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Qualifying the promise of Universal Health Coverage

In his recent Comment (April 7, p 1342),¹ Richard Horton underlined the importance of the Universal Health Coverage (UHC) campaign, promoted by WHO on World Health Day 2018. He also problematised UHC on two counts: first, by arguing that, although UHC might sound like a finite achievable goal, it is not so in practice, and second, by underlining that UHC is not sufficient by itself, but must be coupled to targeted political actions, including legislation and programmes that address specific national health problems, such as diabetes and safer water.

Experiences with UHC in Denmark prompt yet another problematisation. In the WHO campaign on UHC and in existing understanding, UHC is

described as a means of promoting health equity.^{2,3} However, although Denmark's health-care system is an exemplification of UHC, Denmark has one of the steepest gradients in health inequality across socioeconomic groups among European countries, and social inequalities in life expectancy are increasing, particularly for men of lower socioeconomic status.⁴ These disparities provoke uneasy questions about the coexistence of UHC and health inequity.

At the very least, the case of Denmark reveals the importance of problematising the accepted associations between UHC and health equity, as well as the relationship between access and health outcomes. It also suggests that, if WHO's UHC campaign were combined with national attempts to understand and address the socioeconomic and sociocultural determinants of health, the campaign would be better placed to meet its aim of securing health for all.⁵

I declare no competing interests.

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Preventing rural to urban spread of Ebola: lessons from Liberia

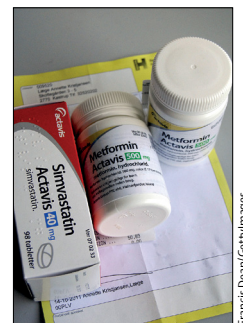
There has been an eerie mirroring of events between the ongoing outbreak of Ebola virus disease in the Democratic

Republic of the Congo (DRC) and the 2014–15 outbreak in Liberia. The DRC has vast historical experience from containing eight prior outbreaks, but the country has not previously had to respond to urban Ebola spread.

The current and ninth DRC outbreak was declared by the Ministry of Health on May 8, 2018.¹ By May 14, Ebola virus had escaped the rural epicentre of Bikoro and travelled 150 km into Mbandaka, an urban centre populated by 1.2 million people.¹ In a similar manner, during late June, 2014, Ebola virus disease escaped rural Sierra Leone into Foya District of rural Liberia and proceeded to enter the densely populated New Kru Town community of Monrovia, a city of over 1 million inhabitants.² The unprecedented case counts of the west African epidemic were largely due to this unprecedented migration into unprepared urban centres. At the height of the outbreak in September, 2014, Monrovia alone was accounting for 51% of all the Ebola cases in Liberia. Given the parallel scenario of cases emerging in Mbandaka, the response in the upcoming weeks and its sensitivity to the local context will be critical in informing the final outbreak size in the DRC.

Understanding the cause of spread in Liberia provides important lessons for the DRC. Why did the index urban case decide to leave Bikoro for Mbandaka?

First, to seek care. She may have come to the city to seek medical care since care in her village was inadequate and she was observing others die in spite of the treatment they were receiving. Given this root cause of movement, case investigation should hone in on hospitals and clinics visited for treatment to identify highest risk contacts. In Liberia, Monrovia's case zero in 2014 visited Redemption Hospital and exposed nurses and a doctor. Some of those exposed at Redemption Hospital went to a clinic in a neighbouring community and infected two nurses, who themselves sought treatment in another



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Published Online
June 25, 2018,
[http://dx.doi.org/10.1016/S0140-6736\(18\)31435-1](http://dx.doi.org/10.1016/S0140-6736(18)31435-1)

Panel: Five actions for delivering a trusted response for the control of Ebola virus transmission

- Provide sufficient point-of-need care to prevent rural to urban spread
- Implement and laud successful treatment innovations
- Debunk rumours and generate data through community engagement
- Balance public health with individual rights
- Practice safe burials

community and infected multiple health-care workers.

Second, it is also possible the case left her village to evade cultural threats. If she fled to the city since she attributed her illness to supernatural cause, such as a curse, it could have led her to relatives in Mbandaka with anticipation of finding a spiritual solution from traditional healers. In late June, 2014, migration to Monrovia in response to Ebola disease as a perceived curse prompted the second wave of transmission. A 16-year-old girl from a village in Sierra Leone had seen her family members systematically die from a strange disease. The prevailing belief was that the girl and her family were bewitched since their grandfather stole a goat. In pursuit of a spiritual solution, she and her brother drove to Monrovia from Sierra Leone, leading to cross-border transmission and a large disease cluster in densely populated Monrovia.

In light of these motivations, how can a trustworthy and trusted response be delivered to control the spread of the virus (panel)?

First, sufficient point-of-need care should be provided to prevent rural to urban spread. Access to effective health care for diagnosis and case management will shift the disbelief and distrust around Ebola and prevent outward migration. Rules barring people from travelling in and out of villages will then be possible.

Second, successful treatment innovations should be implemented and lauded. In Liberia, all patients entering Ebola treatment units (ETUs) were given an intravenous line for fluid administration. Some patients also

received ZMapp, a putative immunotherapy for Ebola virus disease.³ A positive feedback loop is essential for building trust in ETU care. Survivors should be paraded in communities to emphasise the role of ETUs in saving lives.

Third, through community engagement, rumours need to be debunked and data generated. Community youth, pastors, and imams should be trained in conducting daily door-to-door surveillance on visitors, the sick, and potential dead.⁴ The communication should be horizontal rather than vertical. The resulting data will govern the response by guiding distribution of ambulances, burial teams, and food for affected homes.

Fourth, public health priorities must be balanced with consideration for individual rights. No patients in the ETU should be allowed to leave until certified as being clear of Ebola virus.

Finally, practicing safe burials is essential. Local community leaders, religious leaders, and youth leaders should be mobilised to identify secret deaths and burials so that the dead body management teams can conduct safe and dignified burials. In Liberia, a Muslim burial team was formed to handle bodies in protective suits while allowing the appropriate ablutions.

At a macrocosmic level, the relationship between virulence and transmissibility is perturbed by population-level beliefs and practices. Beyond the establishment of ETUs and targeted vaccination, understanding root causes of disease emergence in urban DRC will be essential to preventing additional rural to urban spread and to containing the outbreak within urban centres.

We declare no competing interests.

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Can Shoulder Arthroscopy Work? (CSAW) trial

We read with interest the Can Shoulder Arthroscopy Work? (CSAW) study by David Beard and colleagues (Jan 27, p 329).¹ We note that 20 hospitals recruited fewer than ten patients with subacromial impingement over 3 years. More than a quarter of all patients (n=84, 27%) were recruited from one centre that was running the trial. Given the disparity in recruitment, we are concerned that patient selection criteria were not uniform in all participating centres. It is not specified whether other pathologies commonly associated with impingement, such as acromioclavicular joint and long head of biceps degeneration,^{2,3} were considered. This omission could be an important confounding variable. In the arthroscopy only group, the protocol specifies that surgery does not involve surgical removal of bursal tissue. The arthroscopy findings give details of the bursal partial thickness tears found intraoperatively. We would argue that it is not possible to assess the rotator cuff tendons as such without performing a substantial amount of clearance and resection of the bursal tissue.

Bursectomy has been previously shown to result in equivalent