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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

undertakings in cardiac surgery. Professor Edmond Bertrand similarly led the first open heart surgery in Cote d'Ivoire in 1978. A successful pulmonary valvotomy under cardiopulmonary bypass was recorded at the University College Hospital, Ibadan by a wholly indigenous team led by Professor Adebonojo in September 1979. A further four successful open-heart procedures were carried out by the same team over the following year. But the first successful open-heart surgery in the world had taken place on July 9, 1893 in Chicago, U.S.A. and was undertaken by Dr. Daniel Hale Williams. Although we were far behind in Africa we have not shown the same accelerated progress in the field of cardiovascular surgery as we have seen more recently in other areas such as information technology. A pertinent question is, where did we go wrong?

Using Nigeria as a case study, we may find some answers and pointers to the way forward. In 1981, there was a military coup, and the economy took a nose-dive for the worse. The national currency, the Naira which previously had exchanged for 1.8 dollars suffered progressive devaluation. Consequently, imported medical equipment became quite expensive. This was compounded by dwindling government subvention to healthcare establishments and Government was no longer able to fund open-heart procedures. Patients were required to pay the full cost of their treatment which was clearly an impossible demand. This brought cardiac by-pass surgery to a halt. About the same time, highly skilled manpower could not withstand the under-utilization of their skills and so began the exodus to greener pastures which

became known as 'brain drain'. Many years would pass before a good number of specialist cardiovascular healthcare personnel in the diaspora would organize into viable groups, link up with home groups to organize medical missions. One such mission was undertaken to Ibadan in 2006, and just surmounting the odds to get equipment setup, ensure uninterrupted power supply, appropriate oxygen delivery outlets and a viable postoperative intensive care proved to be a daunting undertaking on that first occasion. They could only manage two cases, a VSD and an ASD repair in 8 days with a 14-member team. There were ethical issues over the more than 80 families that turned up for screening only to have their hopes dashed when the team left. Thereafter, Ibadan linked up with Israeli, Indian, Ghanaian, and Italian groups that provided subsidized treatment for children with CHD. In about 10 years, 469 children were successfully treated with 7 surgically related mortalities and 2 non-surgically related mortalities.

We have taken advantage of the relationships developed with these groups to take up 28 training opportunities in the relevant disciplines as part of the human capital development component of our fresh capacity building efforts in Chennai, India and Accra, Ghana. We have had some requisite hardware acquisition through donor-efforts. We have also had donor assisted infrastructural development towards setting up a centre for Cardio-vascular diseases as well as a Cardio-vascular diseases research institute. These latter outcomes will provide training opportunities to meet local and regional needs as well as translational research to develop appropriate technology that will aid cost reduction and more affordable

procedures. Interventional techniques that are less human capital intensive are evolving already in this regard. Hospital Management is supporting these efforts and further aid from the diaspora is being channelled to boost these efforts with a view to making the services more affordable. Finally, as the article in this edition has suggested, the national health insurance scheme could also lend support by including the definitive treatment of at least some of the more common forms of CHD on the list of coverage of the scheme.

While these measures may not address all the problems, they do represent a good starting place in the management of CHDs in Africa.

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