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EDITORIAL

Challenges of Congenital Heart Disease and the Impact of Covid-19 on Health Workers

It is my pleasure to present the February, 2021 edition of the West African Journal of Medicine. The articles in this edition, as usual, cuts across numerous fields in Medicine and Surgery, making it a compelling read. It also reflects the versatility of our contributors.

I am especially delighted to introduce the editorial on 'The Challenges of Managing Congenital Heart Diseases in Africa' by a passionate and astute Paediatric Cardiologist, who has made significant contributions to the advancement of paediatric cardiac services on the African continent – Professor Samuel Omkhodion.

Morbidity and mortality from congenital heart diseases remain unacceptably high in Africa. While most congenital heart diseases (CHD) are amenable to intervention in developed countries, needless deaths from CHD remain unabated in developing nations. Paediatric cardiovascular healthcare services are capital intensive and require the availability of modern diagnostics facilities, interventional procedures, definitive surgical solutions and matching intensive postoperative care. This editorial is very enlightening and reveals the peculiarities involved in managing congenital heart diseases in resource-constrained environments like ours. The article which the editorial focused on, is quite timely and brings to fore the enormous financial burden associated with congenital heart diseases. The study describes the catastrophic effects of the cost of pre-surgical management of CHD on typical Nigerian families.

The challenges of the previous year have been rolled over into this New Year and the battle with COVID-19 virus

is far from over. The corona virus pandemic is still ravaging, with increased virulence as new strains of the virus are being discovered. The discovery of the UK strain of the COVID-19 virus, including the South African and Brazilian variants have made the battle fiercer with increased rate of infectivity, severe infections and increased mortality. This makes the control of the disease more challenging.¹ While the emergence of new variants can slow down our fight against COVID-19, we are glad that vaccines are now available and health workers have been prioritized in many countries to receive them. However, it is still doubtful that the mutations may be susceptible to antibodies induced by currently available vaccines and might respond to available therapies.²

Health workers globally continue to face the full brunt of this pandemic as they work at the frontline, managing patients infected with this deadly virus. The increasing number of health care workers getting infected with the virus gives cause for concern. Many health-care workers have succumbed to the virus all over the world. A systematic analysis of health workforce infectivity and case fatality rates shows that Europe had the highest number of infections and deaths with the lowest case fatality rate while the Eastern Mediterranean region had the highest case fatality rate.³ Reports from the United States of America and Mexico revealed that health workers represent 'one in every seventh case' of COVID-19 infections. As at mid-last year, data from 37 countries in the Pan American region showed that over 570,000 healthcare workers were infected with the virus and 2,500 died from Covid-19 in North and South America.^{4,5}

Africa and India have reported a relatively lower number of infections and

deaths.³ However, this is increasing in view of the second wave of the pandemic. Report from the World Health Organisation's Regional Office for Africa showed over 10,000 infections among healthcare workers in Africa, mid-last year. This is only the tip of the iceberg as cases are grossly under reported and there is paucity of data in sub-Saharan Africa. Just two months ago, within a period of a week Nigeria lost 20 doctors to COVID-19 and reports from Ghana and other sub-Saharan regions are not encouraging. Recently, some hospitals have lost very senior colleagues. This calls for an increase in preventive and mitigation measures.

Most COVID-19 cases and deaths reported among the health work force were found in the 50–59 age range, while the group aged over 70 years had the highest case fatality rate.³ This is a reflection of the general trend of the disease among the populace. In this edition, a 51-year-old Nigerian frontline health care worker details his terrifying personal experience with the COVID-19 infection. He experienced all the four phases of the infection. This brings closer home the dire consequences of infectivity with COVID-19 among health care workers. African countries are currently facing a crisis in the health sector with the exodus of health workers to Western countries resulting in shortage of man-power. Losing healthcare workers to COVID-19 will further compound the current precarious situation. Nigeria is one of the countries with the highest number of health care workers infected by the corona virus in Africa. This has further hampered the health care system in the country.

The government of African nations

needs to be more proactive in guaranteeing the safety of health care workers by ensuring increased testing, provision of personal protective equipment, safe working environment for health care workers, provision of prophylactic medications and the establishment of more treatment centers to cater for the increasing number of persons infected by the virus.

There is the need for strict enforcement of the COVID-19 guidelines. Isolation centers should be well equipped and maintained. Risk assessment and stratification should be done. Considerations should be made for the elderly, those with co-morbid conditions and the immunosuppressed amongst the health work force who may be at higher risk of being infected with the COVID-19. Elderly health care workers may be assigned to less risky settings such as telemedicine or administrative positions to reduce exposure. Routine testing and vaccination of health care workers for COVID-19 should be done.

We, as health care practitioners, endure considerable psychological and physical stress in caring for patients. Hence, we cannot afford to be careless. We must protect ourselves, colleagues, patients and families. It is time we all must take heed to the call 'Physician heal thyself.' As long as there is still one person infected with COVID-19, we cannot drop our guards.

We commend the efforts of the global health workforce in combating this pandemic and applaud the commitment of researchers who have continued to pursue laudable research in the face of such dire circumstances. We also identify with families of health care workers who have lost their loved ones this period. We must look for a way to immortalize them and help their families. We are all in this together. With concerted efforts by all stakeholders, we can survive this pandemic and come out stronger.

Prof. G. E. Erhabor
Editor-In-Chief

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The Challenges of Managing Congenital Heart Diseases in Africa

Most African countries, especially those in sub-Saharan Africa frequently have an annual budgetary allocation to the entire healthcare sector below the WHO recommended minimum of 6%. Paediatric cardiovascular healthcare services which include the ready availability of modern diagnostics facilities, interventional procedures as well as definitive surgical solutions with extra-corporeal circulatory support and matching postoperative intensive care are capital intensive and are generally not on the healthcare priority lists of such resource-challenged countries. This is in the face of other competing health needs.

The global incidence of congenital heart diseases (CHD) is about 9 per 1000 live births. Without appropriate medical and surgical interventions, about one-third of these children (those with the most complex malformations) do not attain the age of one year before succumbing to the complications. It is known that among congenital anomalies, malformations affecting the cardiovascular system have the greatest effect on infant mortality. Congenital Heart disease is also a major contributor to childhood morbidity in developing countries. There are now almost no CHD that are not amenable to some form definitive solutions in centres where there are appropriate facilities and personnel. On the other hand, in resource challenged settings many of these preventable deaths continue unabated.

The authors of the article in this edition titled 'Caring for children with congenital heart diseases: Economic burden of pre-surgical treatment on Nigerian families' have brought into sharp focus the catastrophic health expenditure imposed on families who had to care for such children before they had access to definitive solutions.

This naturally begs the question, which way forward Africa? Africa has a history of outstanding performance in the field of cardiovascular surgery. Professor C.O. Easmon's team successfully performed closure of an atrial septal defect in Accra Ghana in 1964. The world's first human to human heart transplant led by the surgeon Christiaan Barnard was performed in Africa at the Groote Schuur Hospital in Cape Town on December 3, 1967. A surgical team from the UK led by Professor Magdi Yacoub in 1974 performed the first open heart surgery in Nigeria at the University of Nigeria Teaching Hospital (UNTH) in Enugu. The same Surgeon had earlier pioneered open heart surgical procedures in Egypt before moving on to establish the now famous Harefield hospital UK. He later became a National icon in the field, became a British citizen and was Knighted by the Queen in recognition of his many landmark