HIFA EHS-COVID-19 DISCUSSION

LONG EDIT (1-250 messages)

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HIFA is collaborating with WHO to promote sharing and learning of experience and expertise around the maintenance of essential health services during and after the pandemic, in a spirit of solidarity and co-development. Below is the structured long edit version of the discussion from message number 1 to 250. 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 1-250 (for discussion)

1. The discussion continues on HIFA and the total number of messages at 12 June 2021 is 401. Message number 251 to 401 are now being analysed in the same way.
2. The number of contributors (51) 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 were sent by the moderator. Most of these were directed to mobilise the group and for highlighting new publications.

From 30 October to 28 March 2021, there were 250 messages on the topic of maintaining essential health services during COVID-19, from 51 contributors in 18 countries (Bangladesh, Canada, Croatia, Germany, Honduras, India, Jordan, Kenya, Nigeria, Norway, Pakistan, South Africa, Switzerland, Timor-Leste, Uganda, UK, USA and Zimbabwe).

Our thanks to the contributors:

Alice Nganwa, Uganda
Allan Ragi, Kenya
Allison Squires, USA
Amanda BenDor, USA
Anna E. Schmaus, Germany
Ateeb Ahmad Parray, Bangladesh
Chris Zielinski, UK
Claire Allen, UK
Claire Glenton, Norway
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Farooq Rathore, Pakistan
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Henry Perry, USA
Irina Ibraghimova, Croatia
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Jack Muriungi, Kenya
Jackeline Alger, Honduras
Jagoda Khatri, Switzerland
Jakir Hossain Bhuiyan Masud, Bangladesh
Jane Lennon, UK
Joel Francis, South Africa
Joseph Ana, Nigeria
Katie Foxall, UK
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Mark Lodge, UK
Meena Cherian, Switzerland
Mija Tesse Cora Ververs, USA
Najeeb Al-Shorbaji, Jordan
Natalie Apcar, USA
Neil Pakenham-Walsh, UK
Patrick Wilson, UK
Richard Fitton, UK
Roberto Agapito Flores Olivera, Honduras
Sam Lanfranco, Canada
Shabina Hussain, USA
Shams Syed, Switzerland
Sian Williams, UK
Simon Lewin, Norway
Sunanda Kolli Reddy, India
Ted Lankester, UK
Tomislav Mestrovic, Croatia
Uzodinma Adirieje, Nigeria
Venus Mushininga, Zimbabwe
Vinay Bothra, Timor-Leste
Wale Adeleye, Nigeria
WHO COVID-19 HLH
Yael Misrahi, UK

The following selected extracts are from 17 contributors, whose profiles are shared in the profile section. These contributors included 9 health workers, 5 public health professionals, 1 NGO manager, 1 librarian/editor, and the moderator, representing 5 universities, 3 NGOs, and 2 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.

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).

J. Gnanaraj (India) The COVID-19 Pandemic severely affected the travel to the hospitals. Patients were afraid to go to the Hospitals for treatment for fear of getting infected. This affected many of the rural hospitals too.

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.

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, 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.

Jackeline Alger (Honduras) If we thought that the pandemic was already an extreme tragedy for a country's population and health system, in Honduras the natural phenomena Eta and Iota, category 4 hurricanes and tropical storms that affected Central America in the first two weeks of November 2020, caused extensive general damage especially. In particular, damage to health infrastructure adds to the negative effect of the COVID-19 pandemic on the provision of essential health services.

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

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.

Neil Pakenham-Walsh (U.K.) In the opening remarks[10] 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.

Neil Pakenham-Walsh (UK) Such services (rehabilitation services) might appear to be especially at risk of disruption. Furthermore, given that rehabilitation is already a relatively unsupported specialty in many countries, some services are perhaps vulnerable to being wrongly classified as 'non-essential'.

Neil Pakenham-Walsh (UK) Our discussions to date on HIFA suggest the impact of a COVID-19 resurgence on health services in Africa could be devastating. Let us hope that the current surge in infections will improve.

Neil Pakenham-Walsh (UK) I note that two of the challenges faced in India were to transfer healthcare skills by online training (this was affected also by digital skills challenges) and keeping frontline health workers motivated.

Neil Pakenham-Walsh (UK) The identification of essential health services inevitably means that some services will need to be designated as 'less essential' or 'non-essential'. It would be interesting to review and compare 'essential' and 'non-essential' services across countries. Politically, there are presumably major challenges in designating services as 'less essential' or 'non-essential'.

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

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.

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* *An extract from the report shared 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".*

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.

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

Metrics: 9 contributors in 7 countries (Cameroon, Croatia, Honduras, Hungary, India, 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. Contributors highlighted the need to improve coordination, resource availability and empower healthcare systems to reduce the adverse impacts of COVID-19 on healthcare services; environmental disasters affect resilience of health systems against COVID-19; need for proper identification of essential and non-essential services; problems associated with digital illiteracy; and misplaced fear of contracting COVID-19 in healthcare facilities.

What we have yet to learn: Perspectives from patients, caregivers and healthcare workers. Perspectives from diverse background is required to understand the scale of impact of COVID-19 on essential healthcare services globally.

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).

Jackeline Alger (Honduras) The effects of the epidemiological crisis due to the pandemics and the socio-economic crisis from ecological disasters are added up to produce a high short- and long-term negative impact on the population of Honduras.

Joseph Ana (Nigeria) Many people are engrossed in self-analysis of the tsunami of myths and misinformation and conspiracy theories about the COVID-19 disease, its cause, emerging vaccines (to take or not to take vaccine) that they miss the misery that is global.

Joseph Ana (Nigeria) It is true that the richer fraction of the Nigerian population unable to fly out on medical tourism since COVID-19 struck in 2020 they patronize the private hospitals which are relatively better equipped and managed than their public owned sister hospitals. But all you see is not what you get in practice because the lack of national standards and effective regulations and inspection means that the majority of private clinics are not better in many indicators than the public ones. It is also true that the richer ones who are also mostly the elites have screamed and shouted their newly discovered surprise at the state of the health system and structures. But you wonder

where they were born, where they grew up, where they schooled (primary, secondary and University) and until COVID-19 where they lived most of the time? The system is broken everywhere in the country for decades, so where were these elites?

Roberto Agapito Flores Olivera (Honduras) Fear and stress are normal responses in situations of change or crisis. So, it is understandable that patients experience these feelings in the context of the COVID-19 pandemic. Stress due to fear of contracting the virus, adds the impact of the important changes in our daily lives caused by the efforts to contain and stop the spread of it. Fears that patients transfer as frustration towards health personnel, including personal discrimination. As health personnel it is important to instil in patients to take care of both our physical and mental health.

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."* *

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).

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: 7 contributors in 6 countries (Cameroon, Honduras, Hungary, Nigeria, Timor Leste, & U.K.)
What we learned: **Cameroon:** People no longer come to clinic, fled to rural areas; **India:** Acute food insecurity, malnutrition and high child mortality; prolonged period of unemployment and hunger; **Timor Leste:** Anxiety, reduction in hospital deliveries of the new-born; increase in home deliveries; reduction in ante-natal visits; drop in family planning; anxiety and concerns around COVID-19 have adversely impacted health services.
Contributors reported the lack of emergency preparedness and poor pandemic response in many countries due to socioeconomic limitations, environmental disaster and the lack of a developed healthcare ecosystem which leads to poor quality of care and ineffective management.
What we have yet to learn: Perspectives from different regions; direct and indirect consequences of the pandemic; conditions in low capacity and in humanitarian settings; effect of pandemic/lockdown on vulnerable groups, patients suffering with communicable and non-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.

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 feed-back are parts from evaluation sheet. In some low resources setting, the students contribute to buy the needed equipment and resources.

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 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.

Joseph Ana (Nigeria) At this point, it actually does not feel like genuine cries, does not feel like a renaissance of strong health system strengthening is about to hit African countries, including Nigeria. Where is the investment to back any plans? It does not feel like COVID-19 is the thing that will change everything about weak health system. I would like to be pleasantly surprised!

Neil Pakenham-Walsh (UK) By contrast with the UK, where the elderly are prioritized for vaccination over health workers, India has resolved to vaccinate an estimated 10 million health workers in the first round.

Neil Pakenham-Walsh (UK) This paper[43] presents a multi-faceted approach. Success is perhaps more dependent on planning and implementing basic public health measures, than on identifying innovative 'magic bullets'. The last comment is interesting: 'Open communication, partnership and strong local leadership are free and can be fostered in any environment.' This has become atruism in public health, and yet it is not straightforward to foster 'open communication, partnership and strong local leadership'.

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%.

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.

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.

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

Metrics: 7 contributors in 5 countries (Cameroon, Croatia, Hungary, Nigeria & UK)
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.
Contributors highlighted the need for protection and empowerment of frontline healthcare workers; need to establish open communication, partnership and strong local leadership; effective policy legislation and implementation is much needed to overcome the challenges faced by countries and healthcare systems worldwide.
What we have yet to learn: Perspectives from different health systems; assessment at national, sub-national and lowest governance rung; targeted policies, principles and practical recommendations implemented by countries to ensure the continuity of essential health services.

Q4. Which groups are especially vulnerable to health service disruptions? How can we ensure they are protected at this time?

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.

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).

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.

Jack Muriungi (Kenya) From where I stand, I do believe, lack of health care education has really contributed to social/economic suffering for poor urban and rural communities and so developing countries governments should emphasize more on community health education as opposed to doing quick short term health interventions.

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.

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.

Joseph Ana (Nigeria) In a world suffering from decades of severe shortages in Human Resources for Health, COVID-19 exacerbates the situation to unbearable levels, again, LMICs are more affected. One hopes that the HIC (with their own economic hardship) can carry LMICs along especially on the vaccines and eventual effective treatments.

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 [(11)] 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 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.

Neil Pakenham-Walsh (UK) There is indeed a strong case for a greater focus in 2021 on empowerment. Empowerment of the general public, caregivers and health workers with the reliable healthcare information they need to protect their own health and the health of those for whom they are responsible. This is especially important in low-resource settings where trained health workers may not be readily available.

Neil Pakenham-Walsh (UK) Many of us have been truly shocked by the blatant disregard of science by several political leaders. We can never have global health if such leaders are allowed to continues to act against science, with impunity. They must be held to account.

Neil Pakenham-Walsh (UK) This paper[(39)] is a reminder that it is not only the content of healthcare information that needs to be evidence-informed. So too does the process of healthcare communication in all its complexity and diversity.

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.

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.

Venus Mushininga (Zimbabwe) I concur with the need to harness the use of telemedicine as we work to revitalise oncology services. This also requires a shift of policy in some countries which did not have provisions for telemedicine in their legislation. In my opinion it will be critical to look at issues of data integrity and issues of confidentiality as we try to serve our clients in the best ways we can.

Editorial Comment: Q4. Which groups are especially vulnerable to health service disruptions? How can we ensure they are protected at this time?

Metrics: 10 contributors in 9 countries (Cameroon, Croatia, Kenya, Nigeria, Switzerland, Timor Leste, Uganda, UK, Zimbabwe)

What we learned:

Group/people identified as vulnerable are - Mothers; new-born; unprotected children in need of routine immunization services; people with chronic illness: patients in need of palliative care; poor citizens; people with disabilities; orphans; people living far from the health clinic/facilities; patients suffering with NCDs; patients in need of surgical treatment/care.

Actions taken/needed to ensure protection of vulnerable groups - Invest in specialised nurses & community health care workers; use of mobile palliative care teams; better timed national or regional restrictions; enforcement of population-wide preventive messages; re-purposing WHO technical staff to work closely with district immunisation coordinators has been invaluable in building trust and competence for health workers; door-to-door campaigns to identify and vaccinate unprotected children; efficient use of allied health care workers; role of community health education; telemedicine and integration of technology-driven solutions; role of evidence-based health communication.

What we have yet to learn: On-ground data from rural communities and resource limited settings; conditions of vulnerable population; experience from frontline workers; experience of COVID-19 recovered patients and their families; impact of disrupted delivery of care; use of strategies and policies by various Governments.

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.

Neil Pakenham-Walsh (UK) The WHO guidance is understandably thin on detail around implementation of telehealth. Its recommendations do not specifically link to further details.

Neil Pakenham-Walsh (UK) The (Lancet) commission[40] barely mentions the impact of COVID-19 on eye health services. I also note that eye health services are not mentioned in the WHO guidance on Maintaining essential health services: operational guidance for the COVID-19 context interim guidance.

Neil Pakenham-Walsh (UK) It's notable that the WHO Guidance on Maintaining Essential Health Services during COVID barely mentions the role of Community Healthcare Worker (CHWs). In what ways can CHW services be deployed or adapted to help maintain essential health services during COVID?

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

Metrics: 2 contributors from 2 country (Nigeria & UK)
What we learned: Though all principles are equally important but highest level of "Political Will" can make all the other nine points achievable; use of digital platforms needs modification to meet specific community needs (e.g., multilingual content)
Contributors reported WHO guidance lacks detailed planning and guidance on following aspects: implementation of telehealth; eye health services during COVID-19; and the role of CHWs during COVID-19.
What we have yet to learn: How each principle can shape and define essential health services and what necessary steps and policies should be framed to achieve this goal. Thorough investigation is required to better understand community/region specific requirements.

Misinformation

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 effectively; 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.

Impact of COVID-19 Pandemic on Healthcare Workers

Joseph Ana (Nigeria) It took strike actions by different sets of health workers for the Nigerian government to ensure front line health workers and increase the paltry risk allowance earlier in the pandemic. Why it must take a strike by workers In African countries to do what is safe and right, bothers many of us.

Neil Pakenham-Walsh (UK) I was outraged to learn today that exhausted NHS (UK) health workers treating COVID patients are receiving a torrent of abuse from the general public. This abuse is fuelled by false beliefs that COVID is a hoax or a conspiracy. This must be hugely distressing to health workers at a time when they need the most support. Meanwhile we hear that nearly half of NHS critical care staff are currently suffering from Post-Traumatic Stress Disorder (PTSD), depression or anxiety.

Editorial Comment: Impact of COVID-19 Pandemic on Healthcare Workers

Metrics: 2 contributors from 2 countries (Nigeria & UK)
What we learned: Rise in discrimination and abuse of healthcare workers; demand to increase allowance for healthcare workers; role of false news and myths; healthcare workers suffering with PTSD.
What we have yet to learn: How to protect healthcare workers; role of government and the community in creating a safe, stress-free working environment for healthcare workers; sustainable solutions and long-term approach to end the plights of healthcare workers.

Profiles

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J Gnanaraj (India) is a Urologist and laparoscopic surgeon trained from Christian Medical College, Vellore. He is currently the Director of Medical Services of SEESHA which is a social service wing of the Jesus Calls ministry. He has upgraded the facilities at the Karunya Rural community hospital at Karunyanagar to a center for minimally invasive surgeries and started the heath care plan and the master heath check -up and the outpatient clinic at Coimbatore. He designed C3MDS the hospital management software along with computer personnel and designed local modifications and installed it many missions and other hospitals. This is being upgraded to a web-based version compliant with the requirement of the National Accreditation Board for hospitals and health care facilities in India. He has designed low-cost medical equipment for use at the mission hospitals and doing research on medical equipment in Karunya University. He is the Editor of the Rural surgery Journal of the Association of rural surgeons of India and has 45 publications in national and international Journal. He has presented papers at the conferences of Association of Surgeons of India (Calcutta, Cuttack and Madras), Urological Society of India (Bangalore & Nagarjunasagar), Association of Southern Urologist of India (Ooty & Vellore), Indian Medical Association (Trichy), Rural Surgery (Sivakasi, Ujjain, Sewagram), Association of surgeons of Assam (Silchar), International Federation of rural surgeons (Ifakara, Tanzania), WHO CME for rural surgeons (Herbertpur), International College of Surgeons conference (Trichy). He has organized many innovative diagnostic and surgical camps at interior rural places in India. jgnanaraj@gmail.com

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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. http://www.hifa.org/support/members/joseph-0 http://www.hifa.org/people/steering-group Email: jneana@yahoo.co.uk

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