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both of whom are leading the Global Registry of COVID-19 in Childhood Cancer,¹ launched the Global Initiative for Childhood Cancer with the overall target to cure 60% of all children with cancer globally and decrease suffering for all.⁹

The CureAll Framework for childhood cancer outlines the steps necessary to improve access to care and reduce inequalities as part of building more resilient health systems and achieving universal health coverage (figure).¹⁰ This framework is feasible for all countries and in all contexts.

The data from Mukkada and colleagues' study¹ provide us with a new understanding of childhood cancer during the pandemic. When combined with the legacy of global collaboration in childhood cancer and political prioritisation through the WHO Global Initiative for Childhood Cancer, there is a unique opportunity to develop and implement mitigation strategies, tailored to the current threats encountered in specific health systems, and to reduce globally inequalities. Collaboration and solidarity drive progress in childhood cancer care. This approach has been shared among the childhood cancer community for decades and is needed now more than ever.

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Anticipating the COVID-19-related surge in cancer care demand is urgent in Latin America and the Caribbean



The COVID-19 pandemic has disrupted regular health services in every health system worldwide, and cancer care is no exception. In Latin America and the Caribbean, cancer services have been reported to be foregone or delayed, including first-time visits to oncology services, pathology, cancer surgery, chemotherapy, and screening tests,¹ with similar findings in the paediatric cancer field.² The study by Zachary J Ward and colleagues³ published in *The Lancet Oncology* goes a step further; using data from five cancer sites in Chile, their study assesses the future effects of delayed diagnosis on cancer outcomes. The study³ estimates that an overburden of 14% of cancer diagnoses is already starting in

2021, with worse cancer stage distribution, predicting an excess in cancer deaths of 10.8% in 2022–24 compared with a counterfactual scenario with no COVID-19. This analysis does not consider eventual treatment delays or issues with quality of care that might further increase these projected negative trends for Chilean patients with cancer. Further, the trends might be worse for marginalised and minority population groups, such as those from indigenous communities.

Since other countries in Latin American and the Caribbean are showing similar trends of foregone or delayed cancer services, the findings of this study³ serve as a warning sign for governments and other

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See [Articles](#) page 1427

stakeholders in the region. That business as usual will not be enough to cope with the surge in demand is almost certain, and thus, the response will be crucial for the time-critical care that patients with cancer require. Health systems will face the urgent need to innovate and introduce new service-delivery schemes to increase capacity while aiming as much as possible to maintain quality and assure equity in access to cancer services.^{4,5} How to maintain these targets is one of the most crucial questions for decision makers, which can be informed by existing and future research.

Emphasis should be placed on both ends of the cancer care continuum. On the one hand, prioritising screening efforts for high-risk patients and aiming to identify the largest number of patients with early-cancer stages to compensate for the lost time, will increase the odds of successful treatment and good prognosis.⁶ Various frameworks have been proposed, and localised efforts to generate frameworks appropriate for each setting are necessary for adequately prioritising cancer care.⁷ On the other hand, palliative care is an area of great concern considering the excess mortality predicted by Ward and colleagues.³ Estimating the need for palliative care was not in the scope of the study, but the need to alleviate pain and other forms of serious health-related suffering experienced by patients with cancer, from the point of diagnosis to the end of life, is expected to increase in the coming years, and this increase has only been exacerbated by the pandemic.⁸ Given that palliative care is comparatively weak (in terms of access, quality, monitoring, and financial protection) in the health systems of Latin America and the Caribbean,⁹ a special emphasis should be placed on this type of care. National opioid-medication reserves have to be increased, whereas rapid basic training on the rational use of opioid medications and on end-of-life conversations must be offered to health professionals at all levels of care.

From a patient's perspective, communication will be crucially important, both among health-system actors and between health-system actors and patients. For instance, in most Latin American and Caribbean countries, there are no clear pathways of care for most cancers that both patients and providers are aware of and can rely on, which in many cases generates confusion and delays. Case managers and patient-navigation programmes can help to overcome these

issues, with the potential to provide more people-centred services while reducing delays in diagnosis, treatment, and loss to follow-up.¹⁰ In addition, the number and location of all patients with cancer is unclear because of fragmented surveillance systems. Patient organisations represent a complementary resource to improve information flow and can provide a fundamental interface for connecting patients and their families with the health system, while advocating for system-wide improvements. For instance, the Asociación Chilena de Agrupaciones Oncológicas (ie, the Chilean Association of Oncology Organisation) advocated for the approval of the National Cancer Law in 2020, a key milestone for cancer control in the country, and has been the main voice for patients with cancer during the COVID-19 pandemic in several participation spaces within the government and congress. Other Latin American and Caribbean countries could also enhance the organisation of patient-advocacy efforts and the formal involvement of patients in decision making.

Similar studies to that of Ward and colleagues³ can be done in other Latin American and Caribbean countries and elsewhere to inform decision making and health-care provision redesign. The coming surge in cancer-care demand is an issue of urgency for health systems globally.

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Importance of modelling for cancer management during COVID-19



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See [Articles](#) page 1427

Similar to most countries in Latin America, Chile has been greatly affected by the COVID-19 pandemic with very serious and devastating health and economic consequences. The first case of COVID-19 was detected in Chile on March 3, 2020, and since then the country has been implementing control measures (eg, mass testing, centralised intensive care bed management, and mandatory confinement) as recommended by national and international experts to suppress and mitigate the effect of its spread.¹ By July 31, 2021, Chile, which has a population of about 18 million, had more than 1.6 million confirmed COVID-19 cases, with approximately 36 700 deaths and more than 8900 new daily cases reported in June, but 700 new daily cases in August, 2021. Starting on Feb 3, 2021, Chile has been able to rapidly deploy an effective vaccination campaign and 80% of its target population has been fully vaccinated as of Aug 2, 2021.² Rapid scale up of vaccination has enabled a reduction in severe cases among the vaccinated population and we hope to complete full coverage of our population in the next few months.

However, COVID-19 has created major challenges for the health system in the management of other very important health problems, such as cancer. Most patients with cancer have not been able to access the health system because of capacity constraints (particularly bed shortages) and many have delayed contact with the health system even when they had symptoms because of fear of contracting COVID-19. The unprecedented rapid rise in demand for health services has created major capacity constraints with consequent delays in cancer screening, diagnosis, surgery, radiotherapy, and chemotherapy.^{3,4} The

health policy in Chile is focused on controlling the acute COVID-19 cases but also increasingly on the long-term consequences this pandemic will have on the management of chronic non-communicable diseases, such as cancer, to mitigate the adverse health, social, economic, and cultural consequences of the long physical and social confinements on the population in Chile. Understanding the magnitude of the adverse consequences of COVID-19 on the health system and the management of other conditions is crucial for estimating the true effect of COVID-19. This intelligence is also needed to efficiently and effectively manage non-COVID-19 conditions, to guide policy development, and to enable appropriate planning of services and surge capacity to ensure that the health system is responsive and resilient.

Cancer is the second biggest cause of death after cardiovascular disease in Chile, with around 60 000 new cases a year and approximately 30 000 deaths.⁵ A quarter of all deaths in the country are caused by cancer.⁵ Since 2018, the Chilean Ministry of Health has introduced very important changes for cancer control and care. In 2018, the 2018–28 National Cancer Plan was developed with the participation of civil society, including universities, scientific societies, foundations, and patient groups.⁶ The National Cancer Plan defines a comprehensive national strategy to address cancer in all its aspects, including prevention, early diagnosis, timely treatment, palliative care, and rehabilitation. One of the most important contributions of this plan is the implementation of a population-based cancer registry, which will allow Chile to have relevant information for decision making and public policies. In 2020,