Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

*Rebekah Rollston, Elizabeth Wilkinson, Rasha Abouelazm, Petar Mladenov, Nour Horanieh, Yalda Jabbarpour
rrollston@challiance.org

Tufts University School of Medicine, Cambridge Health Alliance, Malden, MA 02148, USA (RR); Robert Graham Center, Washington, DC, USA (EW, YJ); United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), Cairo, Egypt (RA); United Nations Population Fund (UNFPA), Sofia, Bulgaria (PM); and London School of Hygiene & Tropical Medicine, London, UK (NH)

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COVID-19: Africa needs unprecedented attention to strengthen community health systems


Last Mile Health

As the first cases of COVID-19 were confirmed in Liberia, in March, 2020, former President Ellen Johnson Sirleaf,[1] among others,[2] highlighted the need to adopt lessons learned from the response to the 2014–16 outbreak of Ebola virus disease in west Africa. Ebola claimed about 11 300 lives in 21 months across Liberia, Sierra Leone, and Guinea.[3] Comparisons to Ebola benefit from remembering the key differences between the two viruses. Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is a respiratory virus and is infectious among asymptomatic carriers.[4] SARS-CoV-2 differs from Ebola virus in terms of the reproduction number (SARS-CoV-2 5·7 *vs* Ebola 1·5–1·9),[5,6] incubation period (2–14 days *vs* 8–10 days on average),[7,8] and case fatality rate (this varies for SARS-CoV-2 but average is estimated at 4·7% as of July 7, 2020, *vs* up to 90% for Ebola).[9,10] COVID-19 is easier to transmit, harder to diagnose, and can quickly spread in communities.

The Ebola response showed the importance of investments that build health system resilience, notably investments in the health workforce.[11] Unfortunately, community engagement largely occurred too late in the Ebola response.[12,13] To date, there are no studies of how well countries adopted the lessons learnt from Ebola for COVID-19 and this will be a critical future exercise.

At the onset of the COVID-19 pandemic in sub-Saharan Africa, governments took swift action to institute lockdown measures, activate incident management response systems, and mobilise front-line health workers to be trained. However, some months into the pandemic preliminary evidence suggests that human resources for health in sub-Saharan Africa have been inadequately prepared. Community health workers (CHWs) have insufficient personal protective equipment (PPE) to ensure they can continue providing essential care[14] and most countries face severe shortages of health workers.[15] This situation is concerning because of the importance of CHWs in the COVID-19 response. CHWs are a key component of pandemic response strategies,[16] they were used in the COVID-19 response in China,[17] and there are

recommendations on how CHWs can be supported to interrupt virus transmission while maintaining essential services and shielding vulnerable populations.[18]

Feedback from the field in Liberia is, however, alarming. In Rivercess County, Liberia, where there has only been one suspected COVID-19 case that was confirmed negative as of June 30, 2020, some caregivers refuse to attend mobile clinics or facilities for vaccinations and there has been a reduction in care seeking among some adults (Saykpah R, unpublished). People fear health workers are spreading COVID-19 and CHWs, while trusted neighbours, have insufficient PPE to convince people otherwise. The stakes are high for people's health if there is any reduction in care-seeking behaviour for preventable diseases.[19] To its credit, Liberia, scarred from the Ebola outbreak, has been training its National Community Health Assistants to prevent, detect, and respond to COVID-19 while maintaining essential services and is in the process of procuring PPE for CHWs.[20]

COVID-19 is the new public health backdrop and we cannot wait to strengthen community health systems. CHWs matter because they are trusted members of the community who are often the most accessible point of care, particularly for vulnerable populations—eg, in Sierra Leone, CHWs outnumber doctors 95 to one.[21] Indeed, the Africa Centres for Disease Control and Prevention is planning to recruit 1 million community health volunteers to support contact tracing across sub-Saharan Africa,[22] relying on existing CHW cadres. Ongoing efforts to leverage CHWs for the COVID-19 response must not be one-offs in the face of an emergency. CHWs must be equipped, trained, and supported in the long term as a crucial human resource for health.

Trillions of dollars have been committed[23] in just over 6 months for the COVID-19 response globally. A COVID-19 vaccine or therapy will take months to become commercially available and likely longer to access in low-income countries.[24] If a vaccine, treatment, or reliable diagnostic is available, adoption in places with shortages of human resources for health will be a struggle. A comparative US$2 billion[25] annual investment to bolster CHWs as a health system strengthening platform for primary care is a drop in the ocean. Now is the time to invest in community health systems in sub-Saharan Africa and avert a greater crisis.

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*Lyudmila Nepomnyashchiy, Bernice Dahn, Rachel Saykpah, Mallika Raghavan
mila@CHAP.health

Community Health Acceleration Partnership, New York, NY 10020, USA (LN); University of Liberia, Monrovia, Liberia (BD); Last Mile Health, Monrovia, Liberia (RS); and Last Mile Health, New York, NY, USA (MR)

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The Lancet–Chatham House Commission on improving population health post COVID-19

Jorge Silva/Reuters

The health of populations across the planet is in a perilous state during the COVID-19 pandemic, with more than 550 000 deaths worldwide as of July 10, 2020.[1] The disease burden is falling mainly on the most disadvantaged groups worldwide and there are major impacts on health systems across high, middle, and low-income countries. In parallel with these direct health impacts, the economic effects of lockdowns are leading to an unprecedented global recession which will have ramifications well into the future. But while the focus is, rightly, on responding to the immediate threat of the pandemic, it is important to remember that over 40 million people die each year from non-communicable diseases (NCDs), more than 70% of all global deaths.[2]

Meanwhile, the climate and extinction crises pose unprecedented challenges to our planet, with government responses—as yet—inadequate.[3] Global temperatures are set to increase substantially over the coming decades, leading to untold health, environmental, and economic consequences,[4,5] while the unfolding sixth mass extinction threatens to unravel many of the essential ecosystems on which we all depend.[3]

There are, however, some reasons for cautious optimism. Responses to the COVID-19 pandemic show that nations can act rapidly and radically in response to major immediate threats to health, even at huge economic cost. These actions have generated important co-benefits in terms of reductions in urban air pollution[4] and carbon dioxide emissions, at least over the short term.[6] Maintaining resilience during this pandemic—and those yet to come—will require these and many more long-term changes in patterns of travel, development, and human interactions. As economies open up and lockdowns ease, this resilience will once again be under threat, as will both the environment and population health. It will be even more important to take urgent action on climate change, environmental sustainability, economic policy, and health inequalities.[7–12]

These three major threats to population and planetary health—communicable diseases, NCDs, and the climate and environmental emergencies—are too often treated as distinct problems, but they are intimately entwined in a global syndemic as reflected in the top global risks identified by the World Economic Forum in 2020.[13] They possess common underlying causes including unsustainable systems of agriculture, subsidies for harmful products, and overcrowded cities. The transmission of a novel coronavirus from bats to humans might be the dominant model of the genesis of the COVID-19 pandemic, but without urbanisation and global hypermobility it would have spread much more slowly and might have been contained; without high prevalence of NCDs[14] and air pollution[15] it would have exerted a much lower toll.

Breaking the clinical, academic, and policy boundaries that promote separation of these threats demands new ways of understanding and tackling them in order to respond effectively to the combination of the worst pandemic for over a century with the largest economic downturn in modern history. Foregrounding this economic context will be essential for any credible attempt to address these threats.

The dominant policy focus for tackling the key behaviours that contribute to NCDs worldwide—unhealthy diets, smoking, alcohol consumption, and physical inactivity—largely ignores the roles of commercial and other non-state actors, publics, policy makers, and others in driving these behaviours.[16] As with COVID-19,