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The fragility of abortion access in Europe: a public health crisis in the making

Poland is rightly being criticised for suppressing abortion services.¹ Since January, 2021, abortion is only legal if the pregnancy is directly life-threatening or the result of rape or incest. However, countries with allegedly more progressive policies have reasons to be self-critical as well.

An example is Germany, considered a liberal country in terms of abortion law from an international perspective, since women can be granted an abortion on request for any reason, including socioeconomic reasons. Yet, abortion in Germany is technically a crime (albeit not punished up to 12 weeks from conception), and gynaecologists are losing court cases for stating on their websites that they provide abortion care in a supportive environment.² Attacks on abortion rights and services are nourished by vocal conservative and religious forces whose agendas find support in a non-negligible share of the population.

The number of doctors providing abortion services is declining,³ teaching of abortion techniques in medical schools is marginal,⁴ and a mandatory consultation before an abortion (in some regions done by religious organisations) and a so-called cooling-off period add barriers to access.⁵ As a result, some women from Germany (and other European countries) are seeking care in the Netherlands, as highlighted by the Europe Abortion Access Project.

Women on Web, a non-governmental organisation, has recently recorded an increased demand for abortion pills in Germany.⁶ The COVID-19 pandemic has created further access challenges, in the form of reduced opening hours of clinics, fewer social infrastructures, and rise in domestic violence. Contrary to some other countries (eg, the UK and

France),⁷ demands from reproductive health activists to modify medical abortion delivery (eg, through telecare or drug mailing) have remained unheard in Germany.

Yet Germany is still seen as a safe haven for Polish women who are living in fear under one of the strictest abortion laws in Europe. Poland and Germany are only two examples of how fragile abortion access remains in Europe (in both constrained and more liberal societies) paving the way for a public health crisis. Denied or reduced access to abortion services has short-term and long-term health consequences, and disproportionately affects the most vulnerable groups in societies. Initiatives led by civil society (eg, Doctors for Choice, Women on Web) and crossborder care alone cannot compensate for the scarcity of governmental impetus, and cannot mitigate the threats to abortion rights coming from growing right-wing and anti-feminist movements in Europe. As a matter of health equity, abortion access needs to be sustainably guaranteed in practice, including beyond the allegedly permissive legislations.

CM reports funding from Bielefeld University, Germany, for a postdoctoral researcher position. OR declares no competing interests. The funders had no role in the writing of or decision to submit this Correspondence.

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For more on the **World's Abortion Laws** see <https://maps.reproductiverights.org/worldabortionlaws>

Critically ill COVID-19 patients in Africa: it is time for quality registry data

The African COVID-19 Critical Care Outcomes Study (ACCCOS) Investigators are to be commended for providing the first multinational study reporting epidemiological, management, and outcome data of critically ill COVID-19 patients in Africa.¹ However, this important effort lags behind other international cohorts in timing and included less than half of the countries expected by the study investigators.^{1,2}

During this period of accelerated COVID-19 research in low-income and middle-income countries (LMICs),³ it is important to understand barriers to data acquisition, often attributed to research infrastructure limitations.

Critical care registries provide real-time, low-cost epidemiological, management, and outcome data. Although registry output has historically been low in the hierarchy of evidence,⁴ methodological improvements, international harmonisation efforts, and widespread implementation in LMICs are underway, providing



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robust data for pandemic preparedness, reporting, and response.

Crit Care Africa, funded by UK Research and Innovation, and a sibling of the ten-country Wellcome-funded Asia network,⁵ is one such initiative that has built a federated network of high-quality registries of intensive care units across the continent. The network uses a setting-adapted data platform and a Common Data Model, enabling local research priorities and seamless data sharing with the WHO–International Severe Acute Respiratory and Emerging Infection Consortium pandemic protocol (appendix). Informed by this model, a similar network has been implemented across nine African countries: Kenya, Uganda, South Africa, Namibia, Mozambique, Ethiopia, Ghana, Sierra Leone, and Cameroon.

Functionality, rather than limitation of resources, was raised by the ACCCOS findings. Critical care registries in LMICs have the potential to provide quality data in resource-limited environments, overcoming some of the limitations faced by the ACCCOS.

AB and RH received research support from the Wellcome Trust and UK Research and Innovation. RH is first trustee for the UK charity Network for Improving Critical Care Systems and Training and received travel support from the American Thoracic Society as congress faculty. LP, CS, and WW-S received a part time salary from UK Research and Innovation Medical Research Council grant, which funded the African Critical Care registry. The African Critical Care registry network is funded by a UK Research and Innovation Medical Research Council grant (MR/V030884/1).

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Authors' reply

Luigi Pisani and colleagues highlight the potential and needed role of critical care registries in the COVID-19 pandemic response in low-income and middle-income countries (LMICs). Registry data are a powerful tool when operationalised at scale.¹ However, despite funded collaborative efforts, the existing registries in LMICs alone have been insufficient in providing an adequate pandemic response, lamented as recently as May, 2021.² In contrast, the African Perioperative Research Group (APORG), an unfunded network, pivoted to respond to the pandemic in Africa. By April, 2020, the African COVID-19 Critical Care Outcomes Study (ACCCOS) was established, and through funding of the Critical Care Society of southern Africa, the data management of the study was supported. Simple pragmatic research with a clear question and few datapoints generated data documenting outcomes with explanatory variables. These data can now be used for risk stratification during the third wave³ with the ACCCOS risk stratification calculator available on the APORG website. Early ACCCOS findings were available in October, 2020,⁴ and these findings were the largest peer reviewed cohort of COVID-19 outcomes from LMICs at the time of the meta-analysis, exceeding the published data from all other LMICs.³

ACCCOS acknowledged and highlighted various challenges facing critical care research in Africa.³ The true burden of disease is often poorly

measured, as shown by the 3027 (44.7%) patients referred for critical care support but not admitted in ACCCOS.³ A single data source cannot determine the relative importance of functionality or resource limitation on the mortality reported in ACCCOS. This is partly because the true denominator is not easily gauged during a pandemic when the normal baselines are disrupted, because the availability and definitions of a critical care bed change due to demand. Pragmatic research is agile to respond to some of these challenges, which might be more difficult for a registry response, especially where registry penetration is poor.

Going forward, initiatives such as the Critical Care Africa network provide a well thought out technological platform for centres in Africa to collect data relevant to their critical care practice to inform clinical research and quality improvement. Data harmonising efforts will allow more informed study of results within their context. Collaboration between networks is necessary to leverage the differing strengths of these networks, to provide a rapid, comprehensive understanding of drivers of outcomes, especially during a pandemic.

We declare no competing interests.

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See Online for appendix

For more on the ACCCOS risk stratification calculator see <https://www.asos.org.za/index.php>