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quality health care but have not managed to scale up.

Most Africans live under the poverty line and cannot afford to pay for health care. Thus, it is critical to remove financial barriers to ensure that telemedicine reaches all people. There are a number of innovative financing mechanisms that should be tried to scale up telemedicine.<sup>3</sup> These mechanisms include health-care impact bonds that have leveraged US\$25 million to tackle malaria in Mozambique<sup>4</sup> and \$2 million in Cameroon to provide 18 000 cataract surgeries over a 5-year period.<sup>3</sup> Patton and Joseph, in their *New (not-so-Oxford) Dictionary of Innovative Finance*, suggest another alternative is the use of diaspora bonds, which allow Africans living outside of their home countries to invest in local projects. Similarly, they suggest charity bonds are opportunities to provide start-up funding by financing medium-term debt to support project implementation.

Scaling up telehealth requires strong political will to drive innovation by partnering with the private sector and the diaspora to facilitate increased sustainable funding opportunities in African countries to ensure greater health-care access equity.

I declare no competing interests.

Yap Boum

yap.boum@epicentre.msf.org

Epicentre, Yaoundé, Cameroon; Faculty of Medicine and Biomedical Sciences, University of Yaoundé I, 12069 Yaoundé, Cameroon

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## Authors' reply

We thank Yap Boum for taking the time to respond to our Perspective.<sup>1</sup>

Boum focuses on one particular dimension of our argument, namely that scaling up and securing long-term funding poses a considerable challenge for mobile health projects in Africa. It is indeed the case that the vast majority of mobile health interventions in sub-Saharan Africa are being designed as experimental, pilot infrastructure for care or surveillance. In response to this challenge, Boum calls for the creation of innovative financing mechanisms and strong political will. He appears particularly optimistic that more sustainable financing would lead to more viable mobile health infrastructure.

In our own experience, however, long-term financing is only one among many conditions that need to be gathered for scaling up to be made possible. As we suggested in our Perspective,<sup>1</sup> a project such as MOS@N could not be durable without a series of improvisations in the face of challenges of all kinds—including crucial changes in the role of godmothers.

The way that MOS@N has evolved over the course of 3 years was not anticipated. Although financing is certainly an important part of the story, MOS@N was held together by labour, commitments, and relations of care that do not easily translate into predictable features. In other words, while we agree with Boum that sustainable funding solutions are key to integrate mobile health into health-care infrastructure in sub-Saharan Africa, the work it takes to create scalability is messy and capricious. Funding is important but it is only one part of the story. Addressing the other parts entails rethinking our approach to mobile health projects altogether, perhaps insisting less on expectations of scalability and paying more attention to projects' capacity to transform and reinvent themselves as they expand.

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N Hélène Sawadogo, Hamidou Sanou, Jeremy A Greene, \*Vincent Duclos  
duclos-belanger.vincent@uqam.ca

Département de Sociologie, Université Catholique de l'Afrique de l'Ouest, Bobo-Dioulasso, Burkina Faso (NHS); Groupe de Recherche sur les Initiatives Locales, Université Joseph Ki-Zerbo, Ouagadougou, Burkina Faso (HS); Department of History of Medicine, Johns Hopkins University School of Medicine, Baltimore, MD, USA (JAG); Département de Communication Sociale et Publique, Université du Québec à Montréal, Montréal, QC H2L 2C4, Canada (VD)

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For Patton and Joseph's *New (not-so-Oxford) Dictionary of Innovative Finance* see <http://insideoutpaper.org/the-new-not-so-oxford-dictionary-of-innovative-finance/>

## COVID-19 and myocardial infarction

Ioannis Katsoularis and colleagues<sup>1</sup> found that COVID-19 is a risk factor for myocardial infarction and stroke through self-controlled case series evaluation, a method that has been used to establish the risk of myocardial infarction associated with influenza infection.<sup>2,3</sup> Regarding myocardial infarction, as the investigators recognised, one of the possible limitations of this research is the inaccurate diagnosis and codification of myocardial injury or myocarditis as myocardial infarction, particularly because the current myocardial infarction definition (and diagnostic methods) differ from the definition at the time of the registry outcome validation study.<sup>4</sup> In this context, we would like to stress that it is important to report either the risk estimates for ST-segment elevation myocardial infarction similarly to previous influenza studies,<sup>5</sup> or the risk of coronary revascularisation procedures after COVID-19, to decrease the potential bias and increase the robustness of the data and conclusions.

We declare no competing interests.

\*Daniel Caldeira, Fausto J Pinto  
dcaldeira@medicina.ulisboa.pt



Barbara Gindl/APA/APF/Getty Images

Centro Cardiovascular da Universidade de Lisboa, CAML, Faculdade de Medicina da Universidade de Lisboa, Lisbon 1649-028, Portugal; Cardiology Department, Hospital Santa Maria – Centro Hospitalar Universitário Lisboa Norte, Lisbon, Portugal

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### Authors' reply

We thank Daniel Caldeira and Fausto Pinto for their comments regarding our study<sup>1</sup> focusing on COVID-19 and myocardial infarction. We did acknowledge the difficulties in distinguishing between different types of myocardial injuries in the discussion. The International Classification of Diseases versions 9 and 10 unfortunately do not distinguish between ST-segment elevation myocardial infarction (STEMI) and non-ST-segment elevation myocardial infarction (NSTEMI), which is a limitation of our study.<sup>1</sup> Because STEMI and NSTEMI have partly different clinical characteristics and pathophysiology, it is quite possible that one might be affected more by COVID-19 than the other, as Caldeira and Pinto observe.

However, we do not believe that merely looking into coronary revascularisation procedures will provide clear answers, because the clinical decision to go through with these procedures might in itself be affected by the presence of COVID-19. We also observed an increased risk

of ischaemic stroke, which shares some of the same pathophysiological features as myocardial infarction. Furthermore, the increase in the risk of myocardial infarction was of the same magnitude as for ischaemic stroke, for which the risk of inaccurate diagnosis codification was low. Therefore, the case of a connection between COVID-19 and cardiovascular events is strengthened.

We declare no competing interests.

**Ioannis Katsoularis,  
Oswaldo Fonseca-Rodríguez,  
Paddy Farrington, Krister Lindmark,  
\*Anne-Marie Fors Connolly**  
anne-marie.fors.connolly@umu.se

Department of Public Health and Clinical Medicine (IK, KL) and Department of Clinical Microbiology (OF-R, A-MFC), Umeå University, Umeå 901 85, Sweden; School of Mathematics and Statistics, The Open University, Milton Keynes, UK (PF)

- 1 Katsoularis I, Fonseca-Rodríguez O, Farrington P, Lindmark K, Fors Connolly A-M. Risk of acute myocardial infarction and ischaemic stroke following COVID-19 in Sweden: a self-controlled case series and matched cohort study. *Lancet* 2021; **398**: 599–607.

### Department of Error

*The HIP ATTACK Investigators. Accelerated surgery versus standard care in hip fracture (HIP ATTACK): an international, randomised, controlled trial. Lancet* 2020; **395**: 698–708—In this Article, numbers of patients in the subgroup analysis have been corrected, including in the Results and Discussion text and in the appendix. These corrections have been made to the online version as of Nov 25, 2021.

*Ponikowski P, Kirwan B-A, Anker SD, et al. Ferric carboxymaltose for iron deficiency at discharge after acute heart failure: a multicentre, double-blind, randomised, controlled trial. Lancet* 2020; **396**: 1895–904—In this Article, Stephan von Haehling's affiliations should have included "DZHK (German Center for Cardiovascular Research), Göttingen partner site, Göttingen, Germany". Department names within the University Medical Center Göttingen should also have been included for Stephan von Haehling and Tim Friede. These corrections have been made to the online version as of Nov 25, 2021.

*Prasad A, Stephani Hatch: rethinking power in health-care research. Lancet* 2021; **398**: 1559—In this Profile, the second sentence of the fourth paragraph has been corrected to read "...Health and Social Equity Hub for which she is a Co-Principal Investigator". This correction has been made to the online version as of Nov 25, 2021.

*Watts G, Gwynifer Clare Wenger. Lancet* 2021; **398**: 1562—In this Obituary, Richard Hadley has been corrected to Roger Hadley in the final sentence. This correction has been made to the online version as of Nov 25, 2021.

*Abu Dayyeh BK, Maselli DB, Rapaka B, et al. Adjustable intragastric balloon for treatment of obesity: a multicentre, open-label, randomised clinical trial. Lancet* 2021; **398**: 1965–73—In this Article, where missing, 95% CIs, SDs, and n/N have been added. Additionally, findings for alanine aminotransferase concentrations have been added to the Results. These corrections have been made to the online version as of Nov 25, 2021, and the printed version is correct.

*Fleming KA, Horton S, Wilson ML, et al. The Lancet Commission on diagnostics: transforming access to diagnostics. Lancet* 2021; **398**: 1997–2050—In this Commission, in the section about using governance to make diagnostics more affordable, the sixth sentence of the fourth paragraph should have read "The Treatment Action Group was key in the movement to getting equitable pricing for antiretrovirals for HIV/AIDS and, more recently, has applied similar efforts to diagnostics, such as the Time for \$5 campaign for GeneXpert cartridges." This correction has been made to the online version as of Nov 8, 2021, and the printed version is correct.



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