing and under developed countries situation is not good.

Meena Cherian (Switzerland) Surgical services including cancer services were most affected during the initial phase of the pandemic due to various reasons such as the overwhelming COVID-19 admissions, shortage of PPE, ventilators, staff, ICU beds, trained staff etc. The long waiting periods for non-urgent surgeries including Minimally Invasive Surgeries, and surgeries for cancer resulted in grave consequences of morbidity, disability and mortality. However, this initiated the surgical groups to develop protocols and pathways to advise policy makers to address this issue for the coming months.

Q2. What has been the impact of health service disruptions on SURGERY AND EMERGENCY CARE of people in your health facility or country?

J Gnanaraj (India) During the Pandemic most of the rural hospitals in India did the following
1) Stopped all Surgical Work.
2) Later re-started with Only Emergency Surgical work.
3) When the urban hospitals were overwhelmed, only the rural hospitals were available for elective surgical work.

Q3. What have you, your health facility or country done to maintain essential SURGERY AND EMERGENCY CARE services?

J Gnanaraj (India) Many hospitals doing Laparoscopic surgeries especially in the urban areas reported that the Operating Room [OR] staff were getting infected. This made the rural hospitals do elective surgeries either with Open surgeries or when facilities are available by Gas Insufflation Less Laparoscopic surgeries [GILLS]. It is also good to note that although few of the rural hospitals performing GILLS had COVID infection among the OR staff.

Editorial Comment: Surgery and Emergency Care

Metrics: 3 contributors in 2 countries (India & Switzerland)
What we learned: Rise in black market of medicine & oxygen (India); shortage of PPEs, ventilators, ICU beds, trained staff; long waiting periods for non-urgent surgeries; delays in surgical intervention for treating cancer and other conditions further aggravated the health problems of the patients.
What we have yet to learn: Detailed analysis of COVID-19 impact on Surgical & Emergency care in various settings across the globe. Sharing of experience from diverse backgrounds is required.

5. Non-communicable Diseases (NCDs)

Q1. How has COVID-19 affected the delivery of essential health services for NCDs in your health facility or country?

Goran Zangana (Iraq) In Iraq, the pandemic affected the delivery of cancer treatment services greatly. In the Kurdistan Region of Iraq (KRI) the pandemic was associated with a financial crisis and economic depression. A decrease in the size of the fiscal space of the Kurdistan Regional Government (KRG) has resulted in a reduction of payment to essential cancer treatment services.

The failure of the government to pay the financial dues of pharmaceutical companies has resulted in significant difficulties for patients and families. Media reports highlighted recently the plight of cancer patients who are struggling to pay for their treatment in the private market because of the limited availability of such treatments in public hospitals. Private hospitals have filled the void to a limited extent but also at a high price resulting in catastrophic expenditures.

In these difficult circumstances, governments need to think about better policies to create efficiencies while maintaining essential services and life-saving measures.

Tomislav Mestrovic (Croatia) I have read a recent piece published in BMJ Opinion (entitled 'Cancer must not be the forgotten "C" in the fight against COVID-19'), which states that people in Croatia were fearing a COVID-19 diagnosis more than a cancer diagnosis when the pandemic started. As this phenomenon is not only pertinent to Croatia, an aspect of this that worried a global community of oncologists was the realisation that government-backed measures to combat COVID-19 could have destabilized cancer services across Europe. And the data proved them right - there was a 76% drop in urgent referrals for individuals with symptoms potentially indicating cancer (e.g., breast lump, difficulty swallowing, haematuria, just to name a few).

Q2. What has been the impact of health service disruptions on the NCD health and wellbeing of people in your health facility or country?

Tomislav Mestrovic (Croatia) Consequently, I wanted to see what is new regarding the availability of essential oncology services during the pandemic, and read with great interest a recent study published in the Journal of Oncology Pharmacy Practice, entitled 'Global changes to the chemotherapy service during the COVID-19 pandemic', where they found treatment reduction (69%) and lower usage of immunosuppressive agents (50%).[14]

Q3. What have you, your health facility or country done to maintain essential NCD health services?

Tomislav Mestrovic (Croatia) I wholeheartedly support a recent initiative led by the European Cancer Patient Coalition (ECPC), which on World Health Day (April 7, 2021) released a joint letter signed by 292 cancer organisations across the world, calling for a global effort to mitigate the pandemic's impact on cancer services.[15]

Furthermore, the "Time To Act" campaign - co-created by patients and health professionals across Europe - was launched on May 11, 2021 and represents an urgent call for action to take decisive and immediate steps in order to ensure that the current COVID-19 pandemic does not spill into a future cancer epidemic for the citizens of Europe.[16]

As the pandemic marches on, there is a dire need for an ongoing monitoring of service utilization to adequately inform system response and recovery, as well for the additional insights into the impact of COVID-19-related disruptions on cancer outcomes.

Editorial Comment: Non-communicable Diseases (NCDs)

Metrics: 2 contributors in 2 countries (Croatia & Iraq)
What we learned: Oncology services adversely affected; cancer patients struggling to pay for their treatment in the private market because of the limited availability of such treatments in public hospitals; drop in urgent referrals for individuals with symptoms potentially indicating cancer. **Contributor highlighted and supports** initiatives like “European Cancer Patient Coalition” & "Time To Act" campaign.
What we have yet to learn: Conditions of patients suffering with NCDs other than cancer; detailed analysis and sharing of experiences from diverse backgrounds and settings is required.

6. Vulnerable Populations

There were no messages for this theme.

7. COVID-19 Vaccination Services

Dr. Sanchika Gupta (India) Health systems need greater investment in terms of infrastructure, human resources, quality service provision, etc. Accessibility and affordability are a great concern. I was watching a news item that the COVID-19 vaccine pricing is highly varied across geographies. This will have a long-lasting impression on last mile delivery of vaccine provision for all.

Goran Zangana (Iraq) One particular area of concern in Iraq (and its Kurdistan region) is related to vaccines. The misinformation and negative publicity around COVID-19 vaccine did not affect people's willingness to receive the latter but also hesitancy toward vaccines in general. We are receiving worrying information that parents and families are now more reluctant to vaccinate their children because of the misinformation and bad publicity that COVID-19 has received recently.

Video message by an Iraqi doctor has been widely shared on social media that warns people about the 'grave' consequences of receiving a vaccine. These, we believe, have affected the public's acceptance to vaccines in general including those provided in children.

Kristine Yakhama (Kenya) COVID 19 vaccine is going on in the health facility but limited to health workers, teachers and security personnel. CHVs are key first contact with community need to be recognized.

Neil Pakenham-Walsh (UK) I was watching a news item that the COVID19 vaccine pricing is highly varied across geographies. This will have a long-lasting impression on last mile delivery of vaccine provision for all.

Noha S Hassan (Egypt) And since immunization against COVID-19 is probably the hottest health topic at the moment, immunization against vaccine-preventable-diseases (VPDs) is somehow kept in the shadow; as national immunization programs at many developing countries are not working properly for several pandemic-related reasons like the system fatigue, shortage in health workforce and lack of resources.

Immunization programs need the same focus as the pandemic; given we are still in the era of emerging and re-emerging diseases; as neglecting the progress the world has accomplished in combating several vaccine preventable diseases might end up in the world facing future epidemics and maybe even pandemics of VPDs.

I believe further global attention should be provided to the expanded program of immunization (EPI) in conflict settings and countries suffering from already fragile health systems; as these where epidemic foci are probably evolving.

8. Universal Health Coverage & COVID-19

Neil Pakenham-Walsh (UK) The existence of COVID-19 certainly does not reduce the importance of universal health coverage. On the contrary, the emergence of new diseases such as COVID-19 underlines that UHC is critical. Universal access to reliable healthcare information is a prerequisite for universal health coverage, and again COVID-19 emphasises the need for universal access to reliable information and protection from misinformation.

The quotations* clearly reflects that we are far away from Universal Health Coverage. Health systems need greater investment in terms of infrastructure, human resources, quality service provision, etc. Accessibility and affordability are a great concern.

**Refer message number 284 from the EHS-COVID-19 discussion full compilation version of messages 251-401 available here.*

Senkyire Ephraim Kumi (Ghana) Without rural nursing workforce, rural healthcare would collapse and we cannot achieve universal health coverage and SDGs.

9. Hospital Sanitation/Cleaning Services & COVID-19

Goran Zangana (Iraq) One of the areas that COVID-19 affected is the cleaning services at hospitals and operating theatres and other health facilities in the Kurdistan Region of Iraq (KRI). Because of the associated financial crisis, the Kurdistan Regional Government (KRG) is not able to pay companies that hire cleaners of hospitals.

Today, June 10th, 2021, more than 120 cleaners demonstrated in front of the Dr Khalid Hospital in Koya. They protested the inability of the KRG and the contracted companies to pay their salaries for more than 6 months.

The workers have continued to work over those 6 months without a salary. Those workers have reported that they were worried that if they boycott work, their positions will be filled by others who are willing to work as volunteers in the hope that those volunteers would be employed more permanently in the future.

10. Improving Pandemic Preparedness in LMICs & Lessons from COVID-19

Joseph Ana (Nigeria) The challenge for LMICs, the people and their governments: if you do not have functional strong health systems in place before disasters like COVID-19 pandemic, do not expect the citizens [and] the health workers to suddenly change their bad and unethical behaviours and attitudes during the crisis.

If countries have strong men (autocratic Prime Ministers and Presidents) rather than strong institutions, before the pandemic, do not expect the strongmen to suddenly be democratic in governing the country or to become more transparent and accountable.

As Africans in Africa watch what is happening with the deaths and untold suffering from COVID-19 pandemic in other countries like Brazil, India, etc, the prayer is that it never arrives on the continent with such ferocity. Both government and non-government stakeholders are working round the clock to inform, educate and fight misinformation (political, cultural, religious on social media, etc) to get the population to comply with the tried and tested science driven non pharmaceutical measures (Hand washing, Physical and social distancing, wearing face masks, avoiding overcrowding, etc). recent statements from the richer countries, gives hope that there may be no vaccine-apartheid, so that richer countries shall share their COVID-19 Vaccine oversupplies with the poorer nations. So that 'no country is left behind'!

It appears also that government has been woken up by COVID-19 virus and its disastrous consequences on Lives and Livelihoods, to want to finally listen to repeated calls by serious watchers of the weak health system to partner with the private sector to take over selected services /provision of certain items in the failing public hospital and turn them into performing facilities, delivery patient centred, cost-efficient and affordable services. It appears that the government, on preventive health, at all levels is seeking to ensure provision and availability of and access to basic necessities such as running water, electricity, basic hygiene and sanitation and other basic equipment and consumables. It appears lessons that were not learnt after the Ebola virus epidemic in 2014 are about to be learnt this this time from the COVID-19 pandemic by continuing the non-pharmaceutical prevention and control measures, such as 'wearing face mask', 'physical distancing', 'frequent hand washing', and continuing ongoing fumigation and disinfection of public places.

It is to be hoped that these positive effects from what is a disaster COVID-19 pandemic, will actually be implemented so that the health system not only conquers this pandemic but is ready for any other one in future.

11. Comments on WHO - Maintaining essential health services: operational guidance for the COVID-19 context interim guidance (June 2020).

Laura C N Wood (UK) I just saw your request for feedback regarding the WHO COVID-19 interim guidance.* I agree with your proposed thoughts. From my area of modern slavery & human trafficking, if you refer to the recent UN Special Rapporteur's COVID-19 report on the sale and exploitation of children[17], it is clear that the failure for many states to recognise gender-based violence services as essential services (and also challenges to access of reproductive health and contraception) during the pandemic has had major consequences. This is in the context of an estimated 13 million more child marriages by 2030 (related to COVID-19 influenced multi-dimensional poverty and other factors), spikes in sexual violence and unplanned teenage pregnancies, increase in survival sex and sale of virginity. These are potentially health and wellbeing issues with multi-generational impacts and it would be great to advocate for these particular essential support needs.

**Refer message number 349 from the EHS-COVID-19 discussion full compilation version of messages 251-401 available here.*

Neil Pakenham-Walsh (UK) I have just consulted the WHO guidance on Maintaining essential health services during COVID-19 and it says remarkably little about how to maintain essential surgical services. While other areas of health have dedicated sections, surgery is only mentioned in passing.

In particular, this question of "How" to prioritise is fundamental. It seems obvious to me that the question of prioritisation of health services is not a new issue: it is a key issue for all countries, all the time. So, the question is not just about prioritisation during COVID - it is about the ability to prioritise effectively in all crisis situations, at all times. The two pages in the WHO Guidance provide a few preliminary pointers, but I sense that more substantive guidance is needed for policymakers at national level, and for managers of health facilities.

Profile

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