HIFA is collaborating with WHO to promote sharing and learning of experience and expertise around the maintenance of essential health services during and after the pandemic, in a spirit of solidarity and co-development. Below is the structured long edit version of the discussion from message number 1 to 142. Also provided is a list of citations (resources that HIFA members have pointed us to) and a list of profiles of contributors.

General comments on messages 1-142 (for discussion)
1. The discussion continues on HIFA and the total number of messages at 23 March is 249. Messages 142 onwards are now being analysed in the same way.
2. The number of contributors (29) is quite good but more would have been better. There is good geographical spread and representation from health workers.
3. Most of the contributions were pointing people to new publications, services or events. There were relatively few messages sharing personal experience and expertise.
4. A disproportionate number of messages (86/142) were sent by the moderator. Most of these were pointing people to new publications.
5. This analysis has implications for our second thematic discussion (to be discussed).

From 30 October to 18 December there were 142 messages from 29 contributors in 14 countries (Bangladesh, Croatia, Honduras, India, Jordan, Kenya, Nigeria, Norway, South Africa, Switzerland, Timor-Leste, Uganda, UK, USA). Messages 1-46 relate to open discussion before 16 November. Subsequent messages relate to the formal thematic discussion with five guiding questions.

Our thanks to the contributors:

Alice Nganwa, Uganda
Allan Ragi, Kenya
Ateeb Ahmad Parray, Bangladesh
Emma Feeny, UK
Gladson Vaghela, India
Hayat Gommaa, Nigeria
Henry Perry, USA
Irina Ibraghimova, Croatia
Jackeline Alger, Honduras (2)
Jagoda Khatri, Switzerland
Jane Lennon, UK (2)
Joel Francis, South Africa
Joseph Ana, Nigeria (6)
Luis Gabriel Cuervo, USA (2)
Mark Lodge, UK (2)

Meena Cherian, Switzerland (2)
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Richard Fitton, UK (3)
Shams Syed, Switzerland
Sian Williams, UK
Simon Lewin, Norway
Sunanda Kolli Reddy, India
Ted Lankester, UK
Tomislav Mestrovic, Croatia
Uzodinma Adirieje, Nigeria (2)
Vinay Bothra, Timor-Leste
WHO COVID-19 HLH
The following selected extracts are from 12 contributors, whose profiles are shown below. They are represented in the discussion themes below. These contributors included six health workers, four public health professionals, one librarian/editor, and the moderator, representing four universities, three NGOs, and two healthcare facilities.

DISCUSSION THEMES

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

Gwewasang Martin (Cameroon) The lockdown during this COVID-19 has affected our health services and programs drastically. It has caused severe social and economic disruption. Our staff abandoned the project because of no salaries and no money to buy food.

Ted Lankester (U.K.) "The health services are fragile in India's poorer states, routine public health services have been discontinued." 1

Jackeline Alger (Honduras) The unfortunate development of the COVID-19 pandemic has conditioned a pause in the efficient route of care we had achieved for this group of patients (goitre thyroid disease), causing a complete cessation of thyroidectomies in HE during the last 7 months, similar to the situation in other countries, resulting from concern for safety, both of patients (there is evidence of unfavourable postoperative evolution in asymptomatic infected surgically intervened) and hospital staff.

Tomislav Mestrovic (Croatia) Every hospital in the Republic of Croatia was impacted by the pandemic and had to reorganise its work, with many county general hospitals reorganising at least one hospital ward into an isolation unit for the infected. Croatia has also prepared several checkpoints, such as military tents in front of certain clinical hospitals. Hospital policy all around the country is to admit only those patients whose life is in danger, which then creates a problem in access for many different health services. More specifically, all elective diagnostic and therapeutic procedures have been postponed, except those regarding cancer patients or pregnant women.

Joseph Ana (Nigeria) Every facet of the continuum of the health system is affected, from promotive to preventive, curative, rehabilitative and continuity of care.

Jackeline Alger (Honduras) The enormous death toll COVID-19 has taken from health personnel in Honduras, Central America, and specifically from physicians working in the public and private sectors, some as general practitioners and some with specialisation. This loss of human talent affects directly the provision of essential health services and has produced a lot of suffering among the health personnel, their families, and society in general.

Since March 10th, when Honduras reported the first COVID-19 cases, up to October 31st, 61 physicians have passed away. Not all of them due to COVID-19 but all of them and their families affected by the general situation of confinement, limited circulation, closed outpatient clinics,

1 An extract from the report shared through an email (with Ted Lankester) by Dr Kiran Martin, Padma Shri, Founder & Director, Asha Community Health & Development Society, New Delhi, India, on the subject of “Asha COVID-19 Case Study”.
and overwhelmed public and private hospitals, with the shortage of medical equipment and supplies to treat complicated cases and limited Intensive Care Unit beds availability. Among these 61 physicians, 20 were specialised physicians, including specialities such as epidemiology, obstetrics and gynaecology, paediatrics, psychiatry, public health, and urology; some of them less than 40 years old.

**Joseph Ana (Nigeria)** In the facilities, whether government-owned or private facilities, outpatient and inpatient services, across specialties including childbirth conducted by skilled attendants, have dropped drastically, because users are afraid to attend for fear of 'catching' COVID-19 from hospital workers or the facility. The reverse is also true, as news reports are frequent of 'health workers turning away patients who have COVID-19-like symptoms.

Logistics and supply chain disruption has affected facility stocks of medicines, commodities, and already failing utilities like running water and electricity supply, with deadly consequences for patient outcome. The reported rates of new infection seem to have peaked around August 2020, but no one is certain of why that is so or whether the drop is real because most states, if not all bar one or two, are not persisting with a commitment to testing! Routine immunisation, which at best of times was a struggle to improve the rates, has plummeted, the consequences of which may manifest long after the COVID-19 emergency.

Furthermore, some policy decisions and approaches to the mitigation of the pandemic have not helped because they have been too concentrated on Urban centres to the neglect of rural population, even though most of the population live and work in rural areas. Distribution of palliatives has also been urban-centred in the main and therefore has not reached the very poor and unemployed, especially those that became unemployed because of COVID Lockdown and restrictions. The failure of palliative schemes has forced most of the population to buy into the misinformation and to go into denial, preferring to 'die from COVID-19 than by hunger'!

Already, Nigeria was facing scarcity of health workers (in numbers and distribution across the zones of the country) exacerbated by acute Brain Drain to the Global North, but COVID-19 has worsened the situation drastically, as staff become infected in the course of treating positive cases, and have to rightly, isolate and quarantine mandatorily. Many have succumbed and died. Running normal shifts in the hospitals has been serious, adversely, and we read of facilities closing down services altogether or scaling down, both of which imperil access and care to patients. It is probably too early to know how this sad situation can be effectively controlled because the pandemic (even though it appears less burdensome in Africa at this time) has not ended, especially given that a second COVID-19 wave is still ravaging. Western countries and flights have resumed between Africa and those Hotspots.

**Irina Ibraghimova (Croatia)** Here in Croatia, I might say that we are able to use without 'contact' some services that were established before - for example, we do not need to visit a G.P. office to renew a prescription (that could be done online or by phone). But when changes in the system were needed - that took really a long time. Only a couple of weeks ago, they organised a centralised national information service for oncological patients who were not able to get on time therapy or diagnostic procedures due to disruptions in hospital service delivery (as some hospitals were reorganised to treat only COVID-related cases).
Zsuzsanna Kovacs (Hungary) The test policy and capacity are insufficient so the official data do not correspond to reality. Due to overburdened public health care, many people try to perform tests in private laboratories. As the first wave calmed down the state of emergency was withdrawn, so during the summer, the life went back to normal. The result was the increasingly severe second wave.

Neil Pakenham-Walsh (U.K.) In the opening remarks by Loveday Penn-Kekana, USAID’s CIRCLE Project and London School of Hygiene & Tropical Medicine notes the reasons why COVID-19 is Impacting Facility Birth?

- Difficulty reaching facility due to disruption of referral and transport networks and/or movement limitations and restrictions.
- Financial impact of COVID and inability to pay fees.
- Fear of being exposed to COVID at the facility.
- Fear of retention at the facility if diagnosed with COVID-19/ have a temperature.
- Services unavailable and/or poor quality of care due to: HRH understaffing of health workers who are either sick, scared to come to work, or reallocated & supply chain disruptions at-large.
- Disrespectful care from non-evidence-based policies (e.g., separation of mothers and babies or forced c-section for COVID+ mothers).
- Very little work has actually been done talking to women and their families.
- Hugely varies between regions & countries/ over time.

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

Metrics: 8 contributors in 6 countries (Cameroon, Croatia, Honduras, Hungary, Nigeria, U.K.)
What we learned: Profound impact on health services, especially elective surgery, increased home birth without skilled birth attendants; reduction in outpatient visits & supply chains. Many deaths of health workers from COVID-19, and further reduced workforce due to COVID-19 illness. Fear among users of health services; big impact on national and local economy; loss of NGO staff.
What we have yet to learn: Perspectives from patients and patient representatives. Perspectives from frontline health workers. Quantitative data on health outcomes. Qualitative data and clinical case examples.

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

Gwewasang Martin (Cameroon) Patients no longer come to the clinic; many people flee to rural areas, which only help spread corona-virus. As the COVID-19 pandemic overburdens already weak health systems, it is expected to increase the number of new-born deaths, particularly among babies born too soon and babies born by babies (adolescents).

Vinay Bothra (Timor Leste) While there have only been 31 confirmed cases and no evidence of community transmission on this half-island nation in the Asia-Pacific region, anxiety and concerns around COVID-19 have adversely impacted on health services. Preliminary data
gathered on mother and child services have shown a reduction in hospital deliveries (with a concomitant increase in home deliveries), a reduction in ante-natal visits and a drop in family planning methods (with a change in preference from short to long-acting methods of contraception).

Ted Lankester (U.K.) "In India, there is extreme and acute food insecurity resulting in lasting damage from malnutrition and high child mortality, and a prolonged period of unemployment and hunger." 2*

Zsuzsanna Kovacs (Hungary) Fortunately, the data on children, are very favourable, as are the international trends. Less than 1% of the COVID patients were children in the first wave, and only a few needed hospital treatments. In the second wave, 1-2% of infected persons were children. Less than 1% of hospitalised patients were children, and for the time being, none of them needed respiratory treatment, and there were no fatalities among them, and only one COVID-infected pregnant woman underwent caesarean section due to preterm birth.

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

Metrics: 4 contributors in 4 countries (Cameroon, Hungary, Timor Leste, U.K.)

What we learned: Cameroon: "Patients no longer come to the clinic; many people flee to rural areas". Timor Leste: Anxiety and concerns around COVID-19 have adversely impacted on health services... increase in home deliveries, a reduction in ante-natal visits and a drop in family planning. India: acute food insecurity Cameroon: People no longer come to clinic, fled to rural areas. Timor Leste: anxiety, reduction in hospital deliveries of the new-born; increase in home deliveries; reduction in ante-natal visits; drop in family planning. India: malnutrition and high child mortality; prolonged period of unemployment and hunger.

What we have yet to learn: Indirect consequences of the pandemic; conditions in low capacity and in humanitarian settings; Effect of pandemic/lockdown on elderly age groups, patients suffering with NCDs and other communicable diseases.

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

Gwewasang Martin (Cameroon) As the [HIFA] Country Representative in Cameroon, I have created the Higher Clinical Training Institute for Family Planning (HICTI4FP), formerly the Clinical Training Center for Family Planning (CTC4FP), with the main mission to train competent and specialised nurses to care and work to reduce the number of newborn deaths, particularly among babies born too soon and babies born by babies (adolescents). HICTI is self-funded, and with the lockdown for over seven months, it is very challenging and difficult to get the project running.

Joseph Ana (Nigeria) The Civil Society Organisations (CSOs) and NGOs that we belong to, like the Health Resources International Foundation (HRIF); The Dr Bassey Kubiangha Education Foundation (B.K. Foundation); The Mother Hannah Foundation; the Nigerian Universal health

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2* An extract from the report shared through an email (with Ted Lankester) by Dr Kiran Martin, Padma Shri, Founder & Director, Asha Community Health & Development Society, New Delhi, India, on the subject of “Asha COVID-19 Case Study”.
Coverage Action Network (an umbrella organisation for over 50 CSOs and a member of CSEM) have all called on the Presidential Task Force on COVID-19 (PTF) to extend its mitigation efforts to parts of the country outside the urban centres, translate its key messages into many local languages including pidgin, and to engage and empower civil society organisations and NGOs that already operate from those locations and are trusted by the rural population. The private hospital that I chair the Board of Trustees, Lily Hospitals Limited in Warri and Benin City, has done the same positive championing extension of the PTF campaign to include private hospitals who after all, are reputed for seeing over 60% of outpatients in the country. Lily Hospital became the first private hospital in the South Zone of Nigeria to install and commission a PCR machine for testing patients.

**Tomislav Mestrovic (Croatia)** In order to ensure continuity, some hospitals are providing telephone counselling. Family medicine doctors are advised to communicate with their patients by using telephone, e-mail or videoconference whenever possible. All patients whose non-life-threatening condition requires a medical examination are prompted to be examined at home after the doctor makes sure they or any other household member were not exposed to COVID-19.

**Hayat Gommaa (Nigeria)** As I am working in the university and sending the nursing department students to all types and levels of health care facilities, we ensure to provide them with updated national and international standard guidelines of care, the performance checklist and clients feedback are parts from evaluation sheet. In some low resources setting, the students contribute to buy the needed equipment and resources.

**Zsuzsanna Kovacs (Hungary)** Outpatient care has been reduced and referred to online counselling. Hospitals and hospital wards were designated to treat severe COVID patients. Health workers over the age of 65 have been excluded from acute patient care. Protocols for testing, diagnosis and treatment of COVID have been developed.

**Richard Fitton (U.K.)** Extracts from NHS England September 2020 - Use of On-line services: Percentage of patients enabled to book/cancel appointments on line-27.08%; Number of appointments booked on line in September 2020-523,770; Percentage of patients enabled to order repeat prescriptions on line-31.52%; Number of prescription transactions on line in September 2020-4,500,000; Percentage of patients enabled to view detailed record on line-9.84%; Number of record view transactions on line in September 2020-9,930,000; Percentage of patients enabled for at least one of these services-31.97%.

**Editorial Comment:** Q3. What have you, your health facility or country done to maintain essential health services?

**Metrics:** 6 contributors in 5 countries (Cameroon, Croatia, Hungary, Nigeria, U.K.)

**What we learned:** Local effort by NGO to provide services (Cameroon). Call for government support for NGOs (Nigeria). Co-operative efforts undertaken by public & private organizations; actions to focus on rural communities and low-income settings; efficient use of telemedicine. Online services were mentioned in relation to Croatia, Hungary, UK but not in relation to Cameroon or Nigeria.
Q4. Which groups are especially vulnerable to health service disruptions? How can we ensure they are protected at this time?

**Gwewasang Martin (Cameroon)** Disrupted essential health services, like family planning or antenatal check-ups, will leave women more at risk of preterm birth and vulnerable infants without the services they need. We are preparing in the months ahead to invest in training competent and specialised nurses and health workers to care for these mothers and babies. The is the main mission of the Higher Clinical Training Institute for Family Planning (HICTI4FP), formerly the Clinical Training Center for Family Planning (CTC4FP).

**Tomislav Mestrovic (Croatia)** Mobile palliative teams are envisioned to take a proactive role in providing home care services for chronic and palliative patients. Each family medicine doctor is obliged to call all of their palliative patients and explain to them over the phone what they should do in the event of a worsening of their existing condition.

**Joseph Ana (Nigeria)** LICs, like Nigeria, must learn from those countries that have shown relatively better results so far in their management of the COVID-19 pandemic, both in life-saving and mitigation of its unprecedented effects on the economy and livelihoods. There are countries that are reporting that they have avoided recession, etc., even though they have gone through terrible experiences with the pandemic at some point in this dreadful 2020 year. It appears that better timed national or regional restrictions of human movement when the virus strikes, from the grassroots up, coupled with enforcement of population-wide preventive messages, leads to shorter infection and less damage to lives and livelihoods in the end.

**Hayat Gommaa (Nigeria)** As all people should receive respectful and standard care, and some are not able to receive these types of care because they are poor, have some disabilities, orphans, young, or living far from the health clinic.

**Vinay Bothra (Timor Leste)** The provision of clear and credible guidance on the need to continue immunisation services by professionals respected by the health community (including the NITAG Chair, DGHS, senior Paediatricians) built confidence in vaccinators for providing safe services.

Re-purposing WHO technical staff to work closely with district immunisation coordinators has been invaluable in building trust and competence for health workers to deliver vaccination.

The value of user-friendly granular data to target interventions-Districts provided weekly coverage data, disaggregated to the CHC level. This facilitated identification of poor performing health facilities that were provided extra technical support and supervision to improve performance.
Following its first confirmed case in March 2020, childhood immunisation coverage dropped by 30% the next month in April. By over-compensating on the supply side (expanded door-to-door campaigns to identify and vaccinate unprotected children), Timor-Leste has been able to achieve similar coverage by July 2020 as compared with July 2019.

**Alice Nganwa (Uganda)** Management of stroke in low-income countries requires a system that has its base in the community and its apex in the referral hospital. A poor patient with stroke is managed in the near-by hospital by a medical officer. If the family is rich; by a specialist in a higher-level hospital. The challenge is short hospital stay, usually because the family cannot afford a long stay or the medical officers over-look the long process of rehabilitation. When the patient is stable, they are discharged through the rehabilitation unit (if it exists), who request the patient to make monthly visits to the physiotherapy clinic. Many patients do not return and live a poor quality of dependent life and face an early death.

Kisizi hospital in South-West Uganda provides a continuum of care through Community-Level Rehabilitation. The stroke patient and any other patient who requires long-term rehabilitation are referred home through the rehabilitation unit (physiotherapy and occupational therapy - no speech therapists yet). Important to note is the rehabilitation personnel are key cadres who contribute to the discharge decision, unlike in many settings where this is decided by the doctors. The patient is linked to a Community Based Rehabilitation worker who visits the patient in their home once a week to encourage activities of daily living and reintegration in family and community. A patient whose progress is unsatisfactory is visited by the physiotherapist. This system ensures continuity and is less costly for the family. The main challenge is it has not yet been incorporated in the community insurance scheme, which only covers hospital-based services.

**Joseph Ana (Nigeria)** The challenge of Non-Communicable diseases (NCDs) such as Stroke in LMICs are many, especially the lack of effective referral from one practitioner to the other and from one facility to the other. Where some referral occurs, there is hardly a two-system such that the specialists communicate his intervention to the referring colleagues after the patient has been treated. Apart from the lack of continuity of care that results from the ineffective system and poor communication, there is the loss of educating and learning that should flow from specialists to primary health care level of care. There is also the One-Stop Centres / Clinics of care for NCDs, which not only facilitates Patient-Centred Care, such as reducing multiple visits to the hospital to see different health experts on different days, at huge out of pocket cost to the patient and risks from repeated travel on very bad roads. The situation is compounded by the chronic shortage of experts in supportive/rehabilitative care, including speech therapists, physiotherapists, Dietitians and Nutritionist, etc.

**Meena Cherian (Switzerland)** If the poor quality of care in the normal situations led to death and disability, we can imagine how much more the NCDs [42] was affected during the pandemic.

“Sad thing was that children who tested positive for COVID-19 and were due to have surgery, were send back to their referring hospital. These are children coming as far as Eastern Cape province, North West province and Swaziland. They had travelled all this way to have their surgery done and they had to go back without the surgery” 3* – In my personal opinion would it

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3* An extract from the experience shared by Mmusetsi Mokwats (South Africa).
be more sensible to presume all patients could be COVID positive and ensure standard precautions (PPE etc.) prior to any surgical interventions, than turning them away after they tested COVID positive? This has been the reality in LMICs that the patients kept seeking care from one to the other health facilities (often not informing of their tests).

The rich experiences shared in this forum by the health professionals and managers from the field clearly show us the impact of disrupted delivery of care of Non-Urgent Essential Health Services.

Q5. WHO guidance offers ten principles to maintain essential health services. Which principle is especially important to you and why?

Joseph Ana (Nigeria) As a keen follower of country responses to this COVID-19 pandemic, especially the Presidential Task Force on COVID-19 Pandemic in Nigeria, all Ten points are useful, necessary and complement one another. Beginning from point no. 1, on Governance, there is clearly a need to demonstrate the highest level of Political Will that can make all the other nine points doable. In LMICs, no. 10 ('Use digital platforms to support essential health service delivery') shall need modifying to enable there be a hybrid of platforms that includes analogue, other support modalities for essential health services, including robust communication plan delivered in local multilingual content that gains community buy-in to the mitigation efforts against COVID-19 disease and its effect on lives and livelihoods.

Editorial Comment: Q5. WHO guidance offers ten principles to maintain essential health services. Which principle is especially important to you and why?
Joseph Ana (Nigeria) Misinformation (infodemic) has blunted and obscured the dissemination of the evidence-informed key messages with the result that the majority of the populations are in denial of the existence of COVID-19 and would rather believe conspiracy theories, especially in countries like Nigeria. Simple messages that cost little to nothing and which individuals should implement are neglected, e.g., wearing a mask, physical distancing, handwashing, and other infection control measures, etc. The announcement of the imminent arrival in health facilities of potentially useful vaccines has compounded the infodemics situation as anti-vaccine videos are going viral and further confusing the population. Mis-information has led to a drop in routine immunisation, accessing health facilities for non-COVID-19 illnesses, and whether only by coincidence, there are more epidemics of vaccine-preventable diseases like Yellow Fever, Measles, etc.

Mis-information/infodemic coupled with pre-COVID-19 high levels of superstition, ignorance, poverty, and quackery, has taken root, such that most of the population are in denial at this time (November 2020), even as they read of and watch on T.V. Cable channels the devastating second/third wave of infections in the Western World, led by the USA.

Editorial Comment: Misinformation

Metrics: 1 contributor (from Nigeria)
What we learned: Disruption caused by Infodemic in COVID-19 management; misinformation and its impact on the perception and beliefs of the people.
What we have yet to learn: How to curb Infodemic; how to ensure an efficient fact-check system to avoid misinformation; how government can tackle & avoid the spread of misinformation in future public health outbreaks/emergency.

Profiles

Jackeline Alger (Honduras) Works in the Parasitology Service, Department of Clinical Laboratories, Hospital Escuela Universitario, and at the Faculty of Medical Sciences, Universidad Nacional Autonoma de Honduras, Tegucigalpa, 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. http://www.hifa.org/people/country-representatives/map http://www.hifa.org/support/members/jackeline E-mail: jackelinealger AT gmail.com [Health worker, Healthcare facility]
Joseph Ana (Nigeria) 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 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 & 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 & e-health in the Cross River State Ministry of Health, Nigeria in 2007. Website: www.hriwestafrica.com Joseph is a member of the HIFA Steering Group and the HIFA working group on Community Health Workers. [Public health professional, NGO]

Vinay Bothra (Timor Leste) is a Health Policy Advisor with the World Health Organization in Timor Leste. vbothra19 AT gmail.com [Public health professional, WHO]

Meena Cherian (Switzerland) 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 COVID19. https://www.hifa.org/support/members/meena https://www.hifa.org/projects/essential-health-services-and-covid-19 www.gfmer.ch cherianm15 AT gmail.com [Public health professional, WHO]

Richard Fitton (U.K.) 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. E-mail address: richardpeterfitton7 AT gmail.com [Health worker, retired]

Hayat Gommaa (Nigeria) is professor in nursing at the faculty of allied health sciences, Ahmadu Bello University in Nigeria. Professional interests: public health, women health, reproductive health. E-mail address: h_gommaa AT abu.edu.ng [Health worker, Academic]

Irina Ibraghimova (Croatia) is a medical librarian, based in Croatia, and works with health care professionals in the countries of the Former Soviet Union, Central and Eastern Europe, and Africa. Her interests include evidence-based practice (both in health care and in library/informatics field). www.lrcnetwork.org www.healthconnect-intl.org She is a HIFA country representative for Croatia: https://www.hifa.org/support/members/irina E-mail: ibra AT zadar.net [Librarian/Editor, Academic]

Zsuzsanna Kovacs (Hungary) is a paediatrician, based in Hungary. She is a CHIFA Country Representative for Hungary http://www.hifa.org/support/members/zsuzsanna E-mail: drkovacszsuzsa AT freemail.hu [Health worker, Healthcare facility]
Ted Lankester (U.K.) is Co-Leader of Arukah Network in the U.K. Professional interests: Global health. Community based health care. Travel medicine etc. [Health worker, NGO]

Gwewasang Martin (Cameroon) is a clinician at the Adele Reproductive Health Foundation-Clinical Training Center for Family Planning (CTC4FP) in Cameroon. He is also a Researcher, and Sexual and Reproductive Health Consultant. Professional interests: Family health, community & School health, Maternal & Child Health and Alternative & Complementary Medicine. He is a HIFA Country Representative for Cameroon. [Health worker, NGO]

Tomislav Mestrovic (Croatia) is a medical doctor and a clinical microbiologist with a PhD in biomedical sciences, and an Assistant Professor at Croatia's youngest public university, University North. He is also passionately invested in global health communication, health literacy, science journalism and science diplomacy. Tomislav was appointed by the Ministry of Science and Education of the Republic of Croatia as a Managing Committee Member to COST Action on evidence-based medicine run by the European Union. He holds several positions in international societies that resulted in many volunteering initiatives. He is a HIFA Country Representative.
https://www.hifa.org/support/members/tomislav https://www.hifa.org/people/country-representatives E-mail address: tomislav.mestrovic AT gmail.com [Public health professional, Academic]

Alice Nganwa (Uganda) is Executive Director at WIND Consult Limited in Uganda. Professional interests: Promote equity in development that includes marginalised people and addresses less popular but important development issues such as prevention of road traffic crashes, domestic violence, occupational safety, school health, healthy ageing and minimising alcoholism and other addictions. windconsultug AT gmail.com [Public health professional, Academic]

Neil Pakenham-Walsh (U.K.) is coordinator of the HIFA global health campaign (Healthcare Information For All - www.hifa.org ), a global community with more than 19,000 members in 177 countries, interacting on six global forums in four languages in collaboration with WHO. Twitter: @hifa_org F.B.: facebook.com/HIFAdotORG neil@hifa.org [HIFA moderator]

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29. Extracts below from a news release on the WHO Africa Regional Health Office website. Read online: https://www.afro.who.int/news/reinforcing-key-health-services-amid-covid-19

   Video: [https://www.youtube.com/watch?v=3WyEC0Acv_0](https://www.youtube.com/watch?v=3WyEC0Acv_0)


41. Webinar on Sounding the Alarm: Overcoming the fear of using services during Covid-19, by Care-Seeking & Referral Community of Practice. Link to the webinar-[https://us02web.zoom.us/rec/play/kOK1MzfWiCZENBriErgJglKeIwbH2w3mrB6kJU_EmrqBll0BPrr8Jm51-IevBO6HNOrcka7Bj0nvuxL6x.VGOModAghLXX2VBt](https://us02web.zoom.us/rec/play/kOK1MzfWiCZENBriErgJglKeIwbH2w3mrB6kJU_EmrqBll0BPrr8Jm51-IevBO6HNOrcka7Bj0nvuxL6x.VGOModAghLXX2VBt)