



## HIFA Maintaining essential health services during COVID-19 (and beyond)

Full compilation of discussion: Messages 402-508

13 June 2021 to 13 December 2021,

## DOCUMENT A

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## 1. Long Edits

### **EHS-COVID (402) Quality (33) Overinvestigation and overtreatment of COVID-19 (2)**

As for prevention, private retailers increased the prices of masks, gloves and other essential equipment for prevention early on in the pandemic. Several herbal medicines were promoted as effective prophylaxis against COVID-19, and their prices went up. Private pharmacies also increased the prices of Vitamins, particularly Vitamin D, Vitamin C and Zinc. These substances are promoted as preventative medicines against COVID-19, and their prices escalated.

On the investigation/examination front (i.e. tests & diagnostics), the private sector in KRI also made significant profits over the last year. In a classic example of supply-induced demand, patients with even mild symptoms of COVID-19 were referred for CT scan tests of their lungs. Private hospitals didn't hesitate much to increase the prices of doing such tests. Meanwhile, and rather mysteriously, the few CT scan machines available in the public sector suddenly "stopped" working. To make matters worse for patients, some hospitals require patients to have CT scans before admitting them in their COVID-19 units. But the exploitation was not only limited to radiological testing, also other COVID-19- related investigations were affected. All of a sudden, tests such as CRP, D dimer and Ferritin (all nonspecific markers of inflammation) became the 'gold standard' for almost every patient with suspected COVID-19. And guess what, the prices of those non-specific tests also went up. Some private laboratories intentionally abused the similarity between CRP and PCR to sell the former as diagnostics for COVID-19.

Finally, treatment. The most extensive exploitation of the COVID-19 outbreaks arguably happened in this area (of medicines and presumed therapeutics). The prices of many medicines promoted as ‘treatment’ for COVID-19 went up substantially, in some cases even skyrocketing. These included medicines with no evidence for their effectiveness (such as Hydroxychloroquine, Azithromycin, Famotidine, Ivermectin) and ones where the evidence base is ambiguous or still in RCTs (like Tocilizumab, Favipiravir and Remdesivir). They all became part of an informal protocol that the majority of doctors treating COVID-19 prescribed. As for the prices, well, you know the pattern by now. For example, according to receipts from a private pharmacy, a single vial of Tocilizumab was sold for \$3000. Awamedeica, a local pharmaceutical company, sold one box (containing 40 tablets) of Favipiravir for \$200 to the Ministry of Health. And unsurprisingly, oxygen cylinders became another “commodity” with escalating prices for those who decided to treat their family members in their own homes.

### **EHS-COVID (403) COVID-19 and mental health services (9)**

Here is a list of some articles that have been published about COVID-19, Mental Health and Lebanon: <https://pubmed.ncbi.nlm.nih.gov/?term=COVID-19+mental+health+Lebanon&sort=...>

I have also accumulated some important resources about COVID-19 and mental health in my COVID-19 Resource Center: <https://aub.edu.lb/libguides.com/COVID-19/MentalHealth> which target both health care providers and consumers.

### **EHS-COVID (404) Impact of COVID-19 on mental health of health workers (6)**

COVID-19 has affected not only the mental health of health and mental health workers alike but how health care and mental health care is done.

During the first phase of the COVID-19 pandemic, the health system was under extreme strain. Hospitals were under alert. Health providers were under pressure, fear (death and contamination) and stress. For example, in the hospital I was working at, during continuous training sessions occurring every morning, I had to talk on the mental health implications of COVID-19, where I enabled the staff of the hospital to be sensitive about the distress COVID-19 was having on them and to protect and take care of their mental health. In fact, I had had feedback from colleagues on how COVID-19 was affecting them.

Recently, Mboua et al. (2020), assessed the extent of anxious and depressive symptoms among health workers responding to COVID-19, in the context of Cameroon. They found "a high rate of anxiety (41.8%) and depression (42.8%). That there is a higher susceptibility to depression in young people (30-39 years). Fear of contamination and fear of death are modulators of depression and anxiety. The prevalence rates of major depressive disorder and adjustment disorder in the sample were 8.2% and 3.3%, respectively." The implications for health system performance should be highlighted. However, some local NGOs (e.g UNIPSY et Bien-etre, CENTREPSYS...) had initiated free psychological follow-up of the health workers.

For example, UNIPSY funded by UNFPA provided psychological support to 487 health workers (146 physicians and 341 paramedics)

Nevertheless, there was no large-scale initiative of the ministry of public health for health workers. Mboua et al. (2020) discuss, “that the results underlines the urgency of setting up a specialized aid and/or support system, in the context of the current pandemic, such as that of similar health crises. Such a device does not exist in Cameroon, where the mental health response remains weak.”

I am still gathering feedback from mental health providers on the effect of the COVID-19 on their mental health.

The great lack of investment brought to mental health development in Cameroon albeit on the one hand an increasing yet timid political will, and on the other hand growing mental health needs, is quite a big paradox. Unfortunately this situation is a threat to the health system performance and the mental health and wellbeing of the population.

Leveraging mental health capacity from local NGOs on the one hand which still need to be empowered, as well as INGOs on the other hand, can greatly contribute to fill in the mental health treatment gap. The ongoing efforts to put into place universal health coverage will be rendered greatly effective.

#### **EHS-COVID (405) SRHIN Case Study: Access to essential health services for vulnerable communities**

Slum and Rural Health Initiative (SRHIN) is one of Africa's foremost youth-led organizations focused on making health information and services available for the vulnerable populations, residents of slums, rural communities, villages, internally displaced persons camps among others using a unique ART (Advocacy, Research and Technology) approach. SRHIN is officially registered in Nigeria, Ethiopia and The Gambia but operates in more than 8 African countries (Ghana, Uganda, Rwanda, etc). SRHIN Nigeria operates in 20 Nigerian states via its network of State coordinators and over 1,200 volunteers (health professionals, IT experts, etc). SRHIN conducts Monitoring and Evaluation for numerous local and international organizations and also trains young people about the research process via its Research Academy.

We have observed through our advocacy, research and technology projects that the coronavirus pandemic has had immense effects on the health status and access to health information and services for the vulnerable communities and the historically marginalized communities. I would utilize a case study to illustrate the problem and discuss our unique solution.

Case Study:

SRHIN operates in internally displaced persons camps in northern Nigeria. The access to health information for the residents is majorly through outreaches of non-governmental organizations and radio. During this present pandemic, due to restriction of movement to curtail the spread of the virus, they couldn't get the information via that means. So they were also caught in the mace of misinformation and fallacies. Additionally, they didn't get access to other vital health information on important topics such as family planning, mental health, etc as projects conducted in the camp were not resilient in pandemic settings.

The IDP camps don't have a good health post to attend to patients. The makeshift health centre had just a bed, little essential medications and was managed by volunteer health professionals. The health post only manages minor illness and refers the bulk of the patients in the camp to distant health facilities.

Our solution to improve access to health information was use of a community-led and digital innovation. As SRHIN had been working in that camp for over 3 years we called the leaders of the camps via mobile phone to discuss key points about coronavirus prevention and dispelled some of the fallacies and misinformation. Additionally, we developed infographics of prevention of coronavirus in more than 100 languages to satisfy the language needs of the varieties of the camp residents. The infographics were disseminated via online means (Whatsapp and Facebook) through some of the youths with access to mobile phone and internet. We also utilized outreaches led by our volunteers, camp leaders and some of the camp youths.

To improve access to health services we are utilizing a community - based, -led and -participatory models and task shifting approaches. We train community leaders and stakeholders on mental, sexual and physical health and supply them with some resources in order to manage some minor illnesses. This model is resilient in pandemic as we or volunteers/members from other organizations serving the community do not have to be there for the IDPs to have access to these basic health services. Additionally, with funding from Grand Challenges Canada and National Institute of Health Research we plan to construct a solar-powered structure using refurbished cargo with access to 24/7 electricity. We also plan to equip some of the community leaders we are training with mobile tablets pre-installed with our SIMBI health mobile app. Through all these means, community stakeholders will get access to health information and other resources that would ensure members of IDP have access to accurate health information and essential health services.

SRHIN is a youth-led organization that uses innovative means to get health information and services to vulnerable and marginalized communities. I believe other organizations and groups must have utilized innovations in reaching their target audience during this pandemic. This case study is to open the floor for discussion on access to health services for the vulnerable groups and populations during this pandemic.

To explore healthcare needs for the vulnerable and disadvantaged populations, better tailored and specific questions to different areas of healthcare must be asked.

1. What is the access of the vulnerable communities such as residents of slums, villages, rural communities, internally displaced persons camps and other historically marginalized communities to basic medications during this present coronavirus pandemic?
2. What is the access of vulnerable communities to basic surgical care?
3. What is the access of vulnerable communities to immunization services?
4. What is the access of vulnerable communities to maternal and child care?
5. What is the access of vulnerable communities to cancer care?
6. What is the access of vulnerable communities to rehabilitation care?
7. What is the access of vulnerable communities to other healthcare services?

To know more about SRHIN's work and/or partner with us for projects focused on health information and services for vulnerable communities you can reach me via email: [miracle.adesina@srhin.org](mailto:miracle.adesina@srhin.org)

#### **EHS-COVID (406) COVID-19 and mental health services (10) Impact of COVID-19 on mental health (4)**

I think COVID-19 in one way has shed the light on the ravaging impact of mental health problems particularly among developing countries which has long gone unnoticed. We found similar trend for high prevalence of mental health problems of depression, anxiety and stress among Bangladeshi residents during the COVID-19 pandemic

The aim of this study was to examine the prevalence of mental health symptoms (anxiety, depression, and stress) in Bangladesh and the factors associated with these symptoms during the COVID-19 pandemic. In our study published in Annals of global health <https://www.annalsofglobalhealth.org/articles/10.5334/aogh.3269/>

We found that about 64%, 87%, and 61% of the respondents in Bangladesh reported high levels of depression, anxiety, and stress, respectively and this varied between divisions (regions), more in women, those who self-quarantined, and those that experienced classical symptoms of COVID-19. We think there is a need for mental health support in this population to minimise the long term effects.

[\*Note from HIFA moderator (Neil PW): Levi refers to Sanchika Gupta, India: EHS-COVID (398) COVID-19 and mental health services (8)]

<https://www.hifa.org/dgroups-rss/ehs-covid-398-COVID-19-and-mental-health...>

### **EHS-COVID (407) COVID-19 and mental health services (11)**

The COVID-19 pandemic in Cameroon has had an ambivalent effect on Cameroon's mental health care services delivery and on its users. On the one hand mental health care services provided to individuals belonging to vulnerable groups (for example persons living with a physical or mental health disability) was and still is seriously affected and on the other hand, persons who had COVID-19, persons who were to be tested or who were tested COVID-19 positive, including their family members (in the process on contact tracing) received adequate and improved mental health care services. I was informed just recently that Health professionals had also received mental health care services during the COVID-19 from the Ministry of public health. But there is not enough evidence to support a national support coverage to health providers. However, it seems clear that because of funding issues, mental healthcare services initiatives provided by local NGOs or INGOs ran more and more effectively than public initiatives (Ministry of Public health). For instance, UNIPSY covered 5 regions out of the 10 regions of Cameroon in the provision of psychological support to health care providers.

I asked Flore Bouyap a clinical psychologist working at the Cardinal Paul Emile LEGER (CNRPH) National Rehabilitation Center for persons with disabilities how COVID-19 has affected the delivery of essential mental health services in her facility. The CNRPH is a public administrative body with legal and financial autonomy. She told me that the COVID-19 affected her practice, the mental health care services she was providing to users of the CNRPH, basically persons with disability and their families. In fact, the barrier measures put forward by the Cameroonian government restricting the number of persons in public services was a great hindrance to the mental health care services she provided. For instance, group therapies were halted in the CNRPH with hospitalized patients and care givers of these patients. Moreover, Flore had to reframe face to face consultations because of the need to respect physical distancing. The wearing of the mask by patients during clinical encounters was a hindrance to the clinical process's need to rely on nonverbal cues. Distancing had to be adjusted so as to meet-up her clinical needs. Flore now provides more remote psychological support to her patients. Group counselling sessions which were reduced initially have even stopped completely as the fear of going to the hospital and fear of the health professionals increased during the pandemic. Until today mental health service delivery in CNRPH is not what it used to be before the COVID-19.

The COVID-19 pandemic enabled in some regards to put on the base to build a better mental health system in Cameroon. During the pandemic the Ministry of Public Health made two collaborations. One with the Ministry of Secondary Education, with respect to drafting of a psychological manual for students in secondary schools. School counsellors were put into the forefront in the use of this tool. Moreover, with the support of the WHO a response plan targeting children and adolescents was drafted. Cameroon's innovative mental health care set-up during the COVID-19 enabled during that time to provide mental health care services to the affected population. A psychological unit was opened in the Ministry of

Public Health to coordinate this mental health care services. However, the services were seriously challenged as a result of lack of funding necessary to carry on training, sensitization and remote psychological support. Presently the hotline call center has only 10 workers for the whole of Cameroon. There are equally important unmet mental health needs, for instance the psychological support to the mental health teams which worked during the COVID-19. This team was made up of volunteer psychologist and they worked to support the health system. There is need therefore to strengthen the system's human work force by building at all levels more than ever before mental health capacity.

### **EHS-COVID (408) Overinvestigation and overtreatment of COVID-19 (2)**

[In response to <https://www.hifa.org/dgroups-rss/ehs-covid-401-quality-32-overinvestigat...> ]

This is simply the usual case, endemic in COVID-19, of politicians doing something (anything) to be seen to be doing something to cover their incompetence (election rallies and Kumbh Mela is actually criminal in the face of an increasingly infectious virus).

However we, as scientists, share a responsibility as those WITH knowledge do not speak out loudly (eg Fauci with Trump) and also speak about scientific areas we know little about (epidemiologists speaking about virology or immunology!!)

### **EHS-COVID (409) Lancet: India's resurgence of COVID-19 - urgent actions needed**

A comment on the resurgence of COVID-19 in India highlighting the need for urgent actions

Full text link- [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)01202-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01202-2/fulltext)

Recommendations highlighted by the authors:

- 1) Decentralisation of essential health services to provide autonomy and empowerment to district and state level systems for effective management of health services and pandemic response.
- 2) Transparency national pricing of essential health services and ensuring coverage of healthcare expenditure by insurance
- 3) Improve awareness and evidence based information among the general public regarding various aspects of COVID-19 : availability of health services, vaccinations and impact the pandemic on non-COVID-19 health services



- 4) Measures to empower healthcare systems by increasing human resource and availability of personal protective equipment, vaccinations, medications, tele-health services, emphasis of quality of life and mental health support to decrease the burden faced by the healthcare workers due to the resurgence of COVID-19
- 5) Effective optimization of available vaccinations based on priority groups and centralised distribution of vaccines to minimise cross-state inequities in prices of vaccines.
- 6) Active community engagement and public participation to combat the prevalent 'pandemic fatigue' through dissemination of accurate information and promoting safety measures like vaccinations, social distancing and masking among the general public.
- 7) Providing equitable and secure access of healthcare data to government and non-governmental organisations would ensure continuous monitoring and improvements in current protocols and health care policies and is instrumental in creating a robust and competent healthcare ecosystem.
- 8) Monetary compensation by the state to people who lost their jobs during the pandemic would help reduce the adverse socioeconomic implications (in terms of increased economic burden of affected individuals which would directly impact physical, psychosocial and emotional well being as well-being)

**EHS-COVID (410) Lancet: India's resurgence of COVID-19 - urgent actions needed (2)**

The recommendations are timely and much needed. I am wondering if the Government of India (Central Government) is aware of these recommendations and has shown willingness or made any commitment to implement them partially or completely.

Political will is an essential part of public health. Evidence based scientific policies that save precious lives need action from the government.

**EHS-COVID (411) Lancet: India's resurgence of COVID-19 - urgent actions needed (3)**

Some similarities to the recommendations of the Independent Panel commissioned by the WHO:

'The World Health Assembly requested the Director-General of WHO to initiate an impartial, independent, and comprehensive review of the international health response to COVID-19 and of experiences gained and lessons learned from that, and to make recommendations to improve

capacities for the future. The Director-General asked H.E. Ellen Johnson Sirleaf and the Rt Hon. Helen Clark to convene an independent panel for this purpose and to report to the World Health Assembly in May 2021

1. Elevate leadership to prepare for and respond to global health threats to the highest levels to ensure just, accountable and multisectoral action
2. Focus and strengthen the independence, authority and financing of the WHO
3. Invest in preparedness now to create fully functional capacities at the national, regional and global level
4. Establish a new international system for surveillance, validation and alert
5. Establish a pre-negotiated platform for tools and supplies
6. Raise new international financing for the global public goods of pandemic preparedness and response
7. Countries to establish highest level national coordination for pandemic preparedness and response

[\*Note from HIFA moderator (Neil PW): The full report of the Independent Panel (which is global in scope) is available here:

<https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make...>

### **EHS-COVID (412) Evidence based COVID and respiratory advice for global primary care (1) What do you think about your country's health leadership during COVID-19?**

International Primary Care Respiratory Group, a charity working locally, collaborating globally routinely asks its sentinel network questions in relation to COVID-19 and respiratory care.

\*NEW\* answers to primary care questions are now available, including:

- Should we give COVID-positive non-asthmatic patients ICS as preventer of respiratory distress syndrome? <https://www.ipcrg.org/resources/search-resources/should-we-give-covid-po...>

- Does Vitamin D levels and its supplementation affect the risk of mortality or ICU admission from COVID-19? <https://www.ipcrg.org/resources/search-resources/does-vitamin-d-levels-a...>

- Can we safely use nebulisers during the COVID-19 pandemic in the primary care setting, and if so how? <https://www.ipcrg.org/resources/search-resources/can-we-safely-use-nebul...>

- Are patients with COPD at a higher risk of infection with SARS-CoV-2 and are they also more likely to experience a more severe course of COVID-19 illness? <https://www.ipcrg.org/resources/search-resources/are-patients-with-copd-...>

- In addition, the answer on-“ What medicines are available to treat an acutely unwell person with COVID-19 in the primary care setting to reduce the risk of hospitalisation?” has been updated. <https://www.ipcrg.org/ICEQ21>

If you are working in a primary care setting and would like to join our Sentinel Network, please complete the short form on our 'answers' webpage. <https://www.ipcrg.org/resources/ipcrg-practice-driven-answers-on-covid-1...>

In your country, what do you think about your country's health leadership during COVID-19? As well as sending us your questions about COVID and respiratory primary care we want to know a practitioner's view of their country's health leadership during the pandemic.

Click here to complete the short form by Wednesday 23rd June. <https://www.surveymonkey.com/r/LZ9Q8C6>

Respondents typically take under 3 minutes to answer the question response form. If you would rather receive these notifications via WhatsApp please send your mobile number and we will add you to the 'Sentinel Network group'.

The IPCRG Sentinel Network was presented in an e-poster during the 10th IPCRG World Conference. <https://api.ltb.io/show/BGYPX>.

**EHS-COVID (413) Webinar: The role of primary health care in the COVID-19 pandemic response and leading to equitable recovery**

<https://www.who.int/news-room/events/detail/2021/06/22/default-calendar/...>

Would \*you\* like to participate in this event on behalf of HIFA and send a brief message to us with your reflections afterwards? Contact me: [neil@hifa.org](mailto:neil@hifa.org)

## The role of Primary Health Care in the COVID-19 pandemic response and leading equitable recovery

In emergency situations, like the COVID-19 pandemic, primary health care plays a substantial role in prevention, preparedness, response and recovery, and in ensuring the continued access to essential health services. It also has a role to play in strengthening equity and engaging communities as partners.

This streaming event will support the vital role of primary health care in managing the pandemic and will strive to transfer existing knowledge and experience to other countries, governments, and relevant stakeholders.

Last year, the whole world witnessed no country that was 100% ready to overcome the challenges of the global pandemic. The current epidemiological situation associated with the COVID-19 pandemic has highlighted the urgent need to ensure continuous access to essential health services without which, there is an increased indirect morbidity and mortality. In the emergency situations, like the COVID-19 pandemic, PHC plays a substantial role in prevention, preparedness, response and recovery – and in ensuring the continued access of the population to essential health services, thus preventing an increase in morbidity and mortality from causes not directly related to the coronavirus. PHC also has a role to play in improving the equity of efforts to manage health emergencies and maintain health service access, with effective involvement of communities as partners...

The event aims to:

- Call on political leaders worldwide to reaffirm the importance of primary health care in the fight against the COVID-19 pandemic and other health-related emergencies.
- Share best practices and success stories of strengthening primary health care to facilitate COVID-19 response (including COVID vaccine roll-out), promote equitable recovery and boost health system resilience.
- Discuss national health care systems' prevention and preparedness for future health emergencies and the international community's role.
- Discuss the Primary Health Care Operational Framework to strengthen health care systems and support countries to scale up national efforts to strengthen primary health care.

- Improve communication to facilitate preparations for the inclusion of primary health care in the UN General Assembly 2022 Agenda.

### **EHS-COVID (414) Lancet: Protecting refugees during the COVID-19 pandemic**

The editorial in The Lancet alludes to our discussion on 'Maintaining essential health services during COVID-19' in relation to vulnerable populations, and yet I feel we have only scratched the surface of the issues. Can you say more about this from your own experience, whether in relation to refugees, those living in poverty, or other vulnerable groups?

... The COVID-19 pandemic has weighed heavily on the 26.3 million refugees worldwide today. International guidelines and national programmes to curb transmission have not always considered the needs of refugees living in densely populated shelters without water and sanitation facilities. The economic harms of the pandemic disproportionately affect the poorest people, applications for asylum and resettlement were disrupted by lockdowns, and refugees have been blamed for spreading SARS-CoV-2...

Vaccination is the central pillar of global recovery from the COVID-19 pandemic, but most refugees face a double burden of vaccine inequity. First, 86% of refugees live in low-income and middle-income countries (LMICs)... Second, many LMICs that have received vaccines are not prioritising refugees. For example, in Bangladesh, where 2.5% of the population is fully vaccinated, not a single dose has been administered in Cox's Bazar... Refugees and asylum seekers more generally have suboptimal access to primary health-care services. Language barriers contribute to a deficit of accurate information, and social marginalisation has allowed misinformation to spread, fuelling vaccine hesitancy...

### **EHS-COVID (415) Digital technologies (4) Telemedicine supported strengthening of primary care in WHO South East Asia region**

CITATION: Gudi N, Konapur R, John O, et al. Telemedicine supported strengthening of primary care in WHO South East Asia region: lessons from the COVID-19 pandemic experiences. BMJ Innovations Published Online First: 20 May 2021. doi: 10.1136/bmjinnov-2021-000699 Full text: <https://innovations.bmj.com/content/bmjinnov/early/2021/05/19/bmjinnov-2...>

#### **ABSTRACT**

The COVID-19 pandemic has exposed the fragmentation of the healthcare delivery systems and highlighted the role of resilient primary healthcare systems for a robust public health response during health emergencies. Primary care while being the first point of contact between the citizens and the health systems has received scant attention or targeted investments over the past several decades. Through this narrative review, we aim to outline the potential role of telehealth in augmenting health systems capacity. While teleconsultations have increased

exponentially during the pandemic, evidence suggests that utilisation of primary care for non-emergency and non-COVID-19 conditions such as chronic medical conditions has significantly decreased, suggesting that most telemedicine utilisation has been to address an immediate crisis. In countries with pre-existing national digital health framework and enabling regulatory environments, telehealth interventions while strengthening the public health response to COVID-19 also supported the continuum of care at the primary care level. Even after COVID-19 is controlled, telemedicine has the potential to address persistent obstacles to primary care in the South East Asia region, including scarcity of trained healthcare workers, access challenges and costs associated with in-person care. Telemedicine holds promise in strengthening primary care and has the potential to catalyse achieving universal health coverage.

#### SUMMARY POINTS

- During the pandemic, several countries in the SEA region passed various legislations and issued telemedicine practice guidelines resulting in increased uptake and acceptance of telemedicine among patients and providers.

- There is a need [for] robust evidence around the role of telehealth in strengthening primary care.

- Potential opportunities...

1. Integrated service systems (primary, secondary and tertiary) and information systems;

2. Efficient referral systems;

3. Engaging all the stake holders;

4. Evidence-based change management strategies;

5. Capacity building and increased community engagement.

COMMENT (NPW): The five 'opportunities' described above are listed but how they might be implemented is not fully described. These are complex challenges.

#### **EHS-COVID (416) Impact of COVID-19 pandemic on paediatric services at a referral centre in Pakistan**

Selected extracts below from a viewpoint paper in Archives of Disease in Childhood (July 2021)

In a country where routine immunisation coverage was already poor prepandemic, a huge number of children have now missed and will further miss their vaccinations. The consequences unfortunately are already being seen, with multiple new measles and diphtheria cases being reported across the country. One of the serious challenges we are facing is with our National Polio Program, where approximately 25 000 polio workers have been diverted to help with the COVID-19 response... There is also a growing concern among paediatrics providers that this lack of access to preventative and specialised care to millions of children will ultimately lead to a huge surge in preventable morbidity and mortality...

Preparing a hospital facility for this COVID-19 pandemic remains challenging... We created negative pressure rooms in the emergency department, paediatric intensive care units (PICU) and neonatal intensive care units (NICU)... Extensive training of the staff on personal protective equipment (PPEs)... A comprehensive protocol for the safe delivery of newborns born to COVID-19 suspect or COVID-19 positive mothers was created, with a dedicated COVID-19 mother and baby unit...

#### **EHS-COVID (416) Digital technologies (5) Telemedicine supported strengthening of primary care in WHO South East Asia region (2)**

I agree that telemedicine has potential to transform the healthcare systems. The strategic pathways usually start from policy making to implementation, monitoring, feedback mechanism and evidence generation. This is a long process and usually takes decades to derive benefits from health investment.

For telemedicine, two-way communication is the key. Both the healthcare provider and user must be aware of how to use it. There are many mobile applications cropped up during the pandemic providing doctor patient consultation. But availability is for those who have a smartphone with internet connectivity means who already have access to technology and just take one more step to reach out to the healthcare system.

The gap between the existing healthcare system and those who don't have access to technology is the real challenge. It is availability of stable internet connection in a particular geography (mobile network companies and telecom department are stakeholders), availability of electricity (state electricity department is stakeholder) and the most important aspect is the population power (budget) to buy the smartphone and eagerness to use and learn new things. It's more than just a complex phenomenon.

#### **EHS-COVID (417) Meeting the health needs of vulnerable populations in India**

This paper looks at the health needs of vulnerable populations in India, and notes that the services they can afford 'are cheap in quality and might make them even more sick' (it is not clear whether this refers to low-quality allopathic or ayurvedic care, or both). As with other papers we have seen, this one is sanguine about the role of mobile health, even for poor populations 'even the poor have a mobile phone or access to one'. Has anyone on HIFA seen actual evidence that mobile health improves access to health services and/or improves health outcomes in vulnerable populations?

## ABSTRACT

**Purpose:** The COVID-19 pandemic is certain to have an unprecedented impact on the global population, but marginalized and vulnerable groups in low-income countries (LICs) are predicted to carry the largest burden. This study focuses on the implications of COVID-19-related measures on three population groups in India, including (1) migrant laborers (of which a majority come from Scheduled Castes (SCs) and Scheduled Tribes (STs), as well as Other Backward Classes (OBCs)), (2) children from low-income families and, (3) refugees and internally displaced persons (IDPs).

**Design/Methodology/Approach:** This study adopts a sequential mixed-method research design. A desk-based study of a selection of government reports was undertaken on the COVID-19-related mitigation measures. The desk study was followed by in-depth interviews with purposively recruited high-ranking experts in specific sectors of policy implementation and service delivery across the country.

**Findings:** The outcomes of this study shed light on (1) the most urgent needs that need to be addressed per population group, (2) the variety of state-level responses as well as best practices observed to deal with mitigation issues and (3) opportunities for quick relief as well as more long-term solutions.

**Practical implications:** The COVID-19 pandemic has not only reduced people's means of maintaining a livelihood but has simultaneously revealed some of India's long-standing problems with infrastructure and resource distribution in a range of sectors, including nutrition and health, education, etc. There is an urgent need to construct effective pathways to trace and respond to those people who are desolate, and to learn from – and support – good practices at the grassroot level.

## SELECTED EXTRACTS

"What is difficult, furthermore, is that migrants, because of the language barriers, and because their employers are sometimes actively hiding them, do not have access to information and services. We cannot reach them easily. They go to services that are somehow affordable to them, which are cheap in quality and might make them even more sick." (Program manager of a Child Welfare organization in Rajasthan)

'Opportunities might be found in the experience of Mobile Health and other services provided through mobile applications and networks as most people, even the poor, have a mobile phone or access to one... Digital infrastructure, supported by physical care, might empower communities by providing them the right information, guidance and protection, and thus reduce the burden on the health system.'

## **EHS-COVID (418) Digital technologies (6)**



Under NHS emergency measures The NHS in England increased sharing of data from April 2020 and has continued the increased sharing under ministerial directives.

<https://www.publictechnology.net/articles/news/hancock-issues-six-month-...>

This data collection has improved response and planning for COVID-19 management but also for other health management systems and the increased sharing of family doctors' data will be increased from September 1st 2021.

60,860,759 Patients Registered at GP practices in England as of 1 June 2021

<https://digital.nhs.uk/data-and-information/publications/statistical/pat...>

Due to the lack of authoritative contemporary sources, estimates of the population of England for dates prior to the first census in 1801 vary considerably. The population of England in 2019 is \*56,286,961\*. The population at the time of the 2011 census was 53,012,456 <https://www.bing.com/search?form=MOZLBR&pc=MOZD&q=population+of+england>

### **EHS-COVID (419) Maternal and child health services in Africa**

What has been the impact of COVID-19 on the delivery of essential maternal and child health services in Africa? This paper notes that outpatient consultations and child vaccinations were the most commonly affected services and fell by the largest margins.

#### **ABSTRACT**

The coronavirus-19 pandemic and its secondary effects threaten the continuity of essential health services delivery, which may lead to worsened population health and a protracted public health crisis. We quantify such disruptions, focusing on maternal and child health, in eight sub-Saharan countries. Service volumes are extracted from administrative systems for 63 954 facilities in eight countries: Cameroon, Democratic Republic of Congo, Liberia, Malawi, Mali, Nigeria, Sierra Leone and Somalia. Using an interrupted time series design and an ordinary least squares regression model with facility-level fixed effects, we analyze data from January 2018 to February 2020 to predict what service utilization levels would have been in March–July 2020 in the absence of the pandemic, accounting for both secular trends and seasonality. Estimates of disruption are derived by comparing the predicted and observed service utilization levels during the pandemic period. All countries experienced service disruptions for at least 1 month, but the magnitude and duration of the disruptions vary. Outpatient consultations and child vaccinations were the most commonly affected services and fell by the largest margins. We estimate a cumulative shortfall of 5,149,491 outpatient

consultations and 328 961 third-dose pentavalent vaccinations during the 5 months in these eight countries. Decreases in maternal health service utilization are less generalized, although significant declines in institutional deliveries, antenatal care and postnatal care were detected in some countries. There is a need to better understand the factors determining the magnitude and duration of such disruptions in order to design interventions that would respond to the shortfall in care. Service delivery modifications need to be both highly contextualized and integrated as a core component of future epidemic response and planning.

#### KEY MESSAGES

The COVID-19 pandemic and its secondary effects caused significant disruptions in the delivery of essential health services across sub-Saharan Africa and may produce substantial increases in morbidity and mortality.

The largest disruptions were observed in outpatient care and vaccinations, but disruptions were also identified in reproductive and maternal health services with significant cross-country variation in the timing and magnitude.

The ability of health systems to maintain continuity of essential services must be protected as the global community responds to the pandemic and the ensuing economic crises.

Dedicated catch-up campaigns may minimize the adverse consequences of missed care, especially for children.

COMMENT (NPW): These data are now already 1 year old. Can HIFA members comment on the situation more recently? To date, Africa has seen relatively few cases of COVID as compared with Europe and the Americas, but there are continuing concerns about the disproportionate impact that future waves of infection might bring.

#### **EHS-COVID (420) Overview of second thematic discussion (10 May - 25 June)**

This thematic discussion has raised some important points, including related to how any future guidance can be adapted to the changing context of the pandemic. In addition, this discussion has emphasised the broad ranging impact of the pandemic, including the disruption to maternal, child and reproductive services. This chimes with our own reporting from the EHS pulse survey (the results of which are now integrated into the HLH platform).

If you wish to review the previous HIFA action brief or further information as outlined above, please visit us at <https://hlh.who.int/>

[\*Note from HIFA moderator (Neil PW): Here is a direct link to the HIFA action brief: <https://hlh.who.int/ab-detail/findings-from-a-hifa-thematic-discussion> This first action brief consolidates the collective intelligence of HIFA members from our first thematic discussion in November/December 2020.

### **EHS-COVID (421) 'Transformative' platform for COVID-19 research**

'This application has the potential to transform how COVID-19 researchers utilize public literature to enable their research.'

However, when I tried to identify research on Maintaining essential health services during COVID-19, I obtained zero results.

Full text link: <http://pubmed.ncbi.nlm.nih.gov/34138726>

#### **ABSTRACT:**

**BACKGROUND:** The rate of publication of COVID-19 literature is astonishing and the research is extremely varied. Innovative tools are needed to aid researchers to find patterns in this vast amount of literature to identify subsets of interest in an automated fashion.

**OBJECTIVE:** We present a new online software resource with a friendly user interface that allow users to query and interact with visual representations of relationships between publications.

**METHODS:** We publicly released an application called PLATIPUS (Publication Literature Analysis and Text Interaction Platform for User Studies) that allows researchers to interact with literature supplied by COVIDScholar via a visual analytics platform. This tool contains standard filtering capabilities based on authors, journals, high-level categories, and various research-specific details via natural language processing and dozens of customizable visualizations that dynamically update from a researcher's query.

**RESULTS:** PLATIPUS is available at <https://vcs.pnnl.gov/> and currently links to over hundreds of thousands of publications and still growing. This application has the potential to transform how COVID-19 researchers utilize public literature to enable their research.

**CONCLUSIONS:** The PLATIPUS application provides the end-user with a variety of ways to search, filter and visualize over one hundred thousand COVID-19 publications.

COMMENT (NPW): We have HIFA volunteers helping to identify papers relevant to Maintaining essential health services during COVID-19. And yet there is no easy way to identify such research. The 'transformative' application described above does not appear to help.

**EHS-COVID (422) Child health (14) Fwd [CHIFA] How has COVID-19 affected the delivery of essential child health services in your health facility or country?**

I just wanted to share my personal perceptions and observations related to the impact of COVID-19 on child health services in Cameroon. I should say that COVID-19 seems to have affected access to healthcare in general and not only for child health services.

In the first place, the major problem faced in Cameroon is misinformation making a lot of people to lost trust in the modern medicine and turn more to traditional remedies. When the pandemic started in Child by the end of 2019, this first impression in our population was that China was too far and we should not expect to be affected. However, when we registered our first cases early in 2020, a lot of people took to the social media saying that there is nothing like COVID-19 in Cameroon and that the government is using it as a pretext to receive funds from the international community for COVID-19 response. Gradually as the pandemic expanded, I guess, maybe because it touched a lot of people directly or indirectly through their family members, many other versions of the misinformation came out but what I take not is that some people accepted that there is COVID-19 but still saying that the health facilities are "killing" the cases. Talking with several people in my neighbourhood, I realized several of them had symptoms that they suspected COVID-19 but decided to contact a provider to come and manage them at home rather saying that they do not want to go to the hospital and die. However, I think this is associated with stigma because they simply refuse going to the treatment centers but still requested a doctor or nurse to treatment at home. With the introduction of vaccines, a lot of people are reluctant towards taking the vaccines because they think it is not safe. I think is vaccine hesitancy issue is not only about vaccine but about health promotion activities in general because we see the same thing with the wearing of facemask (including even locally made masks).

As people are running away from the hospital, it is of course normal that they do not want to take their children for immunization sessions and other activities in the hospital. However, this generally affected minor situations because I have seen families that are "preaching" that hospitals are dangerous, take their own children to the health facilities though only when it was already critical. As you know, in a critical situation means the patient can die. I was in one of the hospital when my wife was just delivered of a baby and saw a woman whose child died and she was busy shouting "Hospital X has finally killed my child". This is weird but true, she arrived at the hospital already crying because the child was already in a very bad situation and the child died close to 30 minutes later.

There are a lot of situations like this but I cannot say it all.

Comment (NPW): Martin raises several issues here. Lack of trust in allopathic medicine leading to increased use of traditional medicine; denial of COVID-19; belief in health facilities 'killing' patients; stigma against COVID-19 patients; vaccine hesitancy; mistrust of mask wearing; failure to have routine child immunisations; avoidance of care-seeking for child illness; arrival of critically ill children because of delays in seeking care. All are related to lack of availability and use of reliable healthcare information and false belief in misinformation.

### **EHS-COVID (423) Update on HIFA-WHO Maintaining essential health services project**

Our thanks to all HIFA members who have contributed to our discussion on Maintaining essential health services during COVID-19 (and beyond). Our latest 5 week exploration ends officially today and I am delighted that we have shared more than 400 messages. Our volunteer team led by Gladson Vaghela and Sanchika Gupta is currently compiling and editing the latest 200 messages with a view to produce a second action brief for the WHO website. Our first action brief, with highlights from the first 200 messages, is available here: <https://hlh.who.int/ab-detail/findings-from-a-hifa-thematic-discussion>. This HIFA-WHO project continues through to September, when we aim to have a third thematic discussion. In the meantime, please continue to share your observations on essential health services at any time, by email to: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

### **EHS-COVID (424) Child health (15) Inappropriate use of accident and emergency departments**

It's interesting to see the contrasts between countries. Martin Yakum, HIFA country representative for Cameroon, reported earlier today on lack of trust in allopathic medicine leading to increased use of traditional medicine; denial of COVID-19; belief in health facilities 'killing' patients; stigma against COVID-19 patients; vaccine hesitancy; mistrust of mask wearing; failure to have routine child immunisations; avoidance of care-seeking for child illness; arrival of critically ill children because of delays in seeking care. (All related to lack of availability and use of reliable healthcare information and false belief in misinformation.)

Meanwhile the BBC reports that Accident and Emergency departments in the UK are 'seeing record numbers of young children - but most have a mild fever that could be treated at home'. Extracts from BBC news item below. Full text: <https://www.bbc.co.uk/news/health-57583733>

A&Es 'overwhelmed' by children with mild winter viruses, doctors warn Emergency departments across the UK are seeing record numbers of young children - but most have a mild fever that could be treated at home, the Royal College of Paediatrics and Child Health says.

Winter viruses are flourishing as more people mix, and a doctor's chief says many A&Es are being "overwhelmed"...

It found children coming to A&E are mostly under the age of five - but they do not have coronavirus.

In most cases, their fevers, coughs and runny noses are caused by other respiratory infections such as RSV, bronchiolitis, the common cold and parafllu.

After disappearing last winter during lockdown when no-one was mixing in large numbers, these viruses have reappeared in the summer - but at winter levels, putting huge pressure on emergency departments in hospitals...

Dr Damian Roland, a paediatrician who works in Leicester, said he had recently seen nearly 300 patients in one day in his emergency department...

Comment: The reason for inappropriate use is unclear. One element may be heightened health anxiety among parents as a result of the pandemic? Another factor may be that parents do not feel confident or adequately informed about what to do.

Inappropriate use of hospital services for mild illness is clearly a huge problem. Indeed, large numbers of both children and adults inappropriately use emergency services every day in the UK, including dialling the emergency number 999 for trivial situations. To what extent are accident and emergency hospitals used inappropriately in other countries? And have there been any changes in use as a result of COVID-19? We look forward to hearing from you.

### **EHS-COVID (425) Lancet: The WHO global strategy for oral health: an opportunity for bold action**

'Oral health is a neglected issue on the global health agenda', says this new paper in The Lancet, and it could be said that oral health is underrepresented on HIFA too.

The latest WHO Resolution notes: 'Concerned also that oral health services are among the most affected essential health services because of the COVID-19 pandemic, with 77% of the countries reporting partial or complete disruption'

Oral health is a neglected issue on the global health agenda, so it was an important advance when a resolution on oral health was adopted at WHO's 2021 World Health Assembly. [Oral health. Executive Board Resolution WHA74/A74.R5.

The resolution calls for the development of a global oral health strategy by 2022 and action plan by 2023, including a monitoring framework aligned with non-communicable disease (NCD) and universal health coverage (UHC) agendas...

The core global health challenge is the large and unequal burden of preventable oral diseases. Case numbers of untreated oral diseases have more than doubled between 1990 and 2017 in low-income countries and increased by more than 50% globally. Achieving sustained and affordable access to essential oral health-care services and prevention for almost 3.5 billion people affected by untreated oral diseases requires impactful policy solutions and radical system reform...

Striving for greater equity across all dimensions of oral health, including reducing disease burden and risk exposure, expanding access to care and prevention, and improving empowerment and participation, must be foundational for the new oral health policy framework...

The introduction of global targets to measure progress towards 2023 and regular reporting mechanisms, similar to those for NCDs, will build and sustain the momentum for country action. The unmatched burden of oral diseases and the negative impacts of high sugar consumption on many NCDs should, ultimately, lead to recognition of oral diseases as the sixth NCD and of sugar as the sixth major common risk factor...

Comment (NPW): We would welcome more specialists in dentistry and oral health on HIFA. If you are, or know, an oral health professional, please reach out and invite colleagues to join: [www.hifa.org/joinhifa](http://www.hifa.org/joinhifa) Also, what do we know about the links between access to reliable information on oral health, and oral disease? Do the general public and health workers have sufficient access to the information they need to prevent and manage oral health problems? Clearly, many people will be aware that sugar causes caries (and may choose to ignore it), although many may not.

#### **EHS-COVID (426) Child health (16) Lack of trust in government**

I fully agree with what Martin has reported for Cameroon I have experienced the same in my county. Some accused some hospitals in late 2020 of injecting people with covid virus to inflate the figures in exchange for financial benefit from the government.

The ongoing crisis in some regions of Cameroon, for example, North West, South West, Far North and the East regions has also affected the covid response because many people no longer have trust in the government

#### **EHS-COVID (427) Quality (99) Enablers and barriers to implementing primary health care in the COVID-19 context**

This new paper in Health Policy and Planning looks at enablers and barriers to implementing primary health care in the COVID-19 context. The authors describe PHC as 'people centred comprehensive primary health care that incorporates public health and equity principles'. This mirrors how we have defined 'quality' in the current discussion. I am reminded of Dr Tedros's 2018 paper: How could health care be anything other than high quality? I invite reflections on the links between 'Learning for quality health systems' and 'Maintaining essential health services during COVID-19'.

Full text link- [https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(18\)30394-2/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(18)30394-2/fulltext)

#### ABSTRACT

Since the Alma Ata Declaration of 1978, countries have varied in their progress towards establishing and sustaining comprehensive primary health care (PHC) and realizing its associated vision of 'Health for All'. International health emergencies such as the coronavirus-19 (COVID-19) pandemic underscore the importance of PHC in underpinning health equity, including via access to routine essential services and emergency responsiveness. This review synthesizes the current state of knowledge about PHC impacts, implementation enablers and barriers, and knowledge gaps across the three main PHC components as conceptualized in the 2018 Astana Framework. A scoping review design was adopted to summarize evidence from a diverse body of literature with a modification to accommodate four discrete phases of searching, screening and eligibility assessment: a database search in PubMed for PHC-related literature reviews and multi-country analyses (Phase 1); a website search for key global PHC synthesis reports (Phase 2); targeted searches for peer-reviewed literature relating to specific components of PHC (Phase 3) and searches for emerging insights relating to PHC in the COVID-19 context (Phase 4). Evidence from 96 included papers were analysed across deductive themes corresponding to the three main components of PHC. Findings affirm that investments in PHC improve equity and access, healthcare performance, accountability of health systems and health outcomes. Key enablers of PHC implementation include equity-informed financing models, health system and governance frameworks that differentiate multi-sectoral PHC from more discrete service-focussed primary care, and governance mechanisms that strengthen linkages between policymakers, civil society, non-governmental organizations, community-based organizations and private sector entities. Although knowledge about, and experience in, PHC implementation continues to grow, critical knowledge gaps are evident, particularly relating to country-level, context-specific governance, financing, workforce, accountability, and service coordination mechanisms. An agenda to guide future country-specific PHC research is outlined.

#### **EHS-COVID (428) Maternal mental health is being affected by poverty and COVID-19**

The COVID-19 pandemic, and especially its socioeconomic aspects, amplifies existing inequalities and leads to increased mental health problems among women in Colombia.

Full text link:[https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(21\)00245-X/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00245-X/fulltext)



## SELECTED EXTRACTS

Scientific efforts during the COVID-19 pandemic, in respect to pregnancy, have shown that COVID-19 infection is associated with a substantial increase in severe maternal morbidity and mortality, preterm birth, and low birthweight... Yet, less attention has been paid to the maternal health of uninfected women. Challenges that pregnant women face during the COVID-19 pandemic include fear of viral exposure, concerns about their health and of their unborn children, social isolation, childcare, and the increase of job, food, housing, and health-care insecurity...

Andrés Moya and colleagues analyse the effect of the COVID-19 pandemic and associated policy responses on maternal mental health in a highly vulnerable and violence-exposed population in the context of a fragile and conflict-stricken setting in Tumaco, Colombia...

In this worrying scene, the COVID-19 pandemic arrived and amplified existing inequalities. Moya and colleagues report that caregiver mental health significantly worsened during the COVID-19 pandemic, revealing a significant increase in anxiety, depression, and parenting stress... These results show that the effect was greater among people who had a history of forced displacement, low levels of education, pre-existing mental health conditions, and other COVID-19-related stressors, and that these stressors increased mental health detriment in a dose-dependent manner...

We believe that, from a health-care policy perspective, legislators and those planning health-care access are responsible for considering the effect of COVID-19 on vulnerable communities, and should ensure mental health services and social support targeting gender-based violence. Regular income support for vulnerable families need to be assured...

### **EHS-COVID (429) HLH: call for Knowledge Hub materials**

As part of the Health Services Learning Hub, we would like to launch a call for Knowledge Hub materials. Please, kindly share with us resources that are related to maintaining essential health services during COVID-19 and throughout the recovery phase - it can be a PDF, report, article, blog, podcast, webinar, etc. You can submit them to: [hlh@who.int](mailto:hlh@who.int)

### **EHS-COVID (430) WHO press release: COVID-19 pandemic leads to major backsliding on childhood vaccination**

We have noted that immunisation services have been disproportionately affected by COVID-19. This press release gives an indication of the seriousness of the situation.

From the WHO website- <https://www.who.int/news/item/15-07-2021-COVID-19-pandemic-leads-to-majo...>

23 million children missed out on basic vaccines through routine immunization services in 2020 3.7 million more than in 2019 - according to official data published today by WHO and UNICEF. This latest set of comprehensive worldwide childhood immunization figures, the first official figures to reflect global service disruptions due to COVID-19, show a majority of countries last year experienced drops in childhood vaccination rates.

Concerningly, most of these up to 17 million children likely did not receive a single vaccine during the year, widening already immense inequities in vaccine access. Most of these children live in communities affected by conflict, in under-served remote places, or in informal or slum settings where they face multiple deprivations including limited access to basic health and key social services.

“Even as countries clamour to get their hands on COVID-19 vaccines, we have gone backwards on other vaccinations, leaving children at risk from devastating but preventable diseases like measles, polio or meningitis” said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. Multiple disease outbreaks would be catastrophic for communities and health systems already battling COVID-19, making it more urgent than ever to invest in childhood vaccination and ensure every child is reached....

Henrietta Fore, UNICEF Executive Director: “Even before the pandemic, there were worrying signs that we were beginning to lose ground in the fight to immunize children against preventable child illness, including with the widespread measles outbreaks two years ago. The pandemic has made a bad situation worse....”

### **EHS-COVID (431) Reproductive health (23) Guardian: Nepal sees huge rise in maternal deaths as COVID keeps women at home**

Extracts below from The Guardian (UK) news website. Read online: <https://www.theguardian.com/global-development/2021/jul/15/nepal-sees-hu...>

Nepal sees huge rise in maternal deaths as COVID keeps women at home

Health workers fear deaths could reach levels not seen this century as up to 90% miss check-ups and many opt for home births.

Nepal’s maternal health services were fragile before the pandemic. The country has no midwives [\*see note below] so women give birth with the help of auxiliary nurses like Urmila, or skilled birth attendants.

But since the start of the pandemic, maternal deaths have soared. According to the department of health, 258 women died as a result of pregnancy or childbirth between March 2020 and June 2021. Thirty-three women had COVID-19. In the year before March 2020, the country recorded 51 maternal deaths.

Neonatal deaths have also increased, from 13 deaths per 1,000 live births before lockdown to 40 deaths per 1,000 live births during the first lockdown...

Paropakar maternity and women's hospital, the oldest and best maternity hospital in the capital, Kathmandu, recorded a more than 50% decline in antenatal checkups since the pandemic...

Nirmala Mijar, from Bajura district in the west of the country, says she has not had a proper antenatal checkup for five months. The 20-year-old fears visiting a health centre for her first pregnancy. "I am so scared to go to the nearest health post after hearing they have had cases of coronavirus," she said. "I am giving birth next month and I am still confused whether I try home delivery or go to the health post."

#### **EHS-COVID (432) Reproductive health (24) Guardian: Nepal sees huge rise in maternal deaths as COVID keeps women at home (2)**

Revised link for the above article: <https://www.theguardian.com/global-development/2021/jul/15/nepal-sees-hu...>

#### **EHS-COVID (433) Reproductive health (25) PAHO: COVID-19 is inflicting "devastating" impacts on women**

An important news release from PAHO; Read online: <https://www.paho.org/en/news/26-5-2021-COVID-19-inflicting-devastating-i...>

PAHO Director calls for counteracting potential rollback of gains in women's access to family planning and in reducing maternal mortality.

Washington, D.C., May 26, 2021 (PAHO) –Pan American Health Organization (PAHO) Director Carissa F. Etienne warned that continued disruption of women's health services due to COVID-19 could "obliterate" more than 20 years of progress in reducing maternal mortality and increasing access to family planning in Latin America and the Caribbean.

"I want to spotlight the devastating health, social and economic impacts that this virus has had on women," Dr. Etienne said during her weekly media briefing.

Women have been particularly impacted by interruptions of reproductive and maternal health services, she said. “According to UN estimates, up to 20 million women in the Americas will have their birth control disrupted during the pandemic, either because services are unavailable or because women will no longer have the means to pay for contraception.”

Pregnancy and newborn care also have been interrupted in nearly half of countries in the Americas, she said. At the same time, pregnant women are more vulnerable to respiratory infections such as COVID-19. If they get sick, they tend to develop more serious symptoms that require intubation, which can put both the mother and baby at risk.

“If this continues, the pandemic is expected to obliterate more than 20 years of progress in expanding women’s access to family planning and tackling maternal deaths in the region,” Dr. Etienne said. “Nearly all maternal deaths are preventable and even getting back to pre-pandemic levels of maternal mortality, which were already high, could take more than a decade.”...

#### **EHS-COVID (434) Do No Harm – Maternal, Newborn and Infant Care during COVID-19**

IPA – UNICEF Scientific Brief, June 2021

**What it involves:** This brief summarizes current evidence and guidance for maintaining safe and effective care across the spectrum of maternal, newborn and infant care while protecting mother and child and health care providers during COVID-19. The brief reviews implications of the principle of “do no harm” for maternal, newborn and infant care delivery during COVID-19, with the aim that this information is conveniently and readily available to clinical and health system policy leaders and stakeholders in countries and communities. Additionally, considerations for safe oxygen delivery as well as key Infection Prevention and Control (IPC) measures at home and in health care facilities for pregnant women, newborns and children are described in detail.

**Why this matters:** Between 1-10% of COVID-19 cases are in children (in unvaccinated populations), and most children have had mild symptoms, a good prognosis and very low mortality rates. Similarly, most pregnant women experience relatively mild symptoms or remain asymptomatic, but recent data show an increased risk of maternal morbidity and mortality especially among symptomatic pregnant women with COVID-19, as well as an increased likelihood to deliver preterm and admission of their babies to the neonatal unit. These outcomes may be even higher among pregnant women in low- and middle-income countries. This emerging evidence underscores the importance of ensuring quality care during the antenatal and postpartum periods.

Read the full brief online: <https://www.healthynewbornnetwork.org/resource/do-no-harm-maternal-newbo...>

Neil Pakenham-Walsh, HIFA Coordinator, [neil@hifa.org](mailto:neil@hifa.org) [www.hifa.org](http://www.hifa.org)

### **EHS-COVID (435) Webinar: The Struggles of Community Health Workers at the COVID Frontline: Essential but Unrecognised**

Would anyone like to represent HIFA at this event and share your observations with us afterwards? If you can help, contact [neil@hifa.org](mailto:neil@hifa.org)

The Struggles of Community Health Workers at the COVID Frontline: Essential but Unrecognised

PHM Health Systems Thematic Circle cordially invites you to attend the webinar on "The struggles of Community Health Workers at the COVID frontline: Essential but Unrecognised".

Zoom Link- <https://zoom.us/j/92009725688?pwd=Q2J5azJydjAwTUZuUlhPRDAyaUhyd09>

Invite link on PHM website- <https://phmovement.org/webinar-20th-july-2021-tuesday-11-am-utc-the-stru...>

### **EHS-COVID (436) Social innovation in health: a critical but overlooked component of the COVID-19 pandemic response**

A discussion paper from HIFA member Luis Gabriel Cuervo and colleagues in BMJ Innovations

<https://innovations.bmj.com/content/7/3/523>

Here are some extracts:

Social innovations in health are inclusive solutions that meet the needs of end-users through a multistakeholder, community-engaged process to address the healthcare delivery gap. Social innovation is particularly well suited for the COVID-19 response because it focuses on local needs, develops low-cost solutions, and builds on community strengths. In partnership with partner academic institutions, the Special Programme for Research and Training in Tropical Diseases launched the Social Innovation in Health Initiative (SIHI) in 2014... This piece highlights how social innovation has contributed to the COVID-19 response and presents three examples of social innovation projects that have adapted to the pandemic. These examples demonstrate how social innovation during COVID-19 has mobilised local communities, swiftly adapted existing health services and built strong partnerships.

### Community mobilisation in Peru

Local people are selected through community assemblies and receive training to become community health workers. The instructional focus is on traditional birth attendant support, strengthening healthcare facilities and comprehensive supervision...

### Adapting existing services in Malawi

Chipatala Cha Pa Foni, or Health Centre by Phone, is a toll-free health hotline in Malawi that provides health information and referrals on demand. The innovation was driven by the realisation that people in Malawi, especially those at the last mile, travel long distances to the nearest health facility to receive access to information...

### Multisectoral partnership in the Philippines

Training local leaders and promoting meaningful community participation in solving their own health problems helped the local government prepare and respond to COVID-19 challenges.

### **EHS-COVID (437) COVID-19 and palliative care services in Africa**

In a previous HIFA message Vedant Jha asked 'What has been the impact of COVID-19 on the quality of care of Cancer patients? (both palliative/hospice and hospital-based)'. This paper in the WHO Bulletin (August) looks at the situation in Africa. Even before the pandemic, 'only 5–11% of people [in Africa] requiring palliative care had access'.

Extracts and full-text link below.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8319866/>

'In our recent review of African COVID-19 case management guidelines, we found few palliative care approaches and a focus on clinical management to the neglect of important psychosocial and spiritual stressors affecting morbidity and outcomes... Community outreach efforts to improve access to palliative care have been suspended. Furthermore, COVID-19 restrictions that hinder appropriate care delivery to the dying

add to the distress of patients and their families, while social distancing and the ban on group gatherings disrupt the normal experience of grief and communal bereavement practices...

'African institutions must rapidly expand palliative care training to health-care professionals outside palliative care services and support the training with clear, comprehensive case management guidelines focused on palliative care.'

### **EHS-COVID (438) WHO Africa: COVID-19 widens routine immunization gaps in Africa**

Extracts from a news release from WHO Africa Regional Office. Read online: <https://www.afro.who.int/news/COVID-19-widens-routine-immunization-gaps-...>

Brazzaville – Around 7.7 million African children missed out on vital first doses of Diphtheria-Tetanus-Pertussis, Measles and Polio vaccines in 2020. The nearly 10% rise in missed vaccinations on the previous year in Africa was driven by disruptions to health services by the COVID-19 pandemic, new data by the United Nations Children’s Fund (UNICEF) and World Health Organization (WHO) show.

Three African countries are among the top 10 countries globally to record the greatest number of unvaccinated children in 2020 for the first dose of Diphtheria-Tetanus-Pertussis (DTP -1) and Measles: Ethiopia, Nigeria and the Democratic Republic of Congo. Overall, Africa still accounts for the highest percentage of ‘zero dose’ children (those who have not received DTP -1) in the world.

Despite impressive efforts to scale up supplemental immunization campaigns while grappling with the myriad demands of the pandemic, the 7.7 million children in Africa that missed DTP-1 vaccines make up 45% of the global figure...

Dr Tedros Adhanom Ghebreyesus, WHO Director-General, expressed concern that while countries were focusing on COVID-19 vaccines, children were being put at risk.

“We have gone backwards on other vaccinations, leaving children at risk from devastating but preventable diseases like measles, polio or meningitis,” he said, warning that multiple disease outbreaks could be catastrophic for communities and health systems already under pressure from COVID-19...

### **EHS-COVID (439) COVID-19 and palliative care services in Africa (2)**

As a member of the Advance Care Planning (and Palliative Care) Alberta Advisory Committee, I would refer Vedant Jha for his general inquiry on the subject also to the following articles:

1) Palliative Care for Patients With Cancer in the COVID-19 Era. [see note below [1]]

2) Oncology and COVID-19 [2]

3) Impact of the COVID-19 Pandemic on Cancer Care: A Global Collaborative Study: The International Research Network on COVID-19 Impact on Cancer Care [3]

4) Patient Care During the COVID-19 Pandemic: Use of Virtual Care [4]

[\*Note from HIFA moderator (Neil PW): Here are the URLs for the papers that Esha refers to:

[1] <https://jamanetwork.com/journals/jamaoncology/fullarticle/2765828>

[2] <https://jamanetwork.com/journals/jama/fullarticle/2770865>

[3] <https://pubmed.ncbi.nlm.nih.gov/32986516/>

[4] <https://pubmed.ncbi.nlm.nih.gov/33326410/>

### **EHS-COVID (439) Stronger together: a new pandemic agenda for South Asia**

The global increase in COVID-19 cases in 2021 has primarily been due to an uncontrolled surge in South Asia. It is estimated that by 1 September 2021, approximately 1.4 million in South Asians will die due to COVID-19 alone. The total number of excess deaths will be much higher - including non-COVID causes, as health systems are on the brink of collapse. With 33.4% of South Asians being extremely poor and the large-scale loss of livelihood being reported, the region faces a potentially catastrophic future for the ongoing decade. However, countries in South Asia continue to remain divisive. This differs from other geographic 'blocs' that frequently cooperate on mutual interest issues. Tensions in South Asia are shaped by complex domestic, bilateral, intra-regional and international geopolitical factors, despite the region's obvious geographic, economic and cultural interdependence. A key lesson from the current pandemic is that countries need to share lessons and actively coordinate, complement and supplement each other's public health responses, especially between neighbours.



Read the Editorial published in BMJ Global Health presents a pragmatic ‘Stronger Together’ agenda on critical areas of concern for political, social, medical and public health leaders in South Asia to consider and build on here <https://gh.bmj.com/content/6/8/e006776> (open access)

### **EHS-COVID (440) The role of compassion in maintaining EHS during the COVID-19 pandemic**

The role of compassion in maintaining EHS during the COVID-19 pandemic

<https://hlh.who.int/learning-briefs/the-role-of-compassion-in-maintainin...>

#### KEY LEARNING THEMES

Compassion arises from:

- Awareness of human suffering.
- Emotional resonance with that suffering (empathy).
- Action (or a desire) to relieve that suffering.

In other words, Awareness + Empathy + Action = Compassion.

Compassion fuels commitment and innovation to address global health threats, like the effect of COVID-19 on disruption of essential health services, healthcare worker burnout, and collective social trauma.

On an individual level, the biggest impact compassion can make in the delivery of health services is recognizing the whole person, both for those who give and those who receive health services.

On a health provider level, compassionate support of health care workers is critical to their well-being and personal resilience, to mitigating burnout, and to the sustainability of the healthcare workforce to maintain essential health services.

On a leadership/organizational level, it is necessary for organizations to build cultures of compassion - looking after staff and each other as colleagues enables organizations to serve populations in maintaining essential health services. “Be well to serve well”.

## **EHS-COVID (441) WHO HLH Newsletter August 2021**

'The HLH [Health Services Learning Hub] is a WHO knowledge platform to share cross-country learning on maintaining essential health services during the COVID-19 pandemic and in the post-pandemic recovery.

<https://hlh.who.int/about-us/overview>

Read the August issue of the Newsletter in full here: <https://healthserviceslearninghubhlh.cmail20.com/t/ViewEmail/d/99CBDD8C...>

'The HLH Newsletter is a place to share up-to-date information on key knowledge products from WHO and the Network of Networks. If you have any queries or wish to contribute, please email us: [hlh@who.int](mailto:hlh@who.int)

'Do you have an innovative approach to share on maintaining essential health services during COVID-19? Submit your Action Brief!' <https://extranet.who.int/dataformv3/index.php/813253?lang=en>

Note from HIFA moderator (NPW): HIFA is proud to be part of the HLH Network of Networks, through our WHO-supported discussions on Maintaining essential health services during COVID (and beyond). See our first action brief on the WHO website here: <https://hlh.who.int/ab-detail/findings-from-a-hifa-thematic-discussion>

## **EHS-COVID (442) Join the Frontline Health Workers Coalition at UNGA! September 21 & 28, 9 – 10:30 am ET | 4 – 5:30 pm EAT**

Please join our FHWC webinar tomorrow with government leaders.

REGISTER [https://us02web.zoom.us/webinar/register/WN\\_hviTJR9uS4-3Dtei04Rt1A](https://us02web.zoom.us/webinar/register/WN_hviTJR9uS4-3Dtei04Rt1A)

Breaking Barriers: Health Workforce Policies for Pandemic Response and Preparedness

COVID-19 has upended health systems around the world. Now, more than 18 months into the pandemic, health leaders have a clearer perspective of what works and what doesn't work in pandemic response and preparedness.

Sponsored by the Frontline Health Workers Coalition and partners alongside the 76th UN General Assembly, this two-part event will convene government leaders and civil society representatives to share their most effective health workforce policy wins over the last year and a half.

PART ONE will be a frank discussion with government leaders from different continents on how their health worker policies pivoted to respond to COVID-19 and what they would do differently in the event of a future health crises.

### **EHS-COVID (443) Disruptions in maternal and child health service utilization during COVID-19: analysis from eight sub-Saharan African countries**

CITATION: G, Shapira, Ahmed T, Drouard Shp, Amor Fernandez P, Kandpal E, Nzelu C, Wesseh Cs, et al. "Disruptions in Maternal and Child Health Service Utilization during COVID-19: Analysis from Eight Sub-Saharan African Countries." *Health Policy and Planning* 36, no. 7 (August 12, 2021). <https://doi.org/10.1093/heapol/czab064>.

#### **ABSTRACT**

The coronavirus-19 pandemic and its secondary effects threaten the continuity of essential health services delivery, which may lead to worsened population health and a protracted public health crisis. We quantify such disruptions, focusing on maternal and child health, in eight sub-Saharan countries. Service volumes are extracted from administrative systems for 63 954 facilities in eight countries: Cameroon, Democratic Republic of Congo, Liberia, Malawi, Mali, Nigeria, Sierra Leone and Somalia. Using an interrupted time series design and an ordinary least squares regression model with facility-level fixed effects, we analyze data from January 2018 to February 2020 to predict what service utilization levels would have been in March-July 2020 in the absence of the pandemic, accounting for both secular trends and seasonality. Estimates of disruption are derived by comparing the predicted and observed service utilization levels during the pandemic period. All countries experienced service disruptions for at least 1 month, but the magnitude and duration of the disruptions vary. Outpatient consultations and child vaccinations were the most commonly affected services and fell by the largest margins. We estimate a cumulative shortfall of 5 149 491 outpatient consultations and 328 961 third-dose pentavalent vaccinations during the 5 months in these eight countries. Decreases in maternal health service utilization are less generalized, although significant declines in institutional deliveries, antenatal care and postnatal care were detected in some countries. There is a need to better understand the factors determining the magnitude and duration of such disruptions in order to design interventions that would respond to the shortfall in care. Service delivery modifications need to be both highly contextualized and integrated as a core component of future epidemic response and planning.

COMMENT (Neil): Unusually, the paper does not have a formal conclusion, but the last paragraph says: 'The COVID pandemic's scope presents added difficulties by long-lasting lockdown policies that restrict movement and magnify financial pressures, which reduce the ability to pay for medical services. The analysis presented in this study should be seen as a first step in characterizing service disruptions. Disentangling the potential casual pathways behind observed disruptions requires further contextual knowledge and additional data collection of supply and demand-side factors. Targeted facility or household surveys can indicate the primary causes of disruptions to inform public health interventions and investments and uncover pockets of disruption possibly masked by reporting aggregation. Potential instances of service disruptions should also be disaggregated to explore effect heterogeneity by specific populations, regions or types of health facilities and thus better inform a public health response.'

#### **EHS-COVID (444) COVID: Cancer backlog in UK NHS could take a decade to clear**

If this is the picture in the relatively well-resourced UK, what is the situation in other countries? Read online: <https://www.bbc.co.uk/news/health-58670553>

'It could take more than a decade to clear the cancer-treatment backlog in England, a report suggests.

Research by the Institute for Public Policy Research estimated 19,500 people who should have been diagnosed had not been, because of missed referrals. If hospitals could achieve a 5% increase in the number of treatments over pre-pandemic levels, it would take until 2033 to clear the backlog...

Between March 2020 and February 2021, the number of referrals to see a specialist dropped by nearly 370,000 on the year before, a fall of 15%. Behind these figures are thousands of people for whom it will now be too late to cure their cancer, the report, with the CF health consultancy...'

#### **EHS-COVID (445) Priority Setting and Equity in COVID-19 Pandemic Plans in 18 African countries**

A new paper in Health Policy and Planning.

CITATION: Kipiriri, Lydia, Suzanne Kiwanuka, Godfrey Biemba, Claudia Velez, S. Donya Razavi, Julia Abelson, Beverley M. Essue, et al. "Priority Setting and Equity in COVID-19 Pandemic Plans: A Comparative Analysis of 18 African Countries." *Health Policy and Planning*. Accessed January 20, 2022. <https://doi.org/10.1093/heapol/czab113>.

**ABSTRACT:** Priority setting represents an even bigger challenge during public health emergencies than routine times. This is because such emergencies compete with routine programs for the available health resources, strain health systems, and shift health care attention and resources towards containing the spread of the epidemic and treating those that fall seriously ill. This paper is part of a larger global study the aim of which is to evaluate the degree to which National COVID-19 preparedness and response plans incorporated priority setting concepts. IT and provides important insights into what and how priority decisions were made in a context of a pandemic. Specifically, with a focus on a sample of 18 African countries' pandemic plans, the paper aims to: (i) Explore the degree to which the documented priority setting processes adhere to established quality indicators of effective priority setting and (ii) To examine if there is a relationship between the number of quality indicators present in the pandemic plans and the country's economic context, health system and prior experiences with disease outbreaks. All the reviewed plans contained some aspects of expected priority setting processes but none of the national plans addressed all quality parameters. Most of the parameters were mentioned by less than 10 of the 18 country plans reviewed, and several plans identified one or two aspects of fair priority setting processes. Very few plans identified equity as a criterion for priority setting. Since the parameters are relevant to the quality of priority setting that is implemented during public health emergencies, and that most of the countries have pre-existing pandemic plans; it would be advisable that for the future (if not already happening) countries consider priority setting as a critical part of their routine health emergency and disease outbreak plans. Such an approach would ensure that priority setting is integral to pandemic planning, response, and recovery.

**SELECTED EXTRACT:** 'Critical to pandemic planning is the need to maintain routine essential services. We assessed the degree to which the plans included strategies to sustain the country's routine health programs. Of the eighteen plans, eight included plans for sustaining essential services. Identified essential services included maternal and child health, HIV treatment, and chronic diseases.'

**COMMENT (Neil):** Prioritisation is part of our brief for the current discussion supported by WHO. We welcome comments from HIFA members on this topic. Of course, what matters is not just the plan, it is the extent to which it is implemented. A perfect plan has no impact if it is not implemented. We welcome comments on this too.

#### **EHS-COVID (446) Lancet: Global prevalence and burden of depressive and anxiety disorders in 204 countries**

This new paper in The Lancet estimates there were more than 50 million additional cases of major depressive disorder globally due to the COVID-19 pandemic. 'Meeting the added demand for mental health services due to COVID-19 will be difficult, but not impossible. Mitigation strategies should promote mental wellbeing and target determinants of poor mental health exacerbated by the pandemic, as well as interventions to treat those who develop a mental disorder.'

'Strategies to reduce the spread of SARS-CoV-2, such as physical distancing and restricted travel, have made it more difficult to acquire medication, attend treatment facilities, and receive in-person care. In some settings, outpatient and inpatient services have been interrupted or resources redirected to treat those with COVID-19'

CITATION: Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic

COVID-19 Mental Disorders Collaborators

Published: October 08, 2021 DOI: [https://doi.org/10.1016/S0140-6736\(21\)02143-7](https://doi.org/10.1016/S0140-6736(21)02143-7)

## SUMMARY

**Background:** Before 2020, mental disorders were leading causes of the global health-related burden, with depressive and anxiety disorders being leading contributors to this burden. The emergence of the COVID-19 pandemic has created an environment where many determinants of poor mental health are exacerbated. The need for up-to-date information on the mental health impacts of COVID-19 in a way that informs health system responses is imperative. In this study, we aimed to quantify the impact of the COVID-19 pandemic on the prevalence and burden of major depressive disorder and anxiety disorders globally in 2020.

**Methods:** We conducted a systematic review of data reporting the prevalence of major depressive disorder and anxiety disorders during the COVID-19 pandemic and published between Jan 1, 2020, and Jan 29, 2021...

**Findings:** We identified 5683 unique data sources, of which 48 met inclusion criteria (46 studies met criteria for major depressive disorder and 27 for anxiety disorders). Two COVID-19 impact indicators, specifically daily SARS-CoV-2 infection rates and reductions in human mobility, were associated with increased prevalence of major depressive disorder (regression coefficient [B] 0.9 [95% uncertainty interval 0.1 to 1.8;  $p=0.029$ ] for human mobility, 18.1 [7.9 to 28.3;  $p=0.0005$ ] for daily SARS-CoV-2 infection) and anxiety disorders (0.9 [0.1 to 1.7;  $p=0.022$ ] and 13.8 [10.7 to 17.0;  $p<0.0001$ ]). Females were affected more by the pandemic than males (B 0.1 [0.1 to 0.2;  $p=0.0001$ ] for major depressive disorder, 0.1 [0.1 to 0.2;  $p=0.0001$ ] for anxiety disorders) and younger age groups were more affected than older age groups ( $-0.007$  [ $-0.009$  to  $-0.006$ ;  $p=0.0001$ ] for major depressive disorder,  $-0.003$  [ $-0.005$  to  $-0.002$ ;  $p=0.0001$ ] for anxiety disorders). We estimated that the locations hit hardest by the pandemic in 2020, as measured with decreased human mobility and daily SARS-CoV-2 infection rate, had the greatest increases in prevalence of major depressive disorder and anxiety disorders. We estimated an additional 53.2 million (44.8 to 62.9) cases of major depressive disorder globally (an increase of 27.6% [25.1 to 30.3]) due to the COVID-19 pandemic, such that the total prevalence was 3152.9 cases (2722.5 to 3654.5) per 100 000 population. We also estimated an additional 76.2 million (64.3 to 90.6) cases of anxiety disorders globally (an increase of 25.6%

[23·2 to 28·0]), such that the total prevalence was 4802·4 cases (4108·2 to 5588·6) per 100 000 population. Altogether, major depressive disorder caused 49·4 million (33·6 to 68·7) DALYs and anxiety disorders caused 44·5 million (30·2 to 62·5) DALYs globally in 2020.

Interpretation: This pandemic has created an increased urgency to strengthen mental health systems in most countries. Mitigation strategies could incorporate ways to promote mental wellbeing and target determinants of poor mental health and interventions to treat those with a mental disorder. Taking no action to address the burden of major depressive disorder and anxiety disorders should not be an option.

Comment (Neil): There has clearly been a huge increase in mental health burden together with disruption to mental health services. What can be done to maintain and strengthen mental health services so that those who need care now can get it, and so that mental health services are resilient in the face of future - and possibly even worse - public health emergencies?

#### **EHS-COVID (447) Lancet: Global prevalence and burden of depressive and anxiety disorders in 204 countries (2)**

Thanks for sharing this important paper [[https://doi.org/10.1016/S0140-6736\(21\)02143-7](https://doi.org/10.1016/S0140-6736(21)02143-7)]. The conclusion suggests that we need to strengthen mental health services in most countries. We have recently published a Cochrane review on the effects of taskshifting of care for people in LMICs with mental disorders and distress to primary-levels workers. The review includes 95 randomised trials from 30 LMICs, and addresses taskshifting for management of anxiety and depression, and also for a range of other mental health issues. Given the shortages of specialist mental health providers in many LMICs, taskshifting is one pathway to strengthening service provision.

The review is available open access in the Cochrane Library: <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD009149.pub3/...>

#### **EHS-COVID (448) WHO: Tuberculosis deaths rise for the first time in more than a decade due to the COVID-19 pandemic**

Opening paragraphs below and a comment from me. Read online: <https://www.who.int/news/item/14-10-2021-tuberculosis-deaths-rise-for-th...>

WHO: Tuberculosis deaths rise for the first time in more than a decade due to the COVID-19 pandemic

14 October 2021 News release Reading time: 5 min (1368 words)

The COVID-19 pandemic has reversed years of global progress in tackling tuberculosis and for the first time in over a decade, TB deaths have increased, according to the World Health Organization's 2021 Global TB report.

In 2020, more people died from TB, with far fewer people being diagnosed and treated or provided with TB preventive treatment compared with 2019, and overall spending on essential TB services falling.

The first challenge is disruption in access to TB services and a reduction in resources. In many countries, human, financial and other resources have been reallocated from tackling TB to the COVID-19 response, limiting the availability of essential services.

The second is that people have struggled to seek care in the context of lockdowns.

"This report confirms our fears that the disruption of essential health services due to the pandemic could start to unravel years of progress against tuberculosis," said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. "This is alarming news that must serve as a global wake-up call to the urgent need for investments and innovation to close the gaps in diagnosis, treatment and care for the millions of people affected by this ancient but preventable and treatable disease."

COMMENT (NPW): It should be added that even where people can access care, the quality of that care is not assured. Previous research has shown that 'More than 9 in 10 prescriptions for tuberculosis in India are incorrect, predisposing those patients and the general population to multi-drug-resistant tuberculosis in the future.' Part of the reason for this is that health workers' needs, including their information needs, are not adequately supported. <https://www.hifa.org/about-hifa/why-hifa-needed>

### **EHS-COVID (449) WHO's 7 policy recommendations on building resilient health systems**

Extracts below and a comment from me.

WHO's 7 policy recommendations on building resilient health systems

19 October 2021 News release



WHO has released a position paper on building health systems resilience towards UHC and health security during COVID-19 and beyond to reinforce the urgent need for renewed and heightened national and global commitment to make countries better prepared and health systems resilient against all forms of public health threats for sustained progress towards both UHC and health security. This requires an integrated approach to building and rebuilding health systems that serve the needs of the population, before, during and after public health emergencies...

In brief: WHO's 7 policy recommendations on building resilient health systems based on primary health care

1. Leverage the current response to strengthen both pandemic preparedness and health systems
2. Invest in essential public health functions including those needed for all-hazards emergency risk management
3. Build a strong primary health care foundation
4. Invest in institutionalized mechanisms for whole-of-society engagement
5. Create and promote enabling environments for research, innovation and learning
6. Increase domestic and global investment in health system foundations and all-hazards emergency risk management
7. Address pre-existing inequities and the disproportionate impact of COVID-19 on marginalized and vulnerable populations.

COMMENT (NPW): I have skimmed through the report [ <https://www.who.int/publications/i/item/WHO-UHL-PHC-SP-2021.01> ] and there are a few references to health workers, but surely they are central to health systems strengthening. To paraphrase Lincoln Chen et al (2004): The only way to achieve health systems resilience is through the health worker: There are no shortcuts. In my view, far more attention is needed to empower health workers with their basic needs <https://www.hifa.org/about-hifa/hifa-universal-health-coverage-and-human...>

#### **EHS-COVID (450) WHO: Tuberculosis deaths rise for the first time in more than a decade due to the COVID-19 pandemic (2)**

On reading the comment by DG, WHO ("This is alarming news that must serve as a global wake-up call to the urgent need for investments and innovation to close the gaps in diagnosis, treatment ----) and that by Neil ( '----- Part of the reason for this is that health workers' needs, including their information needs, are not adequately supported-----'), I feel the need to return to one of our earlier posts about the transformational impact of PACK (Practical Approach to Care Kit) developed by Knowledge Translation Unit, University of Cape Town, in South Africa over two decades period and now helping primary health care clinicians in other countries (Nigeria, Ethiopia, Brazil and others) to improve on their system

(including during Lockdowns), improve clinicians' clinical competence so that they make better diagnosis and also give the correct treatment in primary health centres.

We currently have almost completed the analysis of a patient experience / satisfaction survey in the PHC facilities in Buachi State, Nigeria where PACK is used and the result seems to be excellent to all the questions about the care they (patients) received. Using tools like PACK to establish strong systems and improve clinical competence of clinicians shall ensure that even after disruptions by situations like lockdowns, patients can continue to receive great care and the system shall always be ready to cope. (Using a mentorship model to localise the Practical Approach to Care Kit (PACK): from South Africa to Nigeria. DOI: 10.1136/bmjgh-2018-001079)

### **EHS-COVID (451) Joint statement on WHO's estimates of health and care worker deaths due to COVID-19**

Extracts below. Read the full statement online: <https://cdn.who.int/media/docs/default-source/health-workforce/year2021/...>

We, the Steering Committee for the International Year of Health and Care Workers in 2021, call for immediate and concrete action to protect health and care workers from the impact of the global COVID-19 pandemic.

WHO estimates that between 80 000 and 180 000 health and care workers could have died from COVID-19 in the period between January 2020 to May 2021...

Health and care workers are experiencing heavy workloads and working long hours. They are exposed daily to human suffering and death. Levels of anxiety, distress, fatigue, occupational burnout, stigmatization, physical and psychological violence have all increased significantly...

Shortages of health and care workers are exacerbated by the COVID-19 pandemic: 66% of countries have reported health workforce shortages as the primary cause of disruption to essential health services...

We therefore call for urgent, multisectoral commitment, coordination and action on the following recommendations:

- (1) Strengthen data collection and reporting on infections, ill-health and deaths among health and care workers due to COVID-19...
- (2) Protection of health and care workers during and beyond the current global COVID-19 pandemic...
- (3) Accelerate the vaccination of all health and care workers in all countries...

It is our moral obligation to protect and invest in health and care workers. And we must move forward together.

### **EHS-COVID (451) WHO: Tuberculosis deaths rise for the first time in more than a decade due to the COVID-19 pandemic (3)**

Thanks for sharing the report on TB death rise due to COVID-19 pandemic. COVID-19 pandemic has resulted to an increase in TB death due to stigma as patients presenting with signs and symptoms refuse to go the health unit for diagnosis and treatment.

This can be reduced if we intensify TB case finding. TB and COVID share similar signs and symptoms and if medical consultants could request a covid test together with a sputum sample for TB diagnosis, more cases will be diagnosed and treated since test and treatment are free.

A research is already ongoing at the level of the District hospital where patients sent for covid test, a sputum sample is collected for analysis as part of the TB case finding intensification to diagnose and treat more patients. This project needs partners and financial resources to be sustainable.

We face challenges like lockdowns due to the conflict in anglophone Cameroon where patients find it difficult to travel to the district hospital for consultation, diagnosis and treatment. Due to these lockdowns, patients could be consulted in their communities, with sample collection and transportation to the district hospital laboratory for analysis.

International and donor organisations should invest their funds in such research and innovations. This will close the gaps in the diagnosis, treatment and care for patients especially those in conflict affected zones of Sub Sahara African countries and other LMICs.

GeneXpert is the test done for the research while microscopy still remains the standard test. TB research laboratory is the doing a lot of work on multi drug resistant TB for diagnosis and treatment.

### **EHS-COVID (453) Scale up digital interventions to beat noncommunicable diseases**

4-minute video from WHO: <https://www.youtube.com/watch?v=3AyVcwoLW8M>

'Digital health interventions are enhancing healthcare delivery and sustainability, and are bringing many exciting innovations in the treatment and management of noncommunicable diseases (NCDs) such as cardiovascular diseases, cancer, diabetes and respiratory diseases. The pandemic has triggered a significant scaling up of digital interventions to bridge the gaps we face in the treatment and management of NCDs.

Innovations include hotlines, online assistance, mobile phone apps and many more. Digital interventions have the potential for reducing the interruption of both NCD and mental health services during the most challenging circumstances, which makes ongoing scaling up a necessity rather than a choice. Let's work together, public and private sector, people and technology, to scale up digital interventions to #BeatNCDs and create a healthier future for everyone.'

### **EHS-COVID (454) WHO COVID-19 Health Services Learning Hub - October Newsletter**

Please, kindly find below the latest updates from the WHO COVID-19 Health Services Learning Hub (HLH). This month's highlight is an Action Brief developed by HIFA Thematic Discussion participants - we will send a separate message to provide you more details on this insightful piece.

Here you can find a link to the HTML version of the HLH October Newsletter: <https://createsend.com/t/d-D8186FE1ABD049F82540EF23F30FEDED>

HLH Newsletter - October 2021

Welcome to the HLH Newsletter!

The HLH is a WHO knowledge platform to share cross-country learning on maintaining essential health services during the COVID-19 pandemic and in the post-pandemic recovery. Learn more about us here [<https://hlh.who.int/about-us/overview>].

The HLH Newsletter is a place to share up-to-date information on key knowledge products from WHO and the Network of Networks. If you have any queries or wish to contribute, please email us: [hlh@who.int](mailto:hlh@who.int)

HLH Action Brief

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

Findings from a HIFA (Healthcare Information For All) Thematic Discussion [<https://hlh.who.int/ab-detail/how-has-covid-19-affected-delivery-of-ehs-...>]

Do you have an innovative approach to share on maintaining essential health services during COVID-19?

Submit your Action Brief! [<https://extranet.who.int/dataformv3/index.php/813253?lang=en>]

## WHO Activities

Maintaining essential MNCH services during COVID-19 pandemic: Lessons from 19 countries. Since the beginning of the COVID-19 pandemic, WHO has engaged with countries to ensure the continuity of essential health services. This global event will share and discuss countries' experiences and lessons learned during the implementation, including establishing structures and systems to coordinate the response and ensure continuity of services, proactive use of data to inform decision-making, adaptation of service delivery and innovation.

Registration is available here [[https://who.zoom.us/webinar/register/WN\\_dFQMmrFNRJ-sgMnZICF\\_rA](https://who.zoom.us/webinar/register/WN_dFQMmrFNRJ-sgMnZICF_rA)].

The first digital space of its kind, the Partners Platform offers a unique meeting ground where national governments, UN agencies and other partners can coordinate global health responses for an acute event, in real time.

Originally conceived as the COVID-19 Partners Platform's, the Platform now also offers global actors the opportunity to develop and share national response plans for Ebola virus disease (EVD) and measles, enabling both transparency and joint ownership in strengthening preparedness and response capacities. Through the use of innovative action checklists, innovative dynamic costing tools for country resource needs, and data-driven dashboards, the Platform tracks the global flow and demand of contributions from both international development banks and national charities, allowing other donors the chance to see where contributions are most needed, particularly in regards to vaccine funding.

Members states and other stakeholders can learn more and are invited to request access on the Partners Platform's landing page [<https://covid19partnersplatform.who.int/en/>].

The WHO Global Learning Laboratory (GLL) for Quality Universal Health Coverage (UHC) is embarking on a learning journey on Quality Essential Health Services during COVID-19. The learning journey will explore the important lessons learned throughout the world as health systems have endeavored to maintain the provision of quality essential health services during the COVID-19 pandemic. If you work with the national quality directorate, sub-national/district health team and facility-level quality improvement teams in your country and would like to document and share your experience, we want to hear from you! Email the team at [[GLL4QUHC@who.int](mailto:GLL4QUHC@who.int)] for more information.

## HLH Network of Networks

On 14th October we gathered for yet another HLH Network of Networks briefing. Our community, dedicated to maintaining essential health services during COVID-19, shared their latest experience and talked about ongoing initiatives. Thank you all for being part of this journey!

Join the FM Pivot initiative by the Besroure Centre for Global Family Medicine. [<https://www.cfpc.ca/CFPC/media/Resources/Global-Health/Besroure-2021-FM-P...>]

The Besroure Centre for Global Family Medicine is excited to announce the FM Pivot learning module “Finding Great Research Questions in Pandemics and Other Crises: An introduction for family medicine researchers” is now available at [www.fmpivot.ca](http://www.fmpivot.ca/) [<http://www.fmpivot.ca/>]. This module aims to build research skills and capacity amongst community-based family doctors and trainees.

The FM Pivot initiative is a series of 5 modules that aims to apply global experiences from the COVID-19 pandemic. Each FM Pivot module is developed by Canadian Primary Care Lead and an International Primary Care Lead to highlight mutual learning and to establish new forms of collaborative leadership (Integrated Care Framework Strategy 5.1). These modules will serve as a co-learning platform to strengthen the skills of family doctors and primary care providers around the world (Integrated Care Framework Strategy 3.3). Start this learning module here [<http://www.fmpivot.ca/>].

THET’s community platform, Pulse, now available in a mobile app - THET is delighted to launch the Pulse app, supporting mobile access to a global community that enables health professionals across the world to connect, create and collaborate. Pulse helps to create a world where health professionals are empowered to grow and lead health systems strengthening worldwide by supporting, motivating and equipping the global health workforce to delivery quality healthcare. Available on both Apple [<https://apps.apple.com/pk/app/pulse-partnerships/id1583550024>] and Android [[https://play.google.com/store/apps/details?id=hivebrite.pulse\\_partnershi...](https://play.google.com/store/apps/details?id=hivebrite.pulse_partnershi...)] devices via the App store.

Catch up on THET’s Annual Conference 2021, Power of Partnership: Solidarity in the shadow of COVID - THET's Annual Conference welcomed 450 registered attendees from across 28 countries and 105 organisations to examine the myriad forms of solidarity across the Health Partnership community in this International Year of the Health and Care Worker. The conference brought together leading voices from across the health, development, academic and government communities, including Dr Tedros Adhanom Ghebreyesus, Director-General, WHO, Professor Chris Whitty, Chief Medical Officer for England, and Dr Manal Gas, Medical Coordinator, Ministry of Health Development, Somaliland. The recordings of each session can be accessed on Pulse [[https://pulsepartnerships.org/media\\_center/folders/7d8d0b63-af03-4f51-a3...](https://pulsepartnerships.org/media_center/folders/7d8d0b63-af03-4f51-a3...)].

Health Services Learning Hub - [<https://hlh.who.int>]

If you would like to be featured in the next issue of the HLH Newsletter, do not hesitate to share your inputs with us.

### **EHS-COVID (455) HIFA has published a new Action Brief**

With great pleasure, I would like to let you know that HIFA has developed and published a new Action Brief. This is an outcome of ongoing collaboration with the WHO COVID-19 Health Services Learning Hub (HLH).

The Action Brief is a second document developed by HIFA. The first one was published a few months ago and was based on findings from the 1st Thematic Discussion. You can access the brief here: <https://hlh.who.int/ab-detail/findings-from-a-hifa-thematic-discussion> (and PDF version here: <https://hlh.who.int/docs/librariesprovider4/hlh---action-briefs/hlh-hifa...> ).

The new Action Brief is a result of fruitful 2nd Thematic Discussion. How has COVID-19 affected delivery of EHS? HIFA 2nd Discussion is accessible on the HLH website: <https://hlh.who.int/ab-detail/how-has-covid-19-affected-delivery-of-ehs-...> (PDF here: <https://hlh.who.int/docs/librariesprovider4/hlh---action-briefs/hifa-2nd...> ). Learn more about impact of COVID-19 on essential health services in the following areas: Reproductive and Child Health, Mental Health, Surgery and Emergency Care, Non-communicable diseases.

Thank you for your interest in the work of HLH and HIFA. If you would like your initiative/project to be published as an Action Brief, you can submit your ideas here: <https://extranet.who.int/dataformv3/index.php/813253?lang=en>

Should you have any questions, do not hesitate to contact HLH direct: [hlh@who.int](mailto:hlh@who.int)

### **EHS-COVID (456) World Stroke Day 29 October (2)**

Below is an extract from a statement on the WHO South East Asia Regional Office website and a few comments from me. Read in full: <https://www.who.int/southeastasia/news/detail/28-10-2021-world-stroke-day>

28 October 2021 Statement SEARO

By Dr Poonam Khetrpal Singh, WHO Regional Director for South-East Asia

'In all countries of the Region, several interventions can be applied to achieve immediate progress in strengthening stroke care services. First, integrating stroke prevention and detection into preventive and promotive health interventions, especially at the primary level. Community intervention, e-health and appropriate medication and lifestyle modification can prevent at least 50% of stroke events. Alongside increased public literacy in the FAST method (Facial drooping, Arm weakness, Speech difficulty and Timely emergency service) they can significantly reduce the incidence and impact of stroke. Second, strengthening existing pathways of care from the primary level up, and through to rehabilitation, ensuring that gaps are identified and addressed using a hub and spoke model. Specific focus is needed to improve fast-track referrals and enhance emergency stroke services. Third, making essential stroke medicines accessible to all. Thrombolytic medicines and other medicines for stroke are now included in WHO's Essential Medicines List and should be integrated into national lists. Fourth, identifying and implementing high-impact innovations. Virtual capacity building in particular holds great promise, alongside tele-networking within and between countries to improve skills and share knowledge and resources.'

#### COMMENTS (NPW):

1. In the context of our WHO-supported discussion on Essential health services during COVID, can anyone share experience on the availability of quality health services for people with stroke? I suspect many people will have had delayed or absent care, and that a negative outcome (death or permanent disability) will have been increased.
2. The fact that thrombolytic medicines and other medicines for stroke are now included in WHO's Essential Medicines List should be reflected in a rapid inclusion on national lists. Why is this not happening?
3. To what extent is the general public able to recognise and appropriately act on FAST symptoms (Facial drooping, Arm weakness, Speech difficulty and Timely emergency service)? How can this be improved. (Indeed, is it appropriate to call this 'public literacy' as above? Recognition of danger signs is surely an issue of basic healthcare knowledge, which is distinct from literacy?

#### **EHS-COVID (457) The Lancet: Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic**

The authors of this systematic review estimate that the COVID-19 pandemic has caused an additional 53.2 million cases of major depressive disorder globally [not including the past 9 months], with clear implications on the need to promote mental wellbeing and strengthen mental health services. I invite HIFA members to share experience of mental health issues in your country and/or in your healthcare facility. How have you responded to these issues?



CITATION: Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic

COVID-19 Mental Disorders Collaborators

Volume 398, issue 10312, p1700-1712, november 06, 2021

Published:October 08, 2021 DOI:[https://doi.org/10.1016/S0140-6736\(21\)02143-7](https://doi.org/10.1016/S0140-6736(21)02143-7)

## SUMMARY

**Background:** Before 2020, mental disorders were leading causes of the global health-related burden, with depressive and anxiety disorders being leading contributors to this burden. The emergence of the COVID-19 pandemic has created an environment where many determinants of poor mental health are exacerbated. The need for up-to-date information on the mental health impacts of COVID-19 in a way that informs health system responses is imperative. In this study, we aimed to quantify the impact of the COVID-19 pandemic on the prevalence and burden of major depressive disorder and anxiety disorders globally in 2020.

**Methods:** We conducted a systematic review of data reporting the prevalence of major depressive disorder and anxiety disorders during the COVID-19 pandemic and published between Jan 1, 2020, and Jan 29, 2021...

**Findings:** ... Altogether, major depressive disorder caused 49·4 million (33·6 to 68·7) DALYs and anxiety disorders caused 44·5 million (30·2 to 62·5) DALYs globally in 2020.

**Interpretation:** This pandemic has created an increased urgency to strengthen mental health systems in most countries. Mitigation strategies could incorporate ways to promote mental wellbeing and target determinants of poor mental health and interventions to treat those with a mental disorder. Taking no action to address the burden of major depressive disorder and anxiety disorders should not be an option.

**EHS-COVID (458) A new HIFA thematic discussion: Maintaining essential health services during the pandemic: What have we learned? Starts 15 November 2021**

We are delighted to welcome many new members who have joined us for our third and final discussion in this series, supported by WHO.

We can now look back on 12-18 months of experience of the COVID-19 pandemic. Some countries have now entered a recovery phase with relatively few new cases and deaths (at least for now). Other countries continue to be facing heavy caseloads. Almost every country has been affected and we have seen that essential health services - reproductive health, child health, mental health, non-communicable disease, surgery - have been severely disrupted in many ways. Even for those countries that are in a recovery phase, there are major challenges in terms of late presentation of disease and delayed access to surgery.

What have we learned? How can we better maintain essential health services during a pandemic? What action(s) did your government take that facilitated (or hindered) the delivery of services? How can we build resilience moving forwards?

1. Looking back over the past 18 months, in what ways has COVID-19 affected your work? What impact has COVID-19 had on your organisation or your health facility? How have things changed over time and where are you now?
2. How have you responded to these challenges? What worked well and not so well?
3. A health service is only as good as the people who work within it. Health workers have been under extraordinary pressures for several months on end. What have we learned and how can we better support health workers going forward?
4. We have noted there is not only disruption to the delivery of services, but also in demand for services, associated with exaggerated fears of contagion from health facilities. How have attitudes changed in your experience/country?

The discussion starts on 15 November and continues through to 19 December. If you are not already a HIFA member, join here! [www.hifa.org/join](http://www.hifa.org/join)

Highlights of earlier HIFA discussions are available as two Action Briefs on the WHO website:

1. HIFA: A Thematic Discussion on Maintaining Essential Health Services

<https://hlh.who.int/ab-detail/findings-from-a-hifa-thematic-discussion>

## 2. How has COVID-19 affected delivery of EHS? HIFA 2nd Discussion

<https://hlh.who.int/ab-detail/how-has-covid-19-affected-delivery-of-ehs-...>

### **EHS-COVID (459) Q1 What have we learned?**

Over the coming days I invite you to reflect on question 1:

Q1. Looking back over the past 18 months, in what ways has COVID-19 affected your work? What impact has COVID-19 had on your organisation or your health facility? How have things changed over time and where are you now?

This question is in the context of wider questions: What have we learned? How can we better maintain essential health services during a pandemic (or any other international health emergency)? What action has your government taken that facilitated (or hindered) the delivery of services? How can we build resilience moving forwards?

I look forward to your reflections. The scope is clearly wide and feel free to choose: past, present, or future; global, national, local, institutional, or personal.

This HIFA discussion will be synthesised by a team of HIFA volunteers led by Gladson Vaghela (HIFA Country Representative, India) and published as our third Action Brief on the WHO website. Through these discussions and Action Briefs, HIFA is making a unique contribution to sharing and learning on the maintenance of essential health services during and after the pandemic in a spirit of solidarity and codevelopment.

I thank you all as ever for sharing your perspectives, experience and expertise: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

### **EHS-COVID (460) Q1 What have we learned? (2)**

Looking back on the theme of "Maintaining essential health services during COVID-19 (and beyond)", here is a brief summary of some of the issues that we have already highlighted on the HIFA forum:

HIFA members reported disruption of services across a number of different areas during the COVID-19 pandemic, particularly for reproductive health and childbirth; child health, immunisation; mental health; cancer prevention and treatment; and surgery. The impact - and the solutions - is complex and multifaceted. Overall, there is a need for strengthening of health systems. Some low- and middle-income have been

overwhelmed at times despite many of them having a lower caseload than many higher-income countries. Particular concerns in LMICs have included the limited availability of intensive care services, availability of oxygen, increase in home births performed by untrained birth attendants, and disruption in routine immunisation schedules.

Lack of public understanding about COVID-19 has led to a surprising burden of stigma against affected families and health workers, together with a reluctance to seek healthcare due to exaggerated fears of becoming infected in health facilities. In all countries, health workers have faced (and continue to face) extraordinary challenges, with impacts on their physical, psychological and social health. The waiting lists for surgery are at record levels in many countries; millions continue to be in pain or are at risk of early death due to lack of access to the surgery they need (a reality in LMICs before the pandemic, but now exaggerated and felt also in HICs).

The above, and more, are captured in an Action Brief on the WHO website: 'How has COVID-19 affected delivery of EHS? HIFA 2nd Discussion'

<https://hlh.who.int/ab-detail/how-has-covid-19-affected-delivery-of-ehs-...>

### **EHS-COVID (461) Q1 What have we learned? (3) Honduras National Medical Meeting as a collective space for reflection**

Sharing with you that in the last week of October, within the framework of the Honduran Medical Doctor's Week, the LXIII National Medical Congress (Congreso Médico Nacional, COMENAC) was held from October 26 to 29, 2021.

The congress was held in virtual mode under the theme "COVID-19 Pandemic: what we know and have learned so far" and was dedicated to the memory of medical doctors who died during the pandemic.

The Congress was organized with the collaboration of the medical societies and associations integrated to the National Center for Continuing Medical Education (Centro Nacional de Educación Médica Continua, CENEMEC) of the Medical College of Honduras (Colegio Médico de Honduras). The scientific program and the abstracts of the pre-Congress courses and conferences were published as a Supplement to the Revista Médica Hondureña which is available at the following link:

<https://revistamedicahondurena.hn/numeros/show/477>

The abstracts describe the experience of physicians according to their area of expertise. Here is an example from psychiatry (Rev Méd Hondur 2021: Vol 89 (Suppl 2): 57).

\*86CMT. POST COVID-19 PSYCHOSIS: A NEW ENEMY\*\*. \*\*Octavio Eduardo López Paredes. Psychiatrist. \*\*Ministry of Health, Sub-Directorate of Assistance, Hospital de Especialidad Psiquiátrica Santa Rosita; Támara, Francisco Morazán. Ministry of Health, Mario Mendoza Hospital; UNITEC, Faculty of Health Sciences; Honduran Association of Psychiatry. Tegucigalpa, Honduras.\*

\*The COVID-19 pandemic has hit Honduras since March 2020. This disease caused by a coronavirus has kept the world subjugated for more than 19 months. Mental health has been affected by this pandemic, with increased anxiety disorders, substance use, depression and even psychosis. It draws attention to the production of a psychotic picture weeks after having resolved the disease by what is defined as Post COVID-19 Psychosis to the appearance of psychotic symptoms weeks after a coronavirus infection in people without previous mental illnesses. According to a British study on neurological and psychiatric complications of COVID-19, in a sample of 153 patients, 23 patients with mental disorders were found, of which 10 had psychosis as a diagnosis, 6 a neurocognitive disorder and 7 other psychiatric disorders. The most frequent symptomatology found was related to delusional ideas with paranoid-type characteristics. In Honduras there is no statistic of this nosological entity. In the Santa Rosita Psychiatric Specialty Hospital, between 2020 and August 2021, 1,302 hospital discharges were registered, of which 4% (52) were classified as F06.2 Schizophreniform Disorder of Organic Origin, code that applies to Post COVID-19 Psychosis. Of this group only 5 are considered suspects for this diagnosis. It is important to note that there are no case definition protocols and that this disorder may be more impactful than is believed either as a trigger for a psychotic mental disorder or as a producer of it. It is important to be able to study this new entity since in the world literature more and more

registered cases appear every day. In addition, changes in pharmacological schemes should be studied if necessary.\*

This scientific event provided an opportunity to make a collective reflection on the 19 months since the first case of COVID-19 reported in Honduras. Additionally, share the effects of the pandemic from the experience of the different medical specialties and discuss the impact on the population and health personnel, as well as in general on Honduran society.

We invite you to review the Supplement of the Honduran Medical Journal,

<https://revistamedicahondurena.hn/numeros/show/477>

#### **EHS-COVID (462) Q1 What have we learned? (4)**

[The message below is forwarded from our sister forum HIFA-Zmabia, with thanks to Arlet Sprint]

Interesting questions! [ <https://www.hifa.org/dgroups-rss/new-hifa-thematic-discussion-maintainin...> ]

From the Netherlands it is hardly possible to answer that.

As secretary to two Dutch Foundations I can only say:

- The West was not fair in sharing their vaccines and knowledge to prevent further spread of the Covid virus for Zambia. The European Union promised a lot but did little so far via WHO or their Covax program.

- Both foundations tried their best to help their friends in Zambia (sending money to purchase protection materials) but due to travel restrictions board members could not visit them personally. Being on the spot is much better to continue the relation. Contact via Skype was possible but a poor substitute.

- I learned from the manager of a big hospital that due to admitted patients with Covid-19, women treated for VVF, were spread all over the hospital as the gyn ward was a Covid ward at that time. The worn out nurses with knowledge how to care for those women had to go around to all wards.

#### **EHS-COVID (463) Q1 What have we learned? (5) Lessons from Singapore**

Citation and abstract of lessons learned from Singapore (a high-income country). We would be interested to learn from the experience of other countries, especially LMICs. This could be in the form of a peer-reviewed paper, as below, or through your own personal observations or experience.

CITATION: Health system resilience in managing the COVID-19 pandemic: lessons from Singapore

Qijia Chua et al. BMJ Global Health 2021

Correspondence to Alvin Qijia Chua; [alvin.chua@nus.edu.sg](mailto:alvin.chua@nus.edu.sg)

[https://gh.bmj.com/content/5/9/e003317?utm\\_source=adestra&utm\\_medium=ema...](https://gh.bmj.com/content/5/9/e003317?utm_source=adestra&utm_medium=ema...)

#### **ABSTRACT**

Singapore, one of the first countries affected by COVID-19, adopted a national strategy for the pandemic which emphasised preparedness

through a whole-of-nation approach. The pandemic was well contained initially until early April 2020, when there was a surge in cases, attributed to Singapore residents returning from hotspots overseas, and more significantly, rapid transmission locally within migrant worker dormitories. In this paper, we present the response of Singapore to the COVID-19 pandemic based on core dimensions of health system resilience during outbreaks. We also discussed on the surge in cases in April 2020, highlighting efforts to mitigate it. There was: (1) clear leadership and governance which adopted flexible plans appropriate to the situation; (2) timely, accurate and transparent communication from the government; (3) public health measures to reduce imported cases, and detect as well as isolate cases early; (4) maintenance of health service delivery; (5) access to crisis financing; and (6) legal foundation to complement policy measures. Areas for improvement include understanding reasons for poor uptake of government initiatives, such as the mobile application for contact tracing and adopting a more inclusive response that protects all individuals, including at-risk populations. The experience in Singapore and lessons learnt will contribute to pandemic preparedness and mitigation in the future.

#### **EHS-COVID (462) Q4 Reduced demand for non-urgent essential health services**

[Q4. The content from previous discussions suggest that in some contexts there has been both a disruption in delivery of services and also in demand, associated with exaggerated fears of infection from health facilities. How have attitudes changed in your experience/country?]

We received a lot of information regarding lack of access, and disruption of non-urgent essential health services resulting in death and disability.

It will be interesting to hear experiences from the local communities if the demand for services was reduced as well and the reasons for this.

What were the factors contributing to the reduction in the demand for seeking non-urgent essential health services e.g. was it due to fear of contracting COVID, or hearing about the poor quality of health facilities such as infrastructure, medicines, skilled health providers, high fees etc.?

#### **EHS-COVID (465) Q4 Reduced demand for non-urgent essential health services (2)**

On Q4 [\*], we were discussing the impact of covid-19 generally in Nigeria because in January 2020 when the deadly virus was just emerging and the WHO had just declared a public health emergency, the predictions were that LMICs especially African countries would be hit the hardest. The world was bracing itself to mount serious offensive against the disease in Africa.

The continent suffers the chronic effects of weak health systems in the 54 countries that make it up: heavy health illiteracy, poor access to health facilities, poor health care delivery in the facilities, poor outcome and unacceptable levels of morbidity and mortality from already

prevalent diseases, talk more of a new deadly virus causing a pandemic. In our discussion mentioned above, we were pleasantly surprised that at least as at today ( 15 November 2021) LMICs like Nigeria continue to escape the worst effects of Covid-19 disease.

Many reasons have been adduced by as many experts and discussants all over the world. Some say it is because Africa is predominantly populated by black race, but that cannot be true. Black Pepple in Europe, USA and the UK have come of worse from the nasty deadly virus. Some say it is the hot sun, but again California, Texas, Southern Europe etc have hot sun. Others say it is because of 'innately stronger immunity of Africans living in Africa because they are forever slowly inoculated by all the various bites from all manner of bugs, at night and daytime, from childhood to old age! Who knows?

Surely robust research is needed to pinpoint why Africa has escaped the worst effects of Covid-19, so far! The problem is that Africa or LMIC does not have the resources to mount such a research, so, would the HICs do the research?? The whole world should be interested in answering the question because in the answer may lie the Prevention and management of a future pandemic.

In our discussion, we noted that this apparent low effect of covid-19 disease on the population means that apart from the first few months (up to day May/June 2020 in Nigeria) when patients attendance dropped, when people were really terrified on watching the television and seeing pictures of the tragedies in countries outside Africa, attendance generally returned to normal levels by the third quarter of 2020 and has stayed so.

The absence of the high numbers of death compared to the colder countries had led to apathy and increasing doubt and ambivalence about even the existence of COVID19 virus in many sections of the population. This is made worse by widespread mid/disinformation and pre-covid superstition, ignorance and weak health care system.

Our discussion adjourned on the note that all stakeholders in the health sector and system need to intensify efforts to educate the public on the need to avoid complacency because COVID19 is real, and to promote acceptance to be vaccinated whenever the vaccines arrive, and to continue preventive actions including regular hand washing, use of mask especially when on a crowd / indoors, and physically distance self from others.

Especially as winter has arrived in colder countries and there seems to another COVID19 surge, while international travel has return full steam!

Joseph Ana

**EHS-COVID (466) Q1 What have we learned (6) Lessons learned from Liberia**



Here is an interesting paper on the experience in Liberia, where active strengthening of the health workforce in the wake of Ebola has strengthened national resilience. I look forward to hear what lessons have been learned in other countries, and in individual health facilities and organisations as we reflect on the past 12-18 months. Email: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

CITATION: Dahn B et al. Liberia's First Health Workforce Program Strategy: Reflections and Lessons Learned

Annals of Global Health 2021;87

<https://www.annalsofglobalhealth.org/articles/10.5334/aogh.3242/>

#### ABSTRACT

Following civil war and the Ebola epidemic, Liberia's health workforce was devastated, essential health services and primary care were disrupted, and health outcomes for maternal and child mortality were amongst the worst in the world. To reverse these trends, the government of Liberia developed the Health Workforce Program (HWP) Strategy 2015-2021. With the goal of building a resilient and responsive health system to ensure access to essential services and the ability to respond to future crises, this strategy aimed to add 6,000 new professionals to the workforce. In the context of the COVID-19 pandemic, we share lessons learned from the program's development and first years of implementation.

#### SELECTED EXTRACTS

Between 2014–2016, Liberia suffered 10,678 cases and 4,810 deaths due to Ebola Virus Disease (EVD)... As the outbreak subsided, it was imperative to address the crisis that was Liberia's health workforce.

To accelerate strategic investment to reach its targets, the government developed the Health Workforce Program (HWP) Strategy 2015–2021 to improve the quality, quantity, and skill diversity of the national health workforce [22]. Incorporating lessons from the Ebola response, the HWP targeted strengthening general and specialist physicians, general and specialized nurses, and midwives, and formalizing two new cadres—health managers and community health assistants.

Health workforce investments have been critical to improving the resilience and responsiveness of the health system...

Continuous national leadership and active coordination are critical for mobilizing and aligning resources for large-scale implementation...

Training faculty to lead training programs for future generations is key to sustainability but takes time and is optimized with investments in clinical infrastructure...

A focus on institutional capacity building is necessary to ensure sustainability of programming at training institutions and teaching hospitals...

As Liberia continues to strengthen its health sector through COVID-19, we hope that the lessons learned can serve as a model for the next phase of health workforce training here and in other countries...

### **EHS-COVID (467) Q3 What have we learned to better support health workers?**

What have we learned? Honduran physicians fallen during the pandemic

At the LXIII National Medical Congress (Congreso Médico Nacional, COMENAC) held from October 26 to 29, 2021 within the framework of the Honduran Doctor's Week, under the theme "COVID-19 Pandemic: what we know and have learned so far", tribute was paid to the doctors who died during the pandemic.

In an opinion article published in the Revista Médica Hondureña as part of the National Medical Congress Supplement (<https://revistamedicahondurena.hn/numeros/show/477>), information is presented on the impact of the pandemic on the medical guild with a significant increase in the number of deaths during the pandemic compared to previous years. Here is an excerpt.

Alger J, Mejía F, Codina HI, Mejía M. Tributo a los médicos hondureños fallecidos durante la pandemia de COVID-19, período marzo 2020 a octubre 2021. Rev Méd Hondur 2021: Vol 89 (Supl 2): 18-21. Available in: <https://revistamedicahondurena.hn/assets/Uploads/Vol89-S2-2021-8.pdf>

"... since the report of the first cases of COVID-19 in Honduras in March 2020, 166 physicians have died, including three students of the last year of the Medicine Career (doctors in social service); in 2020, 82 died and as of October 23, 2021, 84 have died (Table 1). The median age of physicians who died in 2020 is 61 years (range 30-91) and in 2021 it is 64 years (range 27-94). With respect to sex, for the year 2020, the male to female ratio of the deceased is 4.1:1 and for the year 2021, the ratio is 3.4:1. In the three-year period from 2017 to 2019, 31, 29 and 40 physicians died respectively per year, an annual average of 33 + 6 deaths. The data for deaths in the full year 2020 was 95 colleagues, and the data as of October 23, 2021, with 84 colleagues, represent a greater than 2.5-fold increase in deaths per year for each of the years. This increase is directly related to COVID-19 or indirectly to the conditions of health and social precariousness prevailing in times of pandemic in our country..."

To honor the deceased doctors, the Supplement also published a photo collage available at: <https://revistamedicahondurena.hn/assets/Uploads/Vol89-S2-2021-19.pdf>

The back cover also features a commemorative image, available at:

<https://revistamedicahondurena.hn/assets/Uploads/Vol89-S2-2021-cp2.pdf>

The best way to honor all health workers who died during the pandemic is to contribute to improving a weakened and underserved health system.

### **EHS-COVID (467) Q4 Reduced demand for non-urgent essential health services (2)**

Our volunteer literature search expert John Evers has provided citations of more than 300 papers that may be useful to our current discussion (thank you John). I am starting to look at them and the first thing I notice is that fear of COVID-19 infection from visiting health facilities is rampant in many countries worldwide. This is reducing demand for non-urgent essential services such as immunisation, screening, and diagnosis and management of non-communicable diseases (among others). The concern is that this will inevitably worsen what is already a major problem: late presentation and complications, with high morbidity and mortality. Below is an example from Nigeria and a comment from me.

CITATION: Perceived impact of coronavirus pandemic on uptake of healthcare services in South West Nigeria

Afolalu Olamide Olajumoke et al.

The Pan African Medical Journal Pan Afr Med J. 2021; 40: 26.

Published online 2021 Sep 9. doi: 10.11604/pamj.2021.40.26.28279

#### **ABSTRACT**

Introduction: ... The study assessed health providers' perceived impact of coronavirus pandemic on the uptake of health care services in South West Nigeria.

Methods: a descriptive cross-sectional design using an online structured survey was used to elicit responses from 385 Nigerian health workers selected by convenience sampling technique...

Results: findings revealed a significant difference between the uptake of health care prior and during the COVID-19 pandemic... Factors influencing uptake of health services during the COVID-19 pandemic are: fear of nosocomial infection, fear of stigmatization, and misconception/misinformation on COVID-19 diseases and care.

Conclusion: the Nigerian health system in the past months has been remarkably impacted by the pandemic. This calls for immediate restructuring to maintain an equitable distribution of care, while minimizing risk to patients and health providers.

COMMENT (NPW): This fear of COVID-19 infections from health facilities needs to be put in perspective with the risks of non-attendance to such facilities. It seems likely that people's risk-benefit perception is heavily distorted. Is anyone aware of any effective health communication efforts to correct such misperception?

#### **EHS-COVID (469) What have we learned? (7) Perspectives from Burkina Faso, Ethiopia and Nigeria**

This study finds that more than half of health workers reported disruption in essential health services, while 7-21% of community members reported the same. Citation, abstract and a comment from me below.

CITATION: Reported Barriers to Healthcare Access and Service Disruptions Caused by COVID-19 in Burkina Faso, Ethiopia, and Nigeria: A Telephone Survey

Nega Assefa et al. American Journal of Tropical Medicine and Hygiene, August 2021

PMID: 34161296 PMCID: PMC8437171 DOI: 10.4269/ajtmh.20-1619

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8437171/>

ABSTRACT: The coronavirus disease 2019 (COVID-19) pandemic may have short-term and long-term impacts on health services across sub-Saharan African countries. A telephone survey in Burkina Faso, Ethiopia, and Nigeria was conducted to assess the effects of the pandemic on healthcare services from the perspectives of healthcare providers (HCPs) and community members. A total of 900 HCPs (300 from each country) and 1,797 adult community members (approximately 600 from each country) participated in the study. Adjusted risk ratios (ARRs) and 95% confidence intervals (CIs) were computed using modified Poisson regression. According to the HCPs, more than half (56%) of essential health services were affected. Child health services and HIV/surgical/other services had a slightly higher percentage of interruption (33%) compared

with maternal health services (31%). A total of 21.8%, 19.3%, and 7.7% of the community members reported that their family members and themselves had difficulty accessing childcare services, maternal health, and other health services, respectively. Nurses had a lower risk of reporting high service interruptions than physicians (ARR, 0.85; 95% CI, 0.56-0.95). HCPs at private facilities (ARR, 0.71; 95% CI, 0.59-0.84) had a lower risk of reporting high service interruptions than those at governmental facilities. Health services in Nigeria were more likely to be interrupted than those in Burkina Faso (ARR, 1.38; 95% CI, 1.19-1.59). Health authorities should work with multiple stakeholders to ensure routine health services and identify novel and adaptive approaches to recover referral services, medical care, maternal and child health, family planning, immunization and health promotion, and prevention during the COVID-19 era.

COMMENT: I have not had a chance to read this paper in detail, but the respondents among the general public appear to be non-selective, therefore presumably including large numbers of people who would not have been seeking health care at the time of the study. What would perhaps be more illuminating would be to see the difference in patient experience of attempting to seek care, during COVID-19 as compared with other times. Also, these three countries were thankfully not as badly affected as many other countries. Are HIFA members aware of any studies that have attempted to model the potential impact of a greater caseload on a sub-Saharan African country?

#### **EHS-COVID (470) What have we learned? (8) Results of a Medline search to support discussion on Essential health services and COVID-19**

I am grateful to HIFA literature search expert John Eyers who has run a search strategy on Medline to identify papers that may support our current discussion on Maintaining essential health services during COVID-19.

The original search strategy identified 391 papers and I have selected those that are most relevant to our four discussion questions:

1. Looking back over the past 18 months, in what ways has COVID-19 affected your work? What impact has COVID-19 had on your organisation or your health facility? How have things changed over time and where are you now?
2. How have you responded to these challenges? What worked well and not so well?
3. A health service is only as good as the people who work within it. Health workers have been under extraordinary pressures for several months on end. What have we learned and how can we better support health workers going forward?
4. The content from previous discussions suggest that in some contexts there has been both a disruption in delivery of services and also in demand, associated with exaggerated fears of infection from health facilities. How have attitudes changed in your experience/country?

The selection is available here:

<https://www.hifa.org/news/new-hifa-thematic-discussion-maintaining-essen...>

The search results on Medline do not provide the URLs for each paper, but these can usually be identified by cutting and pasting the Title of the paper into a search engine.

### **EHS-COVID (471) What have we learned? (9) Disruption of essential health services**

This paper in BMJ Global Health provides an insight into disruption of essential health services in Mexico. Citation, abstract and a comment from me below.

CITATION: BMJ Glob Health 2021 Sep;6(9):e006204. doi: 10.1136/bmjgh-2021-006204.

Disruption in essential health services in Mexico during COVID-19: an interrupted time series analysis of health information system data

Svetlana V Doubova 1, Hannah H Leslie 2 3, Margaret E Kruk 2, Ricardo Pérez-Cuevas 4, Catherine Arsenault 2

PMID: 34470746 PMCID: PMC8413469 DOI: 10.1136/bmjgh-2021-006204

#### **ABSTRACT**

**Introduction:** The COVID-19 pandemic has disrupted health systems around the world. The objectives of this study are to estimate the overall effect of the pandemic on essential health service use and outcomes in Mexico, describe observed and predicted trends in services over 24 months, and to estimate the number of visits lost through December 2020.

**Methods:** We used health information system data for January 2019 to December 2020 from the Mexican Institute of Social Security (IMSS), which provides health services for more than half of Mexico's population-65 million people. Our analysis includes nine indicators of service use and three outcome indicators for reproductive, maternal and child health and non-communicable disease services. We used an interrupted time series design and linear generalised estimating equation models to estimate the change in service use and outcomes from April to December 2020. Estimates were expressed using average marginal effects on the risk ratio scale.

Results: The study found that across nine health services, an estimated 8.74 million patient visits were lost in Mexico. This included a decline of over two thirds for breast and cervical cancer screenings (79% and 68%, respectively), over half for sick child visits and female contraceptive services, approximately one-third for childhood vaccinations, diabetes, hypertension and antenatal care consultations, and a decline of 10% for deliveries performed at IMSS. In terms of patient outcomes, the proportion of patients with diabetes and hypertension with controlled conditions declined by 22% and 17%, respectively. Caesarean section rate did not change.

Conclusion: Significant disruptions in health services show that the pandemic has strained the resilience of the Mexican health system and calls for urgent efforts to resume essential services and plan for catching up on missed preventive care even as the COVID-19 crisis continues in Mexico.

COMMENT (NPW): These statistics suggest that COVID-19 has seriously disrupted services, particularly cancer screening, family planning, vaccinations, and non-communicable diseases. The implication is that there will be a surge in incidence of some diseases over the coming months. As a HIFA member, can you share the picture in your country?

### **EHS-COVID (472) Q2 How have you responded to the challenges of COVID-19?**

Question 2 of our current discussion asks: 2. How have you responded to the challenges of COVID-19? What worked well and not so well?

Below is the experience of a tertiary care centre, the second largest hospital in Ethiopia. The authors concluded: 'The establishment of a triple setup for fighting against COVID-19, which encompasses non-COVID services, an isolation center and a COVID-19 treatment center, played a vital role in preserving essential health services.' It would be interesting to hear your experience of organising care in your facility, whether tertiary, secondary or primary.

CITATION: Published: 16 October 2021

Impact of COVID-19 and mitigation plans on essential health services: institutional experience of a hospital in Ethiopia

Firaol Dandena, Berhanetsehay Teklewold & Dagmawi Anteneh

BMC Health Services Research volume 21, Article number: 1105 (2021)

<https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-0...>

## ABSTRACT

**Background:** Health systems around the world are being challenged by an on-going COVID-19 pandemic. The COVID-19 pandemic and associated response can have a significant downstream effect on access to routine health care services, and indirectly cause morbidity and mortality from causes other than the disease itself, especially in resource-poor countries such as Ethiopia. This study aimed to explore the impact of the pandemic on these services and measures taken to combat the effect.

**Methods:** The study was conducted at St. Paul's hospital millennium medical college (SPHMMC) from December 15, 2020 to January 15, 2021 using a comparative cross-sectional study design. We collected data on the number of clients getting different essential health care services from May to October 2019 (Pre COVID) and the same period in 2020 (during a COVID-19 pandemic) from the patient registry book. The analysis was done with SPSS version 24 software.

**Result:** Overall, the essential services of SPHMMC were affected by the COVID-19 pandemic. The most affected service is inpatient admission, which showed a 73.3% (2044 to 682) reduction from the pre-COVID period and the least affected is maternal service, which only decreased by 13% (3671 to 3177). During the 6 months after the COVID-19 pandemic, there was a progressive increment in the number of clients getting essential health services.

**Conclusion and recommendation:** The establishment of a triple setup for fighting against COVID-19, which encompasses non-COVID services, an isolation center and a COVID-19 treatment center, played a vital role in preserving essential health services.

### **EHS-COVID (473) Q2 How have you responded to the challenges of COVID-19? (2)**

'Improving the awareness and health literacy of populations, policy-makers and the health workforce is key to preventing and controlling any disease that threatens the safety and security of populations in the region.'

This is the conclusion of a paper in WHO South-East Asia Journal of Public Health (September 2020). It would be interesting to hear from the same authors what lessons have been learned since this paper was published. I have invited them to join us.

**CITATION:** Poonam Khetrpal Singh & Manoj Jhalani. (?2020)?. Safeguarding essential health services during emergencies: lessons learnt from the COVID-19 pandemic. WHO South-East Asia Journal of Public Health, 9 (?2)?, 93 - 94. World Health Organization. Regional Office for South-East Asia. <https://apps.who.int/iris/handle/10665/334177>. License: CC BY-NC-SA 3.0 IGO. Corresponding author: Mr Manoj Jhalani ([jhalanim@who.int](mailto:jhalanim@who.int))



## EXTRACTS

Countries of the World Health Organization (WHO) South-East Asia Region have faced immense challenges in responding to the crisis while maintaining essential health services, owing in part to underprepared medical and public health infrastructures and overwhelmed health workforces.

Between May and July 2020, WHO carried out a rapid situation assessment survey on the impact of the pandemic on the continuity of essential health services during the 3 months prior to the date of survey submission. Across the region, the survey revealed constrained access for pregnant women to antenatal check-ups, delivery and postnatal care, and for children to diarrhoea and pneumonia treatment and routine immunization services. In addition, supplementary polio immunization campaigns and the measles, mumps and rubella vaccination drives were suspended...

Health resilience is strongly promoted by the Sendai Framework for Disaster Risk Reduction 2015–2030, which emphasizes the need for new and existing hospitals and other health facilities that remain safe, effective and operational during and after disasters...

It is imperative that Member States develop a roadmap for

sustaining essential health services and public health programmes

in the context of COVID-19... An

extensive list of sample indicators for monitoring essential health

services during the COVID-19 pandemic is available...

Improving the awareness and health literacy of populations, policy-makers and the health workforce is key to preventing and controlling any disease that threatens the safety and security of populations in the region.

I invite HIFA members to share any papers or reports that relate to the theme of our current discussion on Maintaining essential health services during COVID-19.

**EHS-COVID (474) Lessons (not) learned in Peru**

This letter from a group of doctors in Peru says the 'country failed to learn the lessons identified during the first wave'. The letter talks mainly of COVID-19 and relatively little about essential health services. What lessons have been learned (or not learned) in Peru (and in other countries) from countries' experience of the first or second wave? How easy was it to apply these lessons to help withstand future waves?

CITATION: Herrera-Anazco, Percy et al. Some lessons that Peru did not learn before the second wave of COVID-19

International Journal of Health Planning & Management

First published: 17 February 2021 <https://doi.org/10.1002/hpm.3135>

<https://onlinelibrary.wiley.com/doi/full/10.1002/hpm.3135>

#### EXTRACTS

The lack of equipment in public health facilities forced patients to purchase essential supplies such as oxygen from private sellers at unaffordable prices. Even though the vast lack of oxygen increased mortality, the government did not invest in oxygen infrastructure.

On the other hand, the government published a series of COVID-19 guidelines, with an incomplete description of their methodology and evidence assessment. Guidelines included drugs without scientific support on efficacy such as hydroxychloroquine, azithromycin and ivermectin (for hospitalized and ambulatory patients), leading to massive self-medication, millionaire expenses and probably worsened the system's collapse due to the adverse effects. Although some updates have withdrawn some of those, many persist in the guidelines.

Despite the efforts to reach universal health coverage in Peru, a large proportion of the population does not have adequate access to care due to a chronic lack of infrastructure, insufficient human resources, and lack of essential drugs. Most of the pandemic response was directed towards hospitals and particularly towards intensive care units (ICU), disregarding the need for a primary health approach or pre-ICU interventions.

Healthcare workers have been drastically affected by COVID-19. Before the pandemic, reports showed several gaps in the number, distribution and capacities. The situation exacerbated due to the collapse of the healthcare system and insufficient PPE, placing Peruvian healthcare workers among the most affected in the region.

Finally, communication has been deficient at every level. With a highly politicized environment, media and politicians have played a significant role in disinformation. On several occasions by opening the floor to nonscientist or even charlatans to give their opinion on control measures, or promoting different antiscientific approaches. These messages have caused confusion and distrust in the population.

Last January 26, the president decreed a new lockdown in many regions of the country due to the increase in deaths that is close to the highest number per day in the worst stage of the first wave. With a current tremendous increase in the number of cases, ICU patients, and deaths; Peru faces a second wave without resolving many of the problems detected at the beginning of the pandemic. The country failed to learn the lessons identified during the first wave.

### **EHS-COVID (475) Q2 How have you responded to the challenges of COVID-19? (3) Digital health**

Digital health, and particularly telemedicine, has been widely promoted and implemented throughout the pandemic. This perspective paper from Bangladesh provides a concise description of barriers to telemedicine and recommendations for the future. Citation, abstract, extracts and a comment from me below.

CITATION: Saifur Rahman Chowdhury, Tachlima Chowdhury Sunna, Shakil Ahmed

Telemedicine is an important aspect of healthcare services amid COVID-19 outbreak: Its barriers in Bangladesh and strategies to overcome

The International Journal of Health Planning and Management.

First published: 28 August 2020 <https://doi.org/10.1002/hpm.3064>

<https://onlinelibrary.wiley.com/doi/10.1002/hpm.3064>

#### **ABSTRACT**

The current pandemic of coronavirus disease 19 (COVID-19) has been a global concern since early 2020, where the number of COVID-19 cases is also on a rapid surge in Bangladesh with the report of a total of 276,549 cases after the detection of the first three cases in this country on 8 March 2020. The COVID-19 pandemic has made a seismic shift in the healthcare delivery system, where physician offices have accelerated digital health solutions at record speed, putting telemedicine (i.e., telehealth) at centre stage. Amid the severely contagious COVID-19, telemedicine has moved from being an optional service to an essential one. As the developing country, there are some barriers to get evenly distributed advantages of this approach due to the digital divides and disparities. In this commentary, we have described the importance of telemedicine

service amid the outbreak of COVID-19 in Bangladesh, the barriers and challenges that the country is facing to implement this approach and the strategies to overcome these barriers in this developing country.

#### SELECTED EXTRACTS

Due to the highly contagious nature of the virus, it has made panic among the doctors, nurses and patients alike. In Bangladesh, after its outbreak, not only the patients, but many doctors and nurses have also become the victim of COVID-19 and died from it. Because of the fear and anxiety, many doctors are now reluctant to render services directly and many of them have stopped their private practices also.

#### BARRIERS OF TELEMEDICINE SERVICES IN BANGLADESH

Limited ICT access...

Lack of Internet awareness... 67% of people in Bangladesh do not have Internet awareness, they do not know how to use the Internet and even 27% do not know how to use a basic mobile phone.

Lack of infrastructural support...

Lack of motivation... Older administrative staff in the hospital sectors of Bangladesh has a lack of motivation to start up a new system and resistance to change.

Patient dissatisfaction and lack of trust and effective communication

Low health literacy... a study conducted in 2017 found that 7% of respondents had very poor, 49% had poor and 41% had fair oral health literacy level.

Lack of digital security in the telemedicine sector...

#### RECOMMENDATIONS AND PATH AHEAD

Expansion of ICT access...

Expansion of equipment facilities and infrastructural support...

Accommodations for patient language, literacy and disability...

Increasing awareness and telehealth literacy training...

Digital empathy and webservice manner. It is more challenging to emanate compassion and empathy in a digitally connected platform for those who deliver care. So, medical education must update and needs to include the approach of conveying empathy to patients during telehealth care. Just as bedside manner has been central to medical education for over the period, 'webservice manner' must also be learned and ultimately richly embedded into the fabric of training and practice.

Increasing patient's satisfaction by ensuring qualities of care...

Making telemedicine laws and reimbursement policies...

COMMENT (NPW): Much of the above is familiar, although it's interesting to read there was 'panic among the doctors, nurses and patients alike' and that many health workers were reluctant to provide direct care. To what extent has fear driven changes in health workforce deployment in Bangladesh as compared with other countries? In the UK, I think the vast majority of the health workforce continued to work, and many who were recently retired signed up to contribute. The term 'webservice manner' is new to me, but is indeed likely to be important for communication, trust and patient experience. There was a very good article in the BMJ last year on how to do virtual consultations: <https://www.bmj.com/content/371/bmj.m3945>

### **EHS-COVID (476) Q3 What have we learned to better support health workers? (2)**

As Jackeline Alger (HIFA Country Representative COordinator for the Americas) said last week on HIFA: "The best way to honor all health workers who died during the pandemic is to contribute to improving a weakened and underserved health system." <https://www.hifa.org/dgroups-rss/ehs-covid-467-q3-what-have-we-learned-b...>

Perhaps the most important part of such health system strengthening is that which directly supports the physical and emotional health of health workers. I invite you to review this Action Brief from the Health Services Learning Hub at the World Health Organization. (The Hub has already published two action briefs based on HIFA thematic discussions this year.) You can review all the briefs here: <https://hlh.who.int/action-briefs>

In the current discussion we ask: "A health service is only as good as the people who work within it. Health workers have been under extraordinary pressures for several months on end. What have we learned and how can we better support health workers going forward?"

A large scale virtual support intervention for health care workers

Gareth Kantor et al. South Africa

Extracts below. Read in full: <https://hlh.who.int/ab-detail/a-large-scale-virtual-support-intervention...>

#### Key Learning Themes

- Virtual collaborative learning spaces that are psychologically safe can be rapidly assembled to address workforce issues at a time of crisis.
- Adapt areas of focus to context – e.g. in South Africa, account for important role of unions power in the health care workforce.
- Senior level buy-in and endorsement.
- Seek partnerships for sustainability of work started in an emergency (e.g. Universities in health systems strengthening).
- Virtual designs may need to incorporate more traditional/formal network learning approaches (e.g. BTS) to transition from participatory learning to improvement actions, and improved outcomes.

#### Background

#StaffCare was initiated by IHI in May 2020 to support a South African Provincial Government's efforts to protect and support health workers during the COVID-19 pandemic. The initiative built off a national guideline that was issued to help protect health workers in the face of the COVID-19 pandemic and existing leadership training and virtual convening efforts by the Western Cape Department of Health (30,000 employees serving over 6m people)...

A “sense-making framework” (see the figure below) focused the activities of #StaffCare into 3 streams:

- Effective leadership communication and behaviours.
- Tactics and tools to protect health workers from COVID-19.
- Ways to support the well-being of workers during COVID-19...

Health system strengthening through leadership, learning and improvement (QI) capability is core to ensuring employee wellbeing. A collaborative alliance of connected partners such as universities and NGOs can support public health and government systems. Strong macro and meso level governance capability is needed to maintain the focus on staff safety and wellbeing.

### **EHS-COVID (477) Q1 What have we learned? (7) Impact of COVID-19 on women and girls**

"Q1: Looking back over the past 18 months, in what ways has COVID-19 affected your work? What impact has COVID-19 had on your organisation or your health facility? How have things changed over time and where are you now?"

Back in August 2020 a Lancet paper 'COVID-19 has devastating effect on women and girls' referred to a World Report on the impact of COVID-19 on women and girls. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31679-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31679-2/fulltext)

Extracts below:

'WHO issued interim guidance for maintaining essential services during an outbreak, which included advice to prioritise services related to reproductive health and make efforts to avert maternal and child mortality and morbidity... As the pandemic spread, many countries implemented tough lockdowns and travel restrictions in a bid to slow transmission. In doing so, some governments did not heed WHO's advice, and instead forced sexual and reproductive health services to close because these services were not classified as essential...

'UNFPA predicts there could be up to 7 million unintended pregnancies worldwide because of the crisis, with potentially thousands of deaths from unsafe abortion and complicated births due to inadequate access to emergency care.'

Question: We are now 15 months on from this paper. What have we learned? What is the situation in specific countries? What are the barriers and drivers to quality health care? What measures have been taken to deal with the situation, and have these helped? I look forward to hear about the experience in your country and your work.

### **EHS-COVID (478) Q2 How have you responded to the challenges of COVID-19? (4) Digital health (2)**

A paper from India on the use of telemedicine for eye health during COVID-19. Citation, abstract and a comment from me below.

CITATION: Indian J Ophthalmol. 2020 Jun; 68(6): 1007–1012.

Published online 2020 May 25. doi: 10.4103/ijo.IJO\_1089\_20

Tele-consultations and electronic medical records driven remote patient care: Responding to the COVID-19 lockdown in India

Anthony V Das et al.

#### ABSTRACT

**Purpose:** To describe the experience of tele-consultations addressed at the centre of excellence of a multi-tier ophthalmology hospital network in India during the ongoing novel coronavirus (COVID-19) lockdown.

**Methods:** This cross-sectional hospital-based study included 7,008 tele-consultations presenting between March 23rd and April 19th 2020. A three-level protocol was implemented to triage the calls. The data of patient queries were collected using a Google Form/Sheets and the tele-calls were returned using the patient information retrieved from the electronic medical record system.

**Results:** Overall, 7,008 tele-calls were addressed, of which 2,805 (40.02%) patients where a clinical-related query was answered were included for analysis. The most common queries were related to redness/pain/watering/blurring of vision (31.52%), closely followed by usage of medications (31.05%). The majority of the queries were directed to the department of cornea (34.15%), followed by retina (24.74%). Less than one-fifth of the patients were from the lower socio-economic class (16.08%) and one-fourth were new patients (23.96%). The most common advice given to the patient was related to management of medications (54.15%) followed by appointment related (17.79%). Emergency requests requiring further evaluation by an ophthalmologist accounted for a small percentage (16.36%) of patients.

**Conclusion:** Tracking of tele-consultations and access to patient information from the electronic medical records enabled a timely response in an ongoing lockdown due to the COVID-19 pandemic. The current experience provided valuable insights to the possibility of managing patient follow-up visits remotely in the future.

**COMMENT (NPW):** One of the potential downsides of telemedicine is its potential to increase inequalities in access to care. The authors note that 'less than one-fifth of the patients were from the lower socio-economic class', which can only be interpreted if one knew the proportion of 'lower socio-economic class' in the population. The full text notes also that 75% of the patients accessing the service were men, suggesting a gender divide.



## **EHS-COVID (479) Q2 How have you responded to the challenges of COVID-19? (5) Digital health (3)**

Citation, abstract and a comment from me below.

CITATION: Characteristics of Online Health Care Services From China's Largest Online Medical Platform: Cross-sectional Survey Study

Journal of Medical Internet Research. Jiang, Xuehan et al. 2020

<https://ecommons.aku.edu/cgi/viewcontent.cgi?article=1622&context=pakist...>

**BACKGROUND:** Internet hospitals in China are in great demand due to limited and unevenly distributed health care resources, lack of family doctors, increased burdens of chronic diseases, and rapid growth of the aged population. The COVID-19 epidemic catalyzed the expansion of online health care services. In recent years, internet hospitals have been rapidly developed. Ping An Good Doctor is the largest, national online medical entry point in China and is a widely used platform providing online health care services.

**OBJECTIVE:** This study aims to give a comprehensive description of the characteristics of the online consultations and inquiries in Ping An Good Doctor. The analyses tried to answer the following questions: (1) What are the characteristics of the consultations in Ping An Good Doctor in terms of department and disease profiles? (2) Who uses the online health services most frequently? and (3) How is the user experience of the online consultations of Ping An Good Doctor?

**METHODS:** A total of 35.3 million consultations and inquiries over the course of 1 year were analyzed with respect to the distributions of departments and diseases, user profiles, and consulting behaviors.

**RESULTS:** The geographical distribution of the usage of Ping An Good Doctor showed that Shandong (18.4%), Yunnan (15.6%), Shaanxi (7.2%), and Guangdong (5.5%) were the provinces that used it the most; they accounted for 46.6% of the total consultations and inquiries. In terms of department distribution, we found that gynecology and obstetrics (19.2%), dermatology (17.0%), and pediatrics (14.4%) were the top three departments in Ping An Good Doctor. The disease distribution analysis showed that, except for nondisease-specific consultations, acute upper respiratory infection (AURI) (4.1%), pregnancy (2.8%), and dermatitis (2.4%) were the most frequently consulted diseases. In terms of user profiles, females (60.4%) from 19 to 35 years of age were most likely to seek consultations online, in general. The user behavior analyses showed that the peak times of day for online consultations occurred at 10 AM, 3 PM, and 9 PM. Regarding user experience, 93.0% of users gave full marks following their consultations. For some disease-related health problems, such as AURI, dermatitis, and eczema, the feedback scores were above average.

**CONCLUSIONS:** The prevalence of internet hospitals, such as Ping An Good Doctor, illustrated the great demand for online health care services

that can go beyond geographical limitations. Our analyses showed that nondisease-specific issues and moderate health problems were much more frequently consulted about than severe clinical conditions. This indicated that internet hospitals played the role of the family doctor, which helped to relieve the stress placed on offline hospitals and facilitated people's lives. In addition, good user experiences, especially regarding disease-related inquiries, suggested that online health services can help solve health problems. With support from the government and acceptance by the public, online health care services could develop at a fast pace and greatly benefit people's daily lives.

COMMENT (NPW): The authors of this paper all worked for Ping An Healthcare Technologies, which may well have introduced bias. In contrast with the paper from India I shared earlier today (which showed 75% of telemedicine patients were men) this China study indicates that younger women are most likely to use the Ping An Good Doctor service.

#### **EHS-COVID (480) Q2 How have you responded to the challenges of COVID-19? (6) Digital health (4)**

HIFA is assisting WHO to develop a collection of Action Briefs, which you can review here (including two Action Briefs based on HIFA discussions):

<https://hlh.who.int/action-briefs>

If you have an innovative approach to share on maintaining essential health services during COVID-19, please submit your Action Brief here: <https://extranet.who.int/dataformv3/index.php/813253?lang=en>

Meanwhile, I would like to recommend this Action Brief by HIFA member Arvind Mathur (WHO Representative, Maldives)

The use of digital technology to optimise service delivery platforms

Dr Arvind Mathur, WHO Representative, Maldives

<https://hlh.who.int/ab-detail/the-use-of-digital-health-technologies-to-...>

Key Learning Points

- Digital health strategies can play a key role in maintaining the continuity of essential health services across all levels of the health system.
- Scaling up such interventions in a short time period can present particular challenges with regards to governance and interoperability with

existing platforms.

- Integration of digital health into existing service delivery platforms may have unintended consequences, i.e. widening inequities for vulnerable and marginal populations who may not have access to, or familiarity with, telemedicine platforms.

#### EXTRACTS

'During the lockdown, service delivery platforms were optimized to maintain essential health services. This included strengthening digital health services by leveraging existing internet connectivity in the country...

'Telemedicine services were scaled up to allow for online consultations between health workers and patients at the primary health care level. This was supplemented by electronic prescription of regular medications for vulnerable groups (i.e. patients in long term care facilities or with chronic, complex health conditions). Furthermore, a tele-consultation programme was developed with partner hospitals in India to provide specialist clinical input for patients with complex health conditions in secondary and tertiary care, who were unable to travel abroad for treatment. This was to mitigate the impact of international travel restrictions due to the pandemic...

'A particular challenge in scaling up these interventions was limited in-house technical expertise in establishing online service delivery platforms... The lack of an integrated electronic patient record system within health facilities hampered communication and continuity between different providers.'

#### **EHS-COVID (481) Q3 What have we learned to better support health workers? (3) Lessons from the frontlines: Sri Lanka**

Are you a frontline health worker? WHO and HIFA would really like to hear from you here on the HIFA forum. What has been your experience during COVID-19? What changes need to be put in place to empower you for future waves of this pandemic, and for future pandemics (which may be even worse; see Greg Martin's latest global health video here: <https://www.youtube.com/watch?v=zjTy0NUgly4> ).

Below is a testimony from a frontline junior doctor in Sri Lanka:

CITATION: Lessons from the Frontlines: A Junior Doctor's Experience of the First Wave of the COVID-19 Epidemic in a Resource-Limited Setting

September 17, 2021

Brabakaran Subhani (and Dilushi Wijayaratne)

<https://blogs.bmj.com/medical-humanities/2021/09/17/lessons-from-the-fro...>

#### EXTRACTS

'As a house officer involved on the front line of patient care, I (BS) had a front-row seat to the pandemic... There was palpable fear among health workers... None had received training in the use of personal protective equipment (PPE)...'

'Sometimes I wonder if our patient care focused more on the safety of the public than on the welfare of the individual patient? Did we truly respect patient autonomy and the principle of justice in care?...'

'COVID-19 is taking a huge toll on the mental well-being of health care workers, more so as the condition continues to wax and wane. Understanding the empathetic distress experienced by the health staff and coping with it through compassion training is important for the well-being of both staff and patients. Formal psychosocial support needs to be made available to the staff.'

'There is a need for major structural changes in the wards in our hospitals so that systemic adherence to infection control measures can be instituted...'

'Read the full article on the Medical Humanities journal website. <https://mh.bmj.com/content/47/3/380>

#### **EHS-COVID (482) The Peltzman effect - Risk compensation**

The WHO recently reported concerns of a false sense of security and overprotection through COVID-19 vaccinations in many countries. It believes that public health measures like social distancing, hand hygiene and masking are not required post-vaccination. Such a behavioral inception has led to a significant global resurgence in COVID-19 incidence.

'The Peltzman Effect' given by economics professor Sam Peltzman in 1975 describes the phenomenon of 'Risk Compensation' i.e. people are more likely to engage in risk-taking behaviour when protective measures are in place; which is counter-productive. It also explains that simply observing someone else taking a precaution can potentially increase one's likelihood of taking a risk (bystander effect). Its relevance in context of COVID-19 is observed as-

- 1) Decreased compliance to public health measures post-vaccination (even at vaccination centres, social distancing protocols and masking are not followed)
- 2) Increase in COVID-19 incidence in many countries and communities
- 3) Bystander effect: "If the person next to you is wearing a mask/is vaccinated, you are less likely to do so" (A perceived sense of low risk implies an increased chance of engaging in risk taking behavior)
- 4) Public misinformation and unawareness may encourage risk-taking behaviour
- 5) Role of 'Pandemic fatigue' in risk compensation

Attached herewith is the link to an article on the 'Influence of the Peltzman effect on the recurrent COVID-19 waves in Europe'

Full text link- <https://pmj.bmj.com/content/early/2021/04/28/postgradmedj-2021-140234>

Citation: Iyengar KP, Ish P, Botchu R, et al. Influence of the Peltzman effect on the recurrent COVID-19 waves in Europe Postgraduate Medical Journal Published Online First: 29 April 2021. doi: 10.1136/postgradmedj-2021-140234

Question- As overburdened and under equipped healthcare infrastructures recover from the disruption of essential healthcare services, how might we bypass the 'Peltzman effect' to ensure effectiveness of public health interventions?

Looking forward to hearing about your perspectives :)

### **EHS-COVID (483) Q1 What have we learned? (8) Lessons learned from Nigeria**

This paper in Pan African Medical Journal surveyed health workers in Nigeria and found that 'fear of nosocomial infection, fear of stigmatization, and misconception/misinformation on COVID-19 diseases and care' are the main causes for reduced utilisation of health services. Citation, abstract and two comments from me below.

CITATION: Perceived impact of coronavirus pandemic on uptake of healthcare services in South West Nigeria

Olamide Olajumoke Afolalu et al.

Pan Afr Med J 2021 Sep 9;40:26. doi: 10.11604/pamj.2021.40.26.28279. eCollection 2021.

PMID: 34733394 PMCID: PMC8531964 DOI: 10.11604/pamj.2021.40.26.28279

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8531964/>

#### ABSTRACT

**Introduction:** the COVID-19 pandemic since its emergence has posed a great danger to the health of the general populace while impacting the Nigerian healthcare delivery significantly. Since its emergence, the health system has been stretched with overwhelming responsibilities. The study assessed health providers' perceived impact of coronavirus pandemic on the uptake of health care services in South West Nigeria.

**Methods:** a descriptive cross-sectional design using an online structured survey was used to elicit responses from 385 Nigerian health workers selected by convenience sampling technique. Data analysis was done with the Statistical Package for Social Sciences (SPSS) version 26. Comparison of the uptake of healthcare before and during the COVID-19 pandemic was performed using the Chi-square test.

**Results:** findings revealed a significant difference between the uptake of health care prior and during the COVID-19 pandemic ( $\chi^2= 92.77$ ,  $p=0.000$ ) as 253 respondents (65.7%) reported that the hospital recorded a low turn-out of patients during the pandemic and 184 (47.8%) indicated that some of the facility units/departments were temporarily closed due to COVID-19 pandemic. Similarly, there was a significant difference between health-related conditions requiring hospital admission before and during COVID-19 pandemic ( $\chi^2=3.334$   $p=0.046$ ). Factors influencing uptake of health services during the COVID-19 pandemic are: fear of nosocomial infection, fear of stigmatization, and misconception/misinformation on COVID-19 diseases and care.

**Conclusion:** the Nigerian health system in the past months has been remarkably impacted by the pandemic. This calls for immediate restructuring to maintain an equitable distribution of care, while minimizing risk to patients and health providers.

#### COMMENTS (NPW):

1. Can anyone say more about 'fear of stigmatization'? Is there actual stigmatisation of patients with COVID-19 and if so, why? How might this be addressed?

2. The authors note that 'the Nigerian health system in the past months has been remarkably impacted by the pandemic'. This is despite the fact that the caseload has (to date) been relatively low as compared with other countries. A caseload similar to that seen in Europe, the Americas or South Asia could therefore be devastating in Nigeria. What needs to be done to strengthen the resilience of Nigeria to future pandemics?

### **EHS-COVID (484) Q2 How have you responded to the challenges of COVID-19? (7) Digital health (5)**

WHO is developing a collection of Action Briefs on Maintaining essential health services during the pandemic (and beyond): <https://hlh.who.int/action-briefs>

One of these, from the ESTHER Alliance for Global Health Partnerships, looks at 'The use of digital platforms in maintaining essential health services'

Key points and a comment from me below. Full text here: <https://hlh.who.int/ab-detail/the-use-of-digital-platforms-in-maintainin...>

- International partnerships can play a crucial role in developing and maintaining essential health services in LMICs.
- The adoption of digital learning strategies during the pandemic was an important element in maintaining essential health services in diverse settings.
- The development of webinars centred on the needs of participants, combined with an integrated social media campaign, were effective in driving engagement.
- How has COVID-19 impacted your organisation in delivering essential health services?
- Institutional North-South partnerships play an important role in developing essential services in low and middle-income countries (LMICs). Due to travel restrictions and reduced availability for collaboration COVID-19 has disrupted North-South institutional partnership programmes addressing essential health services.

'The ESTHER Alliance and Irish Global Health Network launched a webinar series 'Conversations on COVID-19' via Zoom with a specific focus on LMICs. The webinar series was aimed at healthcare and development workers, serving to educate, inform, share best practice and evidence-based responses around COVID-19 in LMICs. Most topics directly or indirectly addressed the challenges of maintaining health services in the context of the pandemic.'

'Topics relating to essential services included: Funding Challenges; Hospital Readiness; North-South Partnerships during COVID-19; Lessons learned from HIV & Ebola epidemics; Leveraging Research and Evidence; Protecting Health Care Workers; Health Systems Impacts of COVID-19; Essential Services for NCD Patients in Ethiopia; Malnutrition...'

Outcomes included:

- Supported countries in maintaining essential health services.
- Responded to travel restrictions with alternative way for partners to meet and share learnings.
- Webinars were effective in capturing and sharing learning at sub national level.
- Demonstrated value of North-South partnership model at a time of significant disruption.

COMMENT (NPW): The use of web conferencing tools has clearly been hugely important for North-South partnership communication. Would anyone like to comment on their use for national and subnational communications to maintain essential health services? What are the benefits and challenges compared to face-to-face meetings?

#### **EHS-COVID (485) Q2 How have you responded to the challenges of COVID-19? (8) Digital health (6)**

THET, ESTHER Alliance and ACHEST held a virtual conference on "Partnerships in the time of COVID". Learning points and key reflections can be found here.

<https://www.thet.org/resources/partnerships-in-a-time-of-covid-19-learni...>

#### **SELECTED EXTRACTS**

Eunice Sinyemu, THET, noted that “the stigma associated with Covid-19 is far higher than that associated with HIV.”

'There exist exciting new developments in wider online opportunities with the launch of the WHO's HLH which can support the maintenance of essential health services.#



'The Health Partnership community can provide the critical support that is required to maintain quality essential health services.'

'Health workers should be supported through their associations to learn to advocate to health leaders and politicians to dispel misinformation that can have adverse effects on health seeking behaviour.'

'In particular, we highlight the following:

1. Protect health workers both physically and psychologically.
2. Develop context specific approaches, then learn and adapt if necessary.
3. Maintain quality essential health services to ensure we have functioning health systems when the pandemic is finally under control.
4. Fight misinformation to support health workers safely deliver vital services.
5. Advocate for vaccine roll out to ensure equity of access to Covid as well as to future vaccines.'

### **EHS-COVID (486) World Stroke Day 29 October (3)**

A few weeks ago I posted on HIFA a press release from WHO about stroke in SE Asia [ <https://www.hifa.org/dgroups-rss/ehs-covid-456-world-stroke-day-29-octob...> ] and I added this question at the bottom of my message:

"In the context of our WHO-supported discussion on Essential health services during COVID, can anyone share experience on the availability of quality health services for people with stroke? I suspect many people will have had delayed or absent care, and that a negative outcome (death or permanent disability) will have been increased."

Our HIFA literature search expert John Evers has kindly run a search for us, and we found just one paper relating to stroke care during COVID-19. Citation, abstract and a comment from me below.

CITATION: Decrease in Hospital Admissions for Transient Ischemic Attack, Mild, and Moderate Stroke During the COVID-19 Era

Henrique Diegoli, Pedro S.C. Magalhães, Sheila C.O. Martins, Carla H.C. Moro, Paulo H.C. França, Juliana Safanelli, Vivian Nagel, Vanessa G.

Venancio, Rafaela B. Liberato, Alexandre L. Longo

Originally published 12 Jun 2020

<https://doi.org/10.1161/STROKEAHA.120.030481> Stroke. 2020;51:2315–2321

#### ABSTRACT

**Background and Purpose:** Since the onset of the coronavirus disease 2019 (COVID-19) pandemic, doctors and public authorities have demonstrated concern about the reduction in quality of care for other health conditions due to social restrictions and lack of resources. Using a population-based stroke registry, we investigated the impact of the onset of the COVID-19 pandemic in stroke admissions in Joinville, Brazil.

**Methods:** Patients admitted after the onset of COVID-19 restrictions in the city (defined as March 17, 2020) were compared with those admitted in 2019. We analyzed differences between stroke incidence, types, severity, reperfusion therapies, and time from stroke onset to admission. Statistical tests were also performed to compare the 30 days before and after COVID-19 to the same period in 2019.

**Results:** We observed a decrease in total stroke admissions from an average of 12.9/100 000 per month in 2019 to 8.3 after COVID-19 ( $P=0.0029$ ). When compared with the same period in 2019, there was a 36.4% reduction in stroke admissions. There was no difference in admissions for severe stroke (National Institutes of Health Stroke Scale score  $>8$ ), intraparenchymal hemorrhage, and subarachnoid hemorrhage.

**Conclusions:** The onset of COVID-19 was correlated with a reduction in admissions for transient, mild, and moderate strokes. Given the need to prevent the worsening of symptoms and the occurrence of medical complications in these groups, a reorganization of the stroke-care networks is necessary to reduce collateral damage caused by COVID-19.

**COMMENT:** The authors hypothesize that patients with stroke are 'not seeking hospital care... Patients may be reluctant to seek hospital care for fear of becoming infected...' There are other reasons, such as 'some people may be confused about stay-at-home orders meant to slow the spread of COVID-19'. However, from my perspective of reading HIFA messages, this fear of becoming infected as the result of attending a health facility appears to be a massive issue for patients with stroke and other non-communicable diseases. It seems likely that this will inevitably result in poor health outcomes from those diseases, over and above any risk of nosocomial infection. I would be interested to hear observations and thoughts from others.

**EHS-COVID (487) Despite COVID-19 connectivity boost, world's poorest left far behind**

A UN news item notes there was a sharp rise in the number of people online since 2019, which appears to be largely due to the pandemic. 'There were an estimated 782 million additional people who went online since 2019, an increase of 17 per cent due to measures such as lockdowns, school closures and the need to access services like remote banking.' Previous annual rises were around 10%.

<https://news.un.org/en/story/2021/12/1106862>

The item links to the latest report from the International Telecommunications Union - Measuring digital development: Facts and Figures 2021 -

<https://www.itu.int/itu-d/reports/statistics/facts-figures-2021/>

'The UN agency's report found that the unusually sharp rise in the number of people online suggests that measures taken during the pandemic contributed to the "COVID connectivity boost."

Nevertheless, '2.9 billion people still have never used the internet, and 96 per cent live in developing countries... Internet access is often unaffordable in poorer nations and almost three-quarters of people have never been online in the 46 least-developed countries'.

In relation to our discussion on Maintaining essential health services, this report is important because it reminds us that huge numbers of people are unable to access the digital health innovations that we have been discussing. The digital divide is further widening the health divide, combining to accelerate inequalities.

#### **EHS-COVID (488) World Stroke Day 29 October (4)**

Thinking back to the UK press stories about ICUs not being able to cope, health care staff dying from contact with patients at service provision centres, taking into account the generally limited active surgical anatomical interventions that are available for strokes and the complexity of deciding who would benefit from these interventions, a decision not to seek hospital care by patients and doctors is not so surprising?

Patients make clinical decisions, too, as well as doctors described in the UK GMC's <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/dec...> There were no Cochrane databases to help balanced decisions between the risks of entering hospital for intensive investigations and possibly catching COVID and staying at home. A difficult call?

#### **EHS-COVID (489) WHO: Presentation of Preliminary Results of 2021 Assessment on NCD Service Disruption during COVID-19 Pandemic**

This PowerPoint presentation reveals the priorities expressed by countries. It's notable that they are almost all directly related to HIFA: how to produce, synthesise, package, make accessible, interpret, and apply information.

<https://cdn.who.int/media/docs/default-source/ncds/ncd-surveillance/ncd-...>

Ask 1: Guidance on how to provide continuity for NCD programmes:

- How to include NCDs in public health emergencies protocols?
- How to develop national NCDs tool kits for use in emergencies?
- How to provide ambulatory essential NCD services during lockdown?
- How to provide medical care for NCDs through telemedicine and digital solutions?
- Technical, including digital, tools to promote self-care for those with NCDs who can't access services.
- How to prioritize which services to restart and when?
- Updated guidance on management of NCDs reflecting the stage of the pandemic.

Ask 2: Guidance on managing COVID and NCDs comorbidity:

- Guidelines on COVID vaccination protocols for those with NCD comorbidities
- How to provide appropriate treatment for COVID patients with NCD comorbidities?
- How to protect people living with NCDs? (e.g. clinical guidelines, drug interactions)?
- Algorithms for managing patients with chronic NCDs in a pandemic and limited access to medical care
- Guidance on how to prioritize NCDs after the COVID pandemic has been managed

Ask 3: Better data...

Ask 4: Country support

- Provide training (especially online training) for policy makers on how to include NCDs into national COVID-19 plans
- Provide training for WHO Country Offices and UN Country Teams on how to include NCDs into national COVID-19 plans
- Provide technical assistance to adapt HEARTS and WHO-PEN packages to the COVID-19 context
- Provide clinical definitions and indicators for COVID and NCD comorbidity

#### **EHS-COVID (490) Access to family planning information and services in Uganda during COVID-19**

Extract below from the IntraHealth website and a comment from me. Full text here: <https://www.intrahealth.org/vital/how-connect-young-ugandans-family-plan...>

In Uganda, COVID-19 related restrictions such as lockdowns and school closures led to pregnancies for over 90,000 girls under 18.

These statistics demonstrate how critical it is to help women of reproductive age make informed decisions regarding sexual relationships, contraceptive use, and reproductive health.

To do this, family planning services are key. IntraHealth International, through the USAID-funded Regional Health Integration to Enhance Services in Eastern Uganda (RHITES-E) project, works with the Uganda Ministry of Health to implement a comprehensive program in the eastern Uganda and Karamoja regions that offers clients services in family planning, HIV, and maternal, neonatal, and child health.

Here are six approaches the project uses during COVID-19 lockdowns to improve services for young women and girls:

Community youth-only dialogues...

Our team identified and trained youth champions who now promote the use of a Ministry of Health toll-free line and the Uganda Child Helpline for online counseling services for adolescents and youth. And a new WhatsApp group promotes sexual and reproductive health discussions by

creating a safe space for young people to share experiences and ideas about teenage pregnancies and sexual and other forms of gender-based violence...

Community mobile clinics...

Due to COVID-19 travel restrictions, RHITES-E used family planning mobile clinics...

Civil society engagement...

The local organizations conducted youth-focused community dialogue meetings (by gender and age), home visits, and community sensitization meetings in eight local districts. These included family planning and HIV health education, dispelling myths and misconceptions, and emphasizing the importance of HIV testing. They also provided referrals for services at the nearest health facilities or outreach clinics if needed.

A role for cultural and traditional leaders...

RHITES-E worked with cultural and religious leaders to help them talk to youth about sexual and reproductive health services...

Client-centered approaches like these can bring services to the community and help more women and girls get the services they need—even during a pandemic.

COMMENT (NPW): This approach looks commendable and embraces many of the recommendations that have been previously discussed on HIFA. Are you working in family planning or sexual and reproductive health? Does the above resonate with your experience? Is it implementable in your context, or are these kinds of services only available to limited numbers of people in the context of donor-supported projects?

### **EHS-COVID (491) Use of evidence in humanitarian settings**

CITATION: Use of COVID-19 evidence in humanitarian settings: the need for dynamic guidance adapted to changing humanitarian crisis contexts.

Odlum A et al.

Confl Health. 2021 Nov 19;15(1):83. doi: 10.1186/s13031-021-00418-w.

<https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-021-...>

**BACKGROUND:** For humanitarian organisations to respond effectively to complex crises, they require access to up-to-date evidence-based guidance. The COVID-19 crisis has highlighted the importance of updating global guidance to context-specific and evolving needs in humanitarian settings. Our study aimed to understand the use of evidence-based guidance in humanitarian responses during COVID-19. Primary data collected during the rapidly evolving pandemic sheds new light on evidence-use processes in humanitarian response.

**METHODS:** We collected and analysed COVID-19 guidance documents, and conducted semi-structured interviews remotely with a variety of humanitarian organisations responding and adapting to the COVID-19 pandemic. We used the COVID-19 Humanitarian platform, a website established by three universities in March 2020, to solicit, collate and document these experiences and knowledge.

**RESULTS:** We analysed 131 guidance documents and conducted 80 interviews with humanitarian organisations, generating 61 published field experiences. Although COVID-19 guidance was quickly developed and disseminated in the initial phases of the crisis (from January to May 2020), updates or ongoing revision of the guidance has been limited. Interviews conducted between April and September 2020 showed that humanitarian organisations have responded to COVID-19 in innovative and context-specific ways, but have often had to adapt existing guidance to inform their operations in complex humanitarian settings.

**CONCLUSIONS:** Experiences from the field indicate that humanitarian organisations consulted guidance to respond and adapt to COVID-19, but whether referring to available guidance indicates evidence use depends on its accessibility, coherence, contextual relevance and trustworthiness. Feedback loops through online platforms like the COVID-19 Humanitarian platform (<https://www.covid19humanitarian.com/>) that relay details of these evidence-use processes to global guidance setters could improve future humanitarian response.

#### SELECTED EXTRACTS

'The lack of primary evidence on COVID-19 opened an opportunity for information initiatives to compile and curate pre-existing wisdom from past epidemics, and to screen emerging evidence and guidance for quality and relevance. An example of this was Blanchet et al. who developed a list of 120 essential non-COVID-19 health interventions that needed to be maintained in poor countries based on existing model health benefit packages [22].'

'In multiple cases, organisations at national and local levels adapted or generated guidelines with assistance from their global headquarters.'

**COMMENT:** Are you working, or have worked, in a humanitarian setting during COVID-19? Please share your experience in an email to: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

## **EHS-COVID (492) HLH Learning Brief: The role of compassion in maintaining EHS during the COVID-19 pandemic**

The word 'compassion' has been used 77 times already on HIFA in 2021, compared with 27 times in 2020 and just 9 times in 2019. This increased focus on compassion is largely thanks to WHO's support of our current discussions on Learning for quality health services and Maintaining essential health services during COVID-19 and beyond. The WHO Global Learning Laboratory for Quality UHC describes compassion as 'the heart of quality people-centred health

services'.

This learning brief from the WHO Health Services Learning Hub explores the interface of our two thematic discussions: The role of compassion in maintaining essential health services during the COVID-19 pandemic

Below are the key learning themes. Read in full here: <https://hlh.who.int/ab-detail/the-role-of-compassion-in-maintaining-ehs-...>

Compassion arises from:

Awareness of human suffering.

Emotional resonance with that suffering (empathy).

Action (or a desire) to relieve that suffering.

In other words, awareness + empathy + action = compassion.

Compassion fuels commitment and innovation to address global health threats, like the effect of COVID-19 on disruption of essential health services, healthcare worker burnout, and collective social trauma.

On an individual level, the biggest impact compassion can make in the delivery of health services is recognizing the whole person, both for those who give and those who receive health services.



On a health provider level, compassionate support of health care workers is critical to their well-being and personal resilience, to mitigating burnout, and to the sustainability of the healthcare workforce to maintain essential health services.

On a leadership/organizational level, it is necessary for organizations to build cultures of compassion - looking after staff and each other as colleagues enables organizations to serve populations in maintaining essential health services. "Be well to serve well".

I invite HIFA members to share your thoughts about the role of compassion in maintaining essential health services. Can you share any examples of personal experience of compassion in your work, whether emanating from yourself, colleagues, relatives or patients? Some people have suggested one can have too much compassion, but my understanding is that the opposite is true. Too much empathy alone will indeed lead to burnout, whereas compassion is boundless and protects against burnout.

#### **EHS-COVID (493) What tools are available to help policymakers contextualise the WHO guidance on Maintaining essential health services?**

In a previous message we asked 'What tools are available to help policymakers contextualise the WHO guidance on Maintaining essential health services during the COVID-19 pandemic?'

<https://www.hifa.org/dgroups-rss/ehs-covid-241-what-are-essential-health...>

We haven't yet heard any examples of such tools, nor examples of how the WHO guidance has been put into practice. If you are aware of such examples, please share: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

This is important for many reasons, not least that the current guidance is described as 'interim', indicating that it will be updated and revised in accordance not only with new evidence, but also informed by the inputs of those (us and others) who use and apply the guidance. Does the guidance address the necessary issues adequately? Is it practical and pragmatic? Can the guidance be readily contextualised for use at country, subnational or facility level?

#### **EHS-COVID (494) WHO: Tuberculosis deaths rise (4) GHSP: Lessons Learned During the COVID-19 Pandemic to Strengthen TB Infection Control: A Rapid Review**

A few weeks ago we learned from WHO about a rise in tuberculosis deaths during the pandemic, and we heard from HIFA member Chiabi Bernard Ful, Cameroon about the challenges of tuberculosis control in his country <https://www.hifa.org/dgroups-rss/ehs-covid-451-who-tuberculosis-deaths-r...>

This paper from GHSP describes Lessons Learned During the COVID-19 Pandemic to Strengthen TB Infection Control.

'The coronavirus disease (COVID-19) pandemic has hindered access and availability of TB services to maintain robust TB control. The objective of this rapid review was to describe the challenges to be addressed and recommendations to strengthen health system preparedness for optimal TB control across low- and middle-income countries during and after the COVID-19 pandemic.'

CITATION: Lessons Learned During the COVID-19 Pandemic to Strengthen TB Infection Control: A Rapid Review

Helena J. Chapman and Bienvenido A. Veras-Estévez

Global Health: Science and Practice November 2021, <https://doi.org/10.9745/GHSP-D-21-00368>

#### KEY FINDINGS

Current challenges in TB control efforts, such as an unprepared public health system leadership and infrastructure and an overwhelmed health care workforce, will require novel approaches, practices, and renewed political commitment to maintain sustainable TB programs.

We described proposed recommendations that may strengthen health system preparedness for optimal TB control across low- and middle-income countries:

Ensuring leadership and governance for sustainable national health care budgets

Building networks of community stakeholders

Supporting high-quality health care workforce training and safe workplace environments

Using digital health interventions for TB care

#### KEY IMPLICATIONS

National health systems should develop national policies that promote integral, patient-centered TB care, facilitate the implementation of ethical community interventions, support operational research, and allow the integration of appropriate eHealth applications.

Program managers who understand challenges in TB prevention and control with coexisting health priorities can serve as instrumental leaders and patient advocates to deliver high-quality and sustainable TB care that leads to achieving targets of the End TB Strategy.

#### SELECTED EXTRACT

'A competent health care workforce must be prepared with appropriate knowledge and skills to simultaneously manage endemic and emerging health threats. Health care workers should receive adequate training, appropriate incentives to provide care, and mental health and psychosocial support.<sup>36,41</sup> Continuing education programs can offer up-to-date information about clinical guidelines, best practices, public health principles, and timely health topics... Community fora can offer public platforms to share and discuss evidence-based findings that can promote a call to action for policy changes.'

#### **EHS-COVID (495) Q4 Reduced demand for non-urgent essential health services (3)**

This paper concludes: 'In this population-based cross-sectional study, 1 in 5 individuals avoided healthcare during lockdown in the COVID-19 pandemic, often for potentially urgent symptoms. Healthcare avoidance was strongly associated with female sex, fragile self-appreciated health, and high levels of depression and anxiety. These results emphasise the need for targeted public education urging these vulnerable patients to timely seek medical care for their symptoms to mitigate major health consequences.'

Citation and comment from me below.

CITATION: Prevalence and determinants of healthcare avoidance during the COVID-19 pandemic: A population-based cross-sectional study

Marije J. Splinter, Premysl Velek, M. Kamran Ikram, Brenda C. T. Kieboom, Robin P. Peeters, Patrick J. E. Bindels, M. Arfan Ikram, Frank J. Wolters, Maarten J. G. Leening, Evelien I. T. de Schepper, Silvan Licher

PLOS Medicine, Published: November 23, 2021

<https://doi.org/10.1371/journal.pmed.1003854>

COMMENT (NPW): The paper is from the Netherlands, and it seems likely that healthcare avoidance would show variability between different countries. As we have discussed on HIFA, healthcare avoidance during the pandemic is associated with fear of becoming infected with COVID-19 as a result of seeking health care. What remains unknown is the extent to which fear might be exaggerated, leading to greater health risks as a result of not seeking care. It is also unclear what is the actual risk of contracting COVID-19 as a result of seeking care. Patients and families inevitably face great uncertainties when making decisions about care. The advice from the UK National Health Service is apposite: "At the moment it can be hard to know what to do if you're unwell or have a concern about your health. It's important to get medical help if you think you need it..." <https://www.nhs.uk/conditions/coronavirus-covid-19/using-the-nhs-and-oth...> What is the situation in your country?

### **EHS-COVID (496) What have we learned about policy development during a pandemic?**

Thank you for all you have shared to date on HIFA. The lessons learned from all these exchanges will help others to build resilient health systems that are better prepared for any future SARS-COV-2 variants and indeed future pandemics. Part of this resilience is the ability of countries to develop and implement evidence-informed policy and I invite you to consider the issue of how to strengthen national policy development.

We have previously discussed on HIFA the challenges of policymakers and public health professionals in developing national policy. In particular, policy development needs to take into account a range of issues, including global evidence and guidance (such as the current WHO guidance on Maintaining essential health services during COVID-19); local research and routine data; stakeholder inputs (including civil society); and of course political factors that may push policy in different directions. These challenges are especially difficult in a fluid and emergency situation such as the current pandemic, and in countries with relatively weak capacity. We have seen that even high-income countries have 'messed up' when it comes to policy development. How much more difficult it must be for LMICs.

Have you been involved as a public health professional or policymaker in policy development and/or implementation at country, subnational or facility level in relation to the current pandemic? Or have you helped to produce, synthesise or package the evidence that such decision-makers need?

If so, we would really like to learn from your experience. Please email HIFA: [hifa@hifaforums.org](mailto:hifa@hifaforums.org)

### **EHS-COVID (497) What have we learned about policy development? (2)**

From my experience as part of the Zimbabwe National COVID-19 response team, I have noted that in a pandemic situation there is need to be flexible in coming up with and implementing policy. In my opinion, a very critical aspect that contributed to the ability to be dynamic and evaluate policies as the pandemic unfolded was the way the governance structures of the pandemic response were organised with clearly spelt of terms of reference. This allowed stakeholders to have timely input into policy. One other important aspect was the availability of daily data

from the Surveillance Pillar in terms of the pandemic. Data elements were added to cater for different data needs. Analysis was timely and allowed for adjustment for policy. It was also quick to come up with policies as there was already a system that was in place to respond to other pandemics. Adopting already existing policies for the COVID 19 pandemic contributed to the quick response.

### **EHS-COVID (498) What have we learned about policy development during a pandemic? (3)**

Some HIFA members may find the following interesting

Apropos policy responses to COVID-19, here's a unique resource from India: <https://covid-19-constitution.in/> The 'COVID-19 and the Constitution' timeline is a web-based resource conceptualized and developed by Centre for Health Equity, Law and Policy (<https://www.c-help.org/>) to document India's legal and policy response to the pandemic and contextualize it within fundamental rights guaranteed in the Indian Constitution. The timeline also offers illustrated personal narratives and experiences of citizens' varied struggles, along with critical commentary on emerging issues that implicate fundamental rights. It is hoped that the project will serve to place health challenges within rights-based discourses, and provoke thought on these intersections. For more information please write to [contact@c-help.org](mailto:contact@c-help.org)

### **EHS-COVID (499) What have we learned about policy development during a pandemic? (4) Using patient data to inform public health**

A significant change in England was the issue of COPI notices. These notices on behalf of the Director of Policy and Strategy, NHSX, Department of Health and Social Care On behalf of the Secretary of State for Health and Social Care increased the sharing of personal health data during the pandemic.

From listening to various national and international webinars I have the feeling that these notices will be extended and that the increased data sharing will result permanently.

Here is the link and below it is an extract of the letter. [\*see note below]

<https://digital.nhs.uk/coronavirus/coronavirus-covid-19-response-informa...>

Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002

The health and social care system is taking action to manage and mitigate the spread and impact of the current outbreak of Covid-19. Action to be taken will require the sharing of confidential patient information amongst health organisations and other appropriate bodies for the purposes of protecting public health, providing healthcare services to the public and monitoring and managing the outbreak.

I am therefore writing to you to serve notice on the Health and Social Care Information Centre, known as NHS Digital, under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002 (COPI) to require NHS Digital to process confidential patient information in the manner set out below for purposes set out in Regulation 3(1) of COPI (insofar as those purposes relate to the current outbreak of Covid-19).

#### 1. Purpose of this Notice

The purpose of this Notice is to provide NHS Digital with the necessary statutory power to disseminate confidential patient information to organisations permitted to process confidential patient information under Regulation 3(3) of COPI for the purposes set out in Regulation 3(1) of COPI to support the Secretary of State's response to Covid-19 (Covid-19 Purpose).

Page 2 of 3

I consider this Notice is necessary so that NHS Digital can lawfully and efficiently disseminate confidential patient information to those organisations set out in Regulation 3(3) of COPI being persons employed or engaged for the purposes of the health service or other persons employed or engaged by a Government Department or other public authority in communicable disease surveillance in connection with the health and social care system's management of the response to Covid-19.

#### **EHS-COVID (499) COVID contributed to 69,000 malaria deaths WHO finds, though 'doomsday scenario' averted**

This Malaria report may assist discussions about essential health services during COVID.

<https://news.un.org/en/story/2021/12/1107162>

#### **EHS-COVID (500) Register for "State of Health in the EU – Country Health Profiles 2021 and Companion Report" (Mon 13 Dec, 10:30-11:30 CET)**

May be of interest to HIFA members and may discuss changes to essential services during covid19.

----- Forwarded message -----

From European Observatory on Health Systems and Policies <

[europeanobservatory@campaign.who.int](mailto:europeanobservatory@campaign.who.int)>

Date Tue, 7 Dec 2021, 09:01

Subject Register for "State of Health in the EU – Country Health Profiles

2021 and Companion Report" (Mon 13 Dec, 10:30-11:30 CET)

Virtual Launch Event on 13 Dec 10:30 CET

\*Monday, 13 December 2021\*

\*10:30 - 11:30 CET\*

\*State of Health in the EU – Country Health Profiles 2021 and Companion Report\*

We invite you to join this webinar to find out more about the Country Health Profiles 2021 and the Companion Report, focusing on the resilience of health systems in the face of the COVID-19 pandemic in Europe.

High-level representatives from the European Commission, the OECD and the European Observatory on Health Systems and Policies will present key findings from the new series of Country Health Profiles (EU27 + Iceland and Norway) and the Companion Report that highlights a selection of cross-cutting issues drawn from the Country Health Profiles and showcases the responses to the COVID-19 pandemic.

The Country Health Profiles and Companion Report are part of the State of Health in the EU cycle, which is a two-year recurring project that the European Commission has been carrying out in partnership with the OECD and the European Observatory on Health Systems and Policies since 2016.

The 2021 Country Health Profiles and Companion report will be available on 13 December on the websites of the Observatory <<https://europeanobservatory.cmail19.com/t/d-l-adjlrst-tunhhyhut-y/>>, the OECD <<https://europeanobservatory.cmail19.com/t/d-l-adjlrst-tunhhyhut-j/>> and the European Commission <<https://europeanobservatory.cmail19.com/t/d-l-adjlrst-tunhhyhut-d/>>.

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Moderation: Maya Matthews, Head of Unit, Performance of National Health Systems, European Commission

\*10:30-10:35 Opening remarks\*

- Sandra Gallina, Director General for Health and Food Safety, European Commission

\*10:35-11:00 Presentation of the Country Profiles 2021\*

- Stefano Scarpetta, Director, Employment, Labour and Social Affairs, OEC

- Josep Figueras, Director, European Observatory on Health Systems and Policies

\*11:00-11:25 Presentation of the Companion Report 2021: European health systems resilience in the face of the COVID-19 pandemic (followed by Q&A)\*

- Andrzej Rys, Director, Health Systems, Medical Products and Innovation, Directorate-General for Health and Food Safety, European Commission

\*11:25-11:30 Concluding remarks\*

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## **EHS-COVID (501) COVID contributed to 69,000 malaria deaths WHO finds, though 'doomsday scenario' averted (2)**

Thank you Richard, Below are extracts from the new WHO report and a comment from me.

WHO Secretary-General Dr Tedros writes:

'There were an estimated 14 million more malaria cases and 47 000 more deaths in 2020 compared to 2019, due to disruptions to services during the pandemic. However, things could have been far worse if not for the efforts of malaria endemic countries to maintain services... critical 2020 milestones of WHO's global malaria strategy have been missed, and without immediate and dramatic action, the 2030 targets will not be met...'

From the report summary:

'With support from global, regional and national partners, countries have mounted an impressive response to adapt and implement WHO guidance to maintain essential malaria services during the pandemic.'

COMMENT (NPW): The initial impression is that there has been a large increase in malaria cases and deaths, but that WHO's worst-case scenario (a doubling of malaria deaths) has been averted thanks to a robust public response. However, our discussions on HIFA suggest that disruptions to essential health services in sub-Saharan Africa have been disproportionate to the relatively small caseloads of COVID-19 in Africa, as compared with Europe and the Americas. In addition to reviewing what did happen, it would be important to assess what *\*might\** have happened to malaria services (and all other essential services) if African countries had been hit by COVID-19 as hard as Europe and the Americas.

Read the full report: <https://cdn.who.int/media/docs/default-source/malaria/world-malaria-repo...>

## **EHS-COVID (502) Global Health Security Index**

The 2021 GHS Index launches today <https://www.ghsindex.org/2021launch/>. It 'measures the capacities of 195 countries to prepare for epidemics and pandemics. All countries remain dangerously unprepared for future epidemic and pandemic threats, including threats potentially more devastating than COVID-19.'

The Index shows that no country in the world is fully prepared for future pandemic or epidemic threats.

It also shows that most of the world's least prepared countries are in sub-Saharan Africa. This aligns with our previous observations on HIFA that disruptions to essential health services in sub-Saharan Africa have been disproportionate to the relatively small caseloads of COVID-19 as compared with Europe and the Americas. The implication is that a future pandemic (or future wave of the current pandemic) could be devastating for Africa in particular.

### **EHS-COVID (503) Global Health Security Index (2) NCDs and health system strengthening**

And it is not just only about non preparedness for the next epidemic or surges of this pandemic, but it is also about the silent epidemic that has ravaged sub Saharan Africa for decades and may just get worse as resources (rightly) are pumped into fighting this pandemic: the silent epidemic is the non communicable diseases, NCDs, including mental illness. Some have termed it triple whammy but it remains the case that before COVID19 some countries in Africa were beginning to make some improvement in their health indices but COVID19 may have almost wiped out any such progress, even with the relatively lower number of Covid morbidity and mortality. The reason is that African countries have remained almost at ground zero for decades with very weak health systems. What is needed are interventions that enable whole health sector and system change for better. Especially interventions that are context-designed and fit for purpose. Such interventions include the 12-Pillar Clinical Governance Programme that is suitable for the whole system, and PACK Programme that is tailored specifically for the primary health care tier. (PACK is Practical Approach to Care Kit). Both can be viewed for more information at: [www.hri-global.org](http://www.hri-global.org).

### **EHS-COVID (504) How to classify health services as 'essential' or 'non-essential'?**

As we enter the final weeks of our WHO-supported discussions on Maintaining essential health services, we can address any unanswered questions. This will help us synthesise the learning from the discussions, which have already generated more than 500 exchanges.

One of these, from a year ago: "Can anyone shed light on how services are classified as 'essential' or 'non-essential', with perhaps an example in practice across a country or a healthcare facility?"

<https://www.hifa.org/dgroups-rss/ehs-covid-138-covid-19-and-maternal-health>

### **EHS-COVID (505) How to classify health services as 'essential' or 'non-essential'? (2)**

In Massachusetts it was done by a decree:

<https://www.mass.gov/info-details/covid-19-essential-services>

## **EHS-COVID (506) Action Brief: Maintaining essential health services in Abia State, Nigeria**

Our colleagues at WHO Health Services Learning Hub have just published an Action Brief "Maintaining essential health services in Abia State, Nigeria".

Engagement of local community played a key role in mitigation of the COVID-19's impact on health services - see how else Abia State (Nigeria) is managing the pandemic:

<https://hlh.who.int/ab-detail/maintaining-essential-health-services-in-a...>

Key learning themes:

- Telemedicine played a crucial role in mitigating the impact of the COVID-19 pandemic and maintaining essential health services.
- Community Health Extension Workers (CHEWs) were instrumental in the implementation of an outreach postnatal service during the first COVID-19 lockdown. This formed part of a broader effort to ensure the maintenance of MNCH services in Abia State.
- Engagement with local community leaders was key in building trust in the delivery of modified services. This holistic approach also laid the foundation for combating COVID-19 vaccine hesitancy.

This Action Brief is an outcome of the HLH open call for submissions, find out more: [hlh@who.int](mailto:hlh@who.int)

## **EHS-COVID (507) How to classify health services as 'essential' or 'non-essential'? (2)**

I think the discussion around the word "essential" in health services is a really important and interesting one. I would like to put forward the argument that "essential" should refer to the set of effective services of lowest complexity and lowest cost that should be provided to everyone who needs them in all settings in the world. This is how it was used in a recent consensus around Essential Emergency and Critical Care that a global group published in September (declaration: I was one of the authors) <https://gh.bmj.com/content/6/9/e006585>

In my opinion, it is important to keep the content of "essential" packages simple and low-cost. Such care is likely to be cost-effective and is, by definition, the most feasible to introduce. Care that is simple and low-cost risks being under-prioritised or neglected if more high-tech or glamorous care are included in essential packages.

Settings with the resources to provide more than the essential care should do so - the argument is not to provide the essential care and then stop. Essential care should always be available and provided, and other care added as resources allow.

### **EHS-COVID (508) Oncology nursing in the Global South during COVID-19**

A new special issue published in *ecancer* includes narratives from oncology nurses across the world describing the psychosocial effects of the COVID-19 pandemic on their family and work lives.

Oncology nurses and their patients face a double burden in Lower and Middle Income Countries (LMICs), where resources are limited under normal circumstances and now must accommodate pandemic-related challenges. The special issue includes personal reports and narratives describing the the early psychosocial effects of the pandemic, for example lockdowns and increased staff shortages due to diversion to COVID-19 wards or vulnerable nurses with chronic conditions or pregnancy staying at home while some became infected with COVID-19 and died.

The significance of the oncology nurse’s contribution to the care of people with cancer is more relevant than ever before due to their role as the cornerstone of health services, either on the frontline offering compassionate care or in leadership, research and education.

The special issue is open access and can be read here: <https://ecancer.org/en/journal/special-issue/30-oncology-nursing-in-the-...>

## 2. HIFA Profile List

Message number	HIFA Profile
402	Goran Zangana is a medical doctor and Associate Research Fellow with the Middle East Research Institute, Iraq. He is a HIFA country representative for Iraq and is currently based in the UK. <a href="https://www.hifa.org/support/members/goran">https://www.hifa.org/support/members/goran</a> goran.zangana@meri-k.org
403	Ola El-Zein is the Director of the Medical Library and lecturer at the American University of Beirut (AUB). She serves as a board member of the Arab World Association of Young Scientists (WAYS), an initiative that fosters science diplomacy and impacts scientific cooperation between countries. She is the first woman to hold a PhD degree in Cell and Molecular Biology from AUB. She was chosen as the youngest woman scientist to participate in a plenary session about youth and science diplomacy in WSF2017. She was also nominated as a member of the

	organizing committee for the WSF-2019. She has extensive teaching experience since 2007 and has been in charge of several research initiatives and projects. She had published several research papers in prominent peer-reviewed international journals. She is a HIFA country representative for Lebanon. <a href="https://www.hifa.org/support/members/ola-el">https://www.hifa.org/support/members/ola-el</a> Email: oe14@aub.edu.lb
<b>404</b>	Didier Demassosso is a mental health practitioner, Consultant (WHO, MoPH Cameroon...), Mental health advocate, Youth advocate with 10 years experience in mental health development in Cameroon. He is also a health communicator and educationist. HIFA Country Representative For Cameroon/ HIFA Country Representative of the year 2014 / Regional Coordinator for Africa. He also currently volunteers for the Mental Health Innovation Network Africa as Knowledge Exchange Assistant. <a href="http://www.hifa.org/people/country-representatives/map">http://www.hifa.org/people/country-representatives/map</a> <a href="http://www.hifa.org/support/members/didier">http://www.hifa.org/support/members/didier</a> Email: didier.demassosso@gmail.com
<b>405</b>	Miracle Adesina is a physical therapist, healthcare innovator, global health researcher with focus on sexual and mental health and has over 5 years of experience in sexual and mental health advocacy and research. He is a United Nations Academic Impact Millennium Fellow, Global Youth Ambassador for Theirworld (UK-based), Global Goodwill Ambassador, HundrED Ambassador and sits on the board of US-based Universal Care for Africa Foundation. He currently serves as the Country Coordinator (Nigeria), Slum and Rural Health Initiative (SRHIN) and Senior Research Associate at SRHIN Research Academy. Miracle has over 50 publications in peer-reviewed international journals and serves as journal reviewer for more than 15 journals. He envisions a world where health information and services will be available and affordable for individuals in slums, villages, underserved communities, internally displaced persons camps and rural regions. Miracle is a member of the WHO/HIFA working group on Maintaining essential health services during COVID-19. <a href="https://www.hifa.org/support/members/adesina">https://www.hifa.org/support/members/adesina</a> <a href="https://www.hifa.org/projects/essential-health-services-and-COVID-19">https://www.hifa.org/projects/essential-health-services-and-COVID-19</a> Email: <a href="mailto:miracle.adesina@srhin.org">miracle.adesina@srhin.org</a>
<b>406</b>	Levi is a Researcher at Queensland University of Technology in Australia. Professional interests: Ocular Health, Epidemiology, Population Health, and Diabetes. o_leviuche@ hotmail.com
<b>407</b>	Didier Demassosso is a mental health practitioner, Consultant (WHO, MoPH Cameroon...), Mental health advocate, Youth advocate with 10 years experience in mental health development in Cameroon. He is also a health communicator and educationist. HIFA Country Representative For Cameroon/ HIFA Country Representative of the year 2014 / Regional Coordinator for Africa. He also currently volunteers for the Mental Health Innovation Network Africa as Knowledge Exchange Assistant. <a href="http://www.hifa.org/people/country-representatives/map">http://www.hifa.org/people/country-representatives/map</a>

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<b>408</b>	Camilo Colaco is a CSO at Immuno Biology Ltd in the UK. Professional interests: Vaccine R&D and manufacture, Immunobiology, Cancer Immunotherapy, Dendritic cells, Nutrition, Microbiome, Ayurveda. camilo.colaco AT immunobiology.co.uk
<b>409</b>	Vedant Shekhar Jha is a Medical Cadet at the Armed Forces Medical College Pune, India. Professional interests: Palliative care, exploring unmet needs of cancer patients, the effective communication of health awareness. He is a HIFA catalyst on the HIFA working group on Maintaining essential health services during COVID-19. <a href="https://www.hifa.org/support/members/vedant">https://www.hifa.org/support/members/vedant</a> <a href="https://www.hifa.org/projects/essential-health-services-and-COVID-19">https://www.hifa.org/projects/essential-health-services-and-COVID-19</a> Email address: <a href="mailto:vedantjha2000@gmail.com">vedantjha2000@gmail.com</a>
<b>410</b>	Shabina Hussain is an independent global health consultant and is based in the USA. Professional interests: Maternal & Child Health, Family Planning, Reproductive & Sexual Health, women's rights, survival of girl child, poverty eradication, Prevention of Infectious diseases. Email address- <a href="mailto:hussain.shabina@gmail.com">hussain.shabina@gmail.com</a>
<b>411</b>	Richard Fitton is a retired family doctor - GP, British Medical Association. Professional interests: Health literacy, patient partnership of trust and implementation of healthcare with professionals, family and public involvement in the prevention of modern lifestyle diseases, patients using access to professional records to overcome confidentiality barriers to care, patients as part of the policing of the use of their patient data Email address: <a href="mailto:richardpeterfitton7@gmail.com">richardpeterfitton7@gmail.com</a>
<b>412</b>	Sian Williams is Chief Executive Officer at the International Primary Care Respiratory Group in the UK. Professional interests: Implementation science, NCDs, primary care, respiratory health, education, evaluation, value, breaking down silos. Email address- <a href="mailto:sian.health@gmail.com">sian.health@gmail.com</a>
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<b>416</b>	Dr Sanchika Gupta is an Indian healthcare specialist with eight years of experience as both clinician and public health programmer. She explored wide breadth of public health realm viz. family planning/reproductive health, maternal, adolescent and child health during her association with national and international NGOs namely INCLIN, MAMTA, Jhpiego and Pathfinder International. She acquired technical expertise in advocacy, program management, research, monitoring and evaluation throughout her fieldwork in eight Indian states (Assam, Bihar, Haryana, Jharkhand, Madhya Pradesh, Maharashtra, Rajasthan and Uttar Pradesh). She is the nominee of '120 under 40: the new generation of family planning leaders' in 2019. In the recent years, she has been associated with HIFA through its Social Media Working Group and EHS-COVID-19 project. In

	2021, HIFA nominated her as Global Country Representative Coordinator. Currently, she is based in New Delhi, India and is available on email id <a href="mailto:sanchika12@gmail.com">sanchika12@gmail.com</a> or Twitter @sanchika_gupta. <a href="https://www.hifa.org/support/members/sanchika">https://www.hifa.org/support/members/sanchika</a>
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<b>418</b>	Richard Fitton is a retired family doctor - GP, British Medical Association. Professional interests: Health literacy, patient partnership of trust and implementation of healthcare with professionals, family and public involvement in the prevention of modern lifestyle diseases, patients using access to professional records to overcome confidentiality barriers to care, patients as part of the policing of the use of their patient data Email address: richardpeterfitton7@gmail.com
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<b>420</b>	Sunny Khan is the Project Lead for the WHO COVID:19 Health Services Learning Hub. He has worked with WHO since 2016 on a range of technical projects related to health systems and primary healthcare. In addition, he is a practising primary care physician. He is a member of the HIFA-WHO working group on Maintaining essential health services during COVID-19.
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<b>429</b>	Jagoda Khatri works with the COVID-19: Health Services Learning Hub at the World Health Organization, Geneva. She is a member of the HIFA working group on Essential Health Services and COVID-19. <a href="https://www.hifa.org/support/members/jagoda">https://www.hifa.org/support/members/jagoda</a> <a href="https://www.hifa.org/projects/essential-health-services-and-COVID-19">https://www.hifa.org/projects/essential-health-services-and-COVID-19</a> Email: khatrij@who.int
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<b>432</b>	Ruth Hope is Director of HIV/AIDS Reproductive Health and Gender Equality at Realizing Global Health, USA. Professional interests: health and development, ending inequity in access to resources and services and gender discrimination. ruth.hope@verizon.net
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<b>439</b>	Soumyadeep Bhaumik was the HIFA Country Representative of the Year for 2012, and is a medical doctor from India working in the field of evidence syntheses. He has previously worked as a Senior Research Scientist at the South Asian Cochrane Network and Centre, India and as a Biomedical Genomics Fellow in BioMedical Genomics Centre, Kolkata. He has also consulted for evidence synthesis projects for Evidence Aid, Oxford UK and Public Health Foundation of India. He currently studies international public health in the Liverpool School of Tropical Medicine. In addition he has experience in science and research communication and has written for British Medical Journal, Canadian Medical Association Journal, Lancet and Lancet Oncology and National Medical Journal of India. Soumyadeep is a member of the HIFA working group on Evidence-Informed Policy and Practice. <a href="http://www.hifa.org/projects/evidence-informed-policy-and-practice">http://www.hifa.org/projects/evidence-informed-policy-and-practice</a> drsoumyadeepbhaumik@gmail.com
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<b>447</b>	Simon Lewin is a health systems researcher at the Norwegian Institute of Public Health ( <a href="http://www.fhi.no/en/">www.fhi.no/en/</a> ) and the South African Medical Research Council ( <a href="http://www.mrc.ac.za">www.mrc.ac.za</a> ). He has a keen interest in how research evidence can be used to inform decisions for health systems in low- and middle-income countries (LMICs) and at the global level in multilateral organisations such as the WHO. As Joint Co-ordinating Editor of Cochrane Effective Practice and Organisation of Care (EPOC: <a href="http://epoc.cochrane.org">epoc.cochrane.org</a> ) and lead for the Norwegian EPOC satellite, he has played a key role in strengthening Cochrane's work in the field of health systems and in developing Cochrane methods for qualitative evidence synthesis. Cochrane is a HIFA supporting organisation and Simon is a member of the HIFA working group on CHWs:  <a href="http://www.hifa.org/projects/community-health-workers">http://www.hifa.org/projects/community-health-workers</a>  <a href="http://www.hifa.org/support/members/simon">http://www.hifa.org/support/members/simon</a>  Email: simon.lewin AT fhi.no
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<b>450</b>	Joseph Ana is the Lead Consultant and Trainer at the Africa Centre for Clinical Governance Research and Patient Safety in Calabar, Nigeria. In 2015 he won the NMA Award of Excellence for establishing 12-Pillar Clinical Governance, Quality and Safety initiative in Nigeria. He has been



	<p>the pioneer Chairman of the Nigerian Medical Association (NMA) National Committee on Clinical Governance and Research since 2012. He is also Chairman of the Quality &amp; Performance subcommittee of the Technical Working Group for the implementation of the Nigeria Health Act. He is a pioneer Trustee-Director of the NMF (Nigerian Medical Forum) which took the BMJ to West Africa in 1995. He is particularly interested in strengthening health systems for quality and safety in LMICs. He has written Five books on the 12-Pillar Clinical Governance for LMICs, including a TOOLS for Implementation. He established the Department of Clinical Governance, Servicom &amp; e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: <a href="http://www.hriwestafrica.com">www.hriwestafrica.com</a> Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers.</p> <p><a href="http://www.hifa.org/support/members/joseph-0">http://www.hifa.org/support/members/joseph-0</a></p> <p><a href="http://www.hifa.org/people/steering-group">http://www.hifa.org/people/steering-group</a></p> <p>Email: jneana AT yahoo.co.uk</p>
<b>451</b>	Neil Pakenham-Walsh, HIFA Coordinator, <a href="mailto:neil@hifa.org">neil@hifa.org</a> <a href="http://www.hifa.org">www.hifa.org</a>
<b>451</b>	Chiabi Bernard Ful is Director of Boyo Association for Rural Development (BARUDEV--Cameroon). This is a local NGO found in Boyo district of North Western Cameroon. Our activities are to empower women, protect the sexual and reproductive health for women and girls, and protect the rights of children. We have been training community health workers to follow up patients, pregnant women, sick children and refer them to the hospital. barudev AT yahoo.co.uk
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<b>461</b>	<p>Jackeline Alger, MD, PhD, is a parasitologist working at the Departamento de Laboratorio Clínico, Hospital Escuela and at the Unidad de Investigación Científica, Facultad de Ciencias Médicas, Universidad Nacional Autónoma de Honduras (UNAH), Tegucigalpa, Honduras. She is a board member of the Instituto de Enfermedades Infecciosas y Parasitología Antonio Vidal (IAV), a non-profit organization devoted to training, advising, and conducting research in the field of infectious diseases. She combines clinical laboratory work, teaching, and research activities with mentoring students, faculty and health professionals performing health research, building interdisciplinary bridges, promoting international collaboration, and networking to advance scientific and ethical research and social innovation for health in Honduras. She is a Country Representative for HIFA and CHIFA and is the 2-time holder of HIFA Country Representative of the Year Award 2015 and 2018. <a href="http://www.hifa.org/people/country-representatives/map">http://www.hifa.org/people/country-representatives/map</a></p> <p><a href="http://www.hifa.org/support/members/jackeline">http://www.hifa.org/support/members/jackeline</a></p>

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<b>462</b>	HIFA-Zambia profile: Arlet Splint is Secretary of Platform Zambia, a group of Dutch Foundations, all working for Zambian citizens, spread all over the country. All board members are board member of their "own" foundation but saw it is possible to help each other (sharing knowledge, sharing space in a container etc) if we join via internet and Zambia-days. The last day the Zambian ambassador for the Benelux came from Brussels. There are Foundations working for a school, for an orphanage, for a hospital etc. We show stories and sometimes even a vacancy on our website: <a href="http://www.platformzambia.nl">www.platformzambia.nl</a> pasplint AT hetnet.nl
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<b>462</b>	Meena Cherian is Director, Emergency & Surgical Care program, Geneva Foundation of Medical Education and Research, Geneva, Switzerland. She is a member of the HIFA working group on Essential Health Services and COVID-19. <a href="https://www.hifa.org/support/members/meena">https://www.hifa.org/support/members/meena</a>  <a href="https://www.hifa.org/projects/essential-health-services-and-covid-19">https://www.hifa.org/projects/essential-health-services-and-covid-19</a>  <a href="http://www.gfmer.ch">www.gfmer.ch</a> cherianm15 AT gmail.com
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## Citation Table (Vancouver style)

S. No	Categories	S. No	Resources	Message number
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		<b>9</b>	Oral health. [cited 2022 Jan 21]; Available from: <a href="https://gco.iarc.fr/today/data/factsheets/cancers/1-Lip-oral-cavity-fact-sheet.pdf">https://gco.iarc.fr/today/data/factsheets/cancers/1-Lip-oral-cavity-fact-sheet.pdf</a> ,	<b>425</b>
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<b>24</b>	Assefa N, Sié A, Wang D, Korte ML, Hemler EC, Abdullahi YY, et al. Reported Barriers to Healthcare Access and Service Disruptions Caused by COVID-19 in Burkina Faso, Ethiopia, and Nigeria: A Telephone Survey. Am J Trop Med Hyg [Internet]. 2021 Aug 1 [cited 2021 Dec 24];105(2):323. Available from: <a href="https://pmc/articles/PMC8437171/">/pmc/articles/PMC8437171/</a>		<b>469</b>
<b>25</b>	Dandena F, Teklewold B, Anteneh D. Impact of COVID-19 and mitigation plans on essential health services: institutional experience of a hospital in Ethiopia. BMC Health Serv Res [Internet]. 2021 Dec 1 [cited 2021 Dec 23];21(1):1–9. Available from: <a href="https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-07106-8">https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-07106-8</a>		<b>472</b>



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<b>4</b>	<b>Organisations / Industries/ University websites/Non-profit forums</b>	<b>1</b>	A new HIFA thematic discussion: Maintaining essential health services during the pandemic: What have we learned? Starts 15 November 2021   Health Information For All (HIFA.ORG) [Internet]. [cited 2021 Dec 22]. Available from: <a href="https://www.hifa.org/news/new-hifa-thematic-discussion-maintaining-essential-health-services-during-pandemic-what-have-we">https://www.hifa.org/news/new-hifa-thematic-discussion-maintaining-essential-health-services-during-pandemic-what-have-we</a>	<b>470</b>
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<b>5</b>	<b>Blog articles/ Editorials/ Commentaries / Op-eds</b>	<b>1</b>	Private-public exploitation? The role of the private sector in Kurdistan in the COVID-19 pandemic   IHP [Internet]. [cited 2022 Jan 21]. Available from: <a href="https://www.internationalhealthpolicies.org/featured-article/private-public-exploitation-the-role-of-the-private-sector-in-kurdistan-in-the-covid-19-pandemic/">https://www.internationalhealthpolicies.org/featured-article/private-public-exploitation-the-role-of-the-private-sector-in-kurdistan-in-the-covid-19-pandemic/</a>	<b>402</b>
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		<b>3</b>	COVID-19: Essential Services   Mass.gov [Internet]. [cited 2021 Dec 29]. Available from: <a href="https://www.mass.gov/info-details/covid-19-essential-services">https://www.mass.gov/info-details/covid-19-essential-services</a>	<b>505</b>
<b>7</b>	<b>Summaries/ Reports/ Resources</b>	<b>1</b>	Zein O El. LibGuides: Coronavirus (COVID-19) Resource Center: Mental Health. [cited 2022 Jan 21]; Available from: <a href="https://aub.edu.lb.libguides.com/COVID19/MentalHealth">https://aub.edu.lb.libguides.com/COVID19/MentalHealth</a>	<b>403</b>
		<b>2</b>	mental health covid-19 - Search Results - PubMed [Internet]. [cited 2022 Jan 21]. Available from: <a href="https://pubmed.ncbi.nlm.nih.gov/?term=covid-19+mental+health+Lebanon&amp;sort=date&amp;size=100">https://pubmed.ncbi.nlm.nih.gov/?term=covid-19+mental+health+Lebanon&amp;sort=date&amp;size=100</a>	<b>403</b>
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<b>20</b>	Ebiri-Okoro I, V. Chioma E, Ibeneme C. Maintaining essential health services in Abia State, Nigeria [Internet]. [cited 2021 Dec 29]. Available from: <a href="https://hlh.who.int/ab-detail/maintaining-essential-health-services-in-abia-state-nigeria">https://hlh.who.int/ab-detail/maintaining-essential-health-services-in-abia-state-nigeria</a>		<b>506</b>

<b>8</b>	<b>Multimedia</b>	<b>1</b>	Organization world H. COVID-19 pandemic leads to major backsliding on childhood vaccinations , new WHO , UNICEF data shows [Internet]. 2021 [cited 2022 Jan 21]. p. 5–9. Available from: <a href="https://www.who.int/news/item/15-07-2021-covid-19-pandemic-leads-to-major-backsliding-on-childhood-vaccinations-new-who-unicef-data-shows">https://www.who.int/news/item/15-07-2021-covid-19-pandemic-leads-to-major-backsliding-on-childhood-vaccinations-new-who-unicef-data-shows</a>	<b>430</b>
		<b>2</b>	<a href="https://phmovement.org/webinar-20th-july-2021-tuesday-11-am-utc-the-struggles-of-community-health-workers-at-the-covid-frontline-essential-but-unrecognised/">https://phmovement.org/webinar-20th-july-2021-tuesday-11-am-utc-the-struggles-of-community-health-workers-at-the-covid-frontline-essential-but-unrecognised/</a>	<b>435</b>
		<b>3</b>	Scale up digital interventions to beat noncommunicable diseases - YouTube [Internet]. [cited 2022 Jan 20]. Available from: <a href="https://www.youtube.com/watch?v=3AyVcwoLW8M&amp;ab_channel=WHOEasternMediterraneanRegion">https://www.youtube.com/watch?v=3AyVcwoLW8M&amp;ab_channel=WHOEasternMediterraneanRegion</a>	<b>453</b>
		<b>4</b>	The Next Pandemic - How bad might things get? How should we prepare? - YouTube [Internet]. [cited 2021 Dec 25]. Available from: <a href="https://www.youtube.com/watch?v=zjTy0NUgly4&amp;ab_channel=GlobalHealthwithGregMartin">https://www.youtube.com/watch?v=zjTy0NUgly4&amp;ab_channel=GlobalHealthwithGregMartin</a>	<b>481</b>
<b>9</b>	<b>Social Media: IG, Twitter, Facebook etc.</b>			
	<b>Total</b>	<b>93</b>		