50%.[5] Additionally, differences by SARS-CoV-2 variant were not considered, despite evidence showing up to a 75% reduction in long COVID occurrence among omicron (B.1.1.529) infections compared with delta variant infections.[6]

We agree that more work is needed to recognise, treat, and support patients with long COVID, underpinned by high-quality, coordinated, multidisciplinary research. Perpetuating scientifically invalid estimates of long COVID burden undermines this mission.

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Where will rectal artesunate suppositories save lives?

Severe malaria is a major cause of preventable childhood death in sub-Saharan Africa. Artesunate is the most effective available treatment.[1] In remote areas, where parenteral administration is not possible, rectal artesunate suppositories (RAS) can be given by community health workers to patients unable to take oral medications.

There are two fundamentally divergent views of the role of RAS in reducing deaths from severe malaria, which have different policy implications. In the first view, RAS can save lives only if followed by prompt referral to hospital for consolidation treatment.[2] Thus, RAS should only be deployed in areas where efficient referral is possible. In the second view, most of the life-saving benefit from RAS is after the first dose. Referral is desirable but not essential as consolidation treatment with oral artemisinin combination therapies can be given closer to home, as patients recover. Thus, the greatest effect of RAS will be in places where referral is difficult or impossible.

The WHO Malaria Policy Advisory Group recommendations reflect the first view,[2] emphasising "the critical importance of countries focusing on readiness to provide an effective continuum of care as a prerequisite for introduction of RAS". This prerequisite continuum of care is described as "a good referral system and referral facilities equipped to comprehensively manage a severely sick child".[3] We believe the WHO Malaria Policy Advisory Group view is incorrect and will markedly restrict where RAS are deployed, leading to preventable childhood malaria deaths.

RAS were developed specifically to address delayed referral. Our view is based on three key observations. First, the earlier artesunate is given in the course of a severe malaria infection, the greater is the life-saving benefit. Most of this benefit results from the first dose. Although a single dose is not curative, it results in a 10 000-fold reduction in the parasite biomass within one asexual lifecycle (ie, 48 h); parasite numbers decline from a biomass that is life-threatening ($>10^{10}$ parasites per kg) to one that is tolerable ($<10^{7}$ parasites per kg; the approximate pyrogenic density in non-immune individuals). Second, RAS are safe and effective. The route of administration does not change the antimalarial effect of artesunate, and the variable rectal absorption is offset by a 3-fold higher artesunate dose. Third, where referral is impossible, RAS followed by an oral artemisinin combination therapy will be sufficient in most cases.[4]

We agree that improving the continuum of care for severe illness is a health service priority. But, in places where referral is difficult or impossible, and where malaria mortality is highest, for a child with severe malaria, no RAS administration will mean no treatment. Severe malaria is nearly always fatal if untreated. New guidelines should promote the strengthening and development of trained community health worker networks to provide antimalarial treatment without delay (including RAS) and, where possible, facilitate patient referral.[5] Doing so would support deployment of RAS in remote areas of rural Africa where RAS will save the most young lives.

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New certificate verification guidelines for Nigerian nurses

On Feb 7, 2024, the Nursing and Midwifery Council of Nigeria released its updated guidelines and prerequisites for credential and licence approval.[1] These new verification guidelines have not gone unscathed but have instead sparked widespread protests across the country and on social media platforms from aggrieved nurses and midwives. There are also protests from concerned medical doctors who fear a similar fate from the Medical and Dental Council of Nigeria following a long, arduous outrage against proposed 2023 legislation, which sought to compel freshly trained medical doctors to work for a minimum of 5 years in Nigeria before being granted a qualifying licence to go practise elsewhere.[2]

From the perspective of nurses, one of the most contentious aspects of these new certificate verification guidelines is the requirement for applicants seeking verification of certificates to foreign nursing boards and councils to possess 2 years of post-qualification experience. Additionally, applicants are mandated to provide a letter of good standing from the Chief Executive Officers of their place or places of work and their last nursing training institution attended. This development stands to pose significant barriers to professional growth, numb multidisciplinary cooperation, and further make the process of verification more monotonous and strenuous, thereby stifling opportunities for Nigerian nurses seeking international recognition and opportunities.[1]

The motives of the Nursing and Midwifery Council of Nigeria are to combat quackery, to make sure certified nurses are not involved in fraudulent practice, and to stem the tide of emigration of nurses in the thousands in a bid to salvage a devitalised workforce. However, it is advisable that they retract and review their method of approach as it appears draconian, inconsiderate to the plight of nurses, and does not address systemic challenges, such as bad working conditions, underpayment, insecurity, toxic work environments, and overworking.

The implications of these restrictive measures extend beyond the nursing profession. As integral members of multidisciplinary health-care teams, nurses play a crucial role in supporting and complementing the work of medical doctors and other health workers. Any impediment to their ability to practise and collaborate effectively could have detrimental consequences for patient care and public health outcomes.

Therefore, we must support the rights and professional development of nurses both in Nigeria and worldwide, as their contributions are indispensable to achieving equitable and effective universal health-care systems.

I declare no competing interests.

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Australian medical leadership's silence on Gaza is a moral failure

"I am personally shocked by the systematic undermining of principles and standards we used to take for granted."[1] These words from António Guterres, UN Secretary-General, mirror the feelings of thousands in the global medical community. As Australian doctors, our horror at the humanitarian crisis in Gaza is accompanied by our disbelief at the silence from much of our medical leadership.

Australian medical bodies have a strong precedent in health and humanitarian advocacy, including climate change, refugee rights, marriage equality, and an Aboriginal and Torres Strait Islander Voice to Parliament. When Russia invaded Ukraine in 2022, the Australian Medical Association (AMA) called on our government to support Ukrainian refugees[2] and the President of the Royal Australasian College of Physicians publicly assured a Ukrainian cardiologist "that we stand in absolute solidarity with you and your colleagues and that we deplore and condemn the actions of Russian invaders".[3]

Since Oct 7, 2023, Israel has conducted almost 600 attacks on health facilities[4] and killed at least 300 health-care workers in Gaza.[5] More children were killed in the first week of the conflict in Gaza than in the first year of the war in Ukraine.[6] UNICEF has called Gaza the most dangerous place in the world to be a child.[7] The International Court of Justice has ruled Israel's actions as plausible genocide.[8] Under the Geneva Conventions, Israel, as the occupying power, is responsible for health services in Gaza,[9] but they have banned the entry of critical medical supplies, including insulin pens for children.[10]

The UN, WHO, and Doctors Without Borders have repeatedly condemned Israel's attacks on health care and called for a ceasefire. Disturbingly,