



## Letter to the Editor

# The Bit Part of Universal Health Coverage in Controlling the COVID-19 Pandemic in Africa

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### 1. To The Editors

The COVID-19 pandemic, particularly in Africa establishes the necessity of contextualized inclusive, comprehensive, and harmonious Universal health coverage (UHC) for individual and collective health security. Universal coverage is firmly based on the World Health Organization (WHO) constitution of 1948 declaring health a fundamental human right and on the Health for All agenda that was set by the Alma-Ata declaration in 1978 [1]. The pandemic is burning out national health systems in African countries especially Ghana, Sierra Leone, Liberia,

Gabon, and Rwanda [2] that have been moving forward and striving to provide UHC. COVID-19 has disrupted countries' pathways and ambitions to achieve the custom of universal health coverage which is "to leave no one behind." Nevertheless, substantial inequalities in access to affordable quality health care remain [3] both within and between African member states. In this severe outbreak of COVID-19, UHC should protect African countries, vulnerable people, and communities at large from the vicious cycle of healthcare poverty and catastrophic financial risk which further contributes to COVID-19

spread. Additionally, insufficient or no financial barriers in accessing health services facilitate early case detection, identification of contacts, and contributes to reducing health care expenditures related to the hospitalization of COVID-19 severe cases. Many African countries require technical and financial support to successfully respond to COVID-19 especially in nations that don't adhere to the Abuja declaration [4] of allocating 15 percent of their state budgets to health care and as such, rapidly developing the capacity for emergency preparedness including containment measures of emerging infectious diseases. African countries like Cameroon still need to re-enforce their UHC scope especially as not up to 8 percent of their gross domestic product (GDP) is allocated for the healthcare systems [5]. Bearing in mind that, UHC has a direct impact on a population's health and welfare; access and use of health services enable individuals to be more productive and active contributors to their families and communities. It is in this light that below, we discuss the bit part of UHC in controlling the COVID-19 Pandemic in Africa from a '5As' Complementary Perspectives.

**Firstly**, A strong, efficient, well-run health system that meets priority health needs through people-centered integrated care [1] (including services for COVID-19) contributes to overcoming the COVID-19 Pandemic in Africa. This happens by informing and encouraging people to stay healthy and prevent COVID-19 infection; detecting related health conditions early; having the capacity to treat the disease, and helping patients with rehabilitation. It is worthy to note that, the impact of COVID-19 in Africa is exacerbated by weak health systems, and the pandemic has overwhelmed the health systems of

affected countries, including some of the world's wealthiest nations.

**Secondly**, Affordability – a system for financing [1] COVID-19 health services so people do not suffer financial hardship when using them. The dilemma for most African countries, in particular low-income countries, is that they are not able to provide everyone with all the health services they need at an affordable price, even with the large increases in external donor assistance for health that has resulted in the 'Poverty Industry' [6]. This results in "private practice" and illegal health service delivery which is against the deontology of medical practice. With UHC, in the context of this Pandemic, the goal should be to provide an increasing number of COVID-19 related-health services over time while at the same time reducing out-of-pocket costs to patients.

**Thirdly**, Access to essential medicines and technologies [1] to diagnose and treat COVID-19 medical problems. As the focal point international organization of the current pandemic, WHO together with other partners should support African governments, now more than ever to keep the world safe and serve the vulnerable populations by re-inforcing its mission to promote health, through advocating UHC among its African member states. African local pharma-industries making use of their vast and diverse traditional herbal medicines and plants should be encouraged and as such enhance the cutting down cost of pharmaceuticals. Also, controlling the cost of pharmaceuticals will reduce costs and increasing savings for other COVID-19 related-healthcare investments.

**Fourthly**, A sufficient capacity of well-trained, motivated health workers [1] to provide the services to meet COVID-19 patients' needs based on the best available evidence. Health workers need to be motivated and protected in this era as they are the frontline soldiers against COVID-19 [7]. Medics and paramedics around Africa are facing an unprecedented workload in overstretched health facilities, and with no end in sight [3]. They are working in stressful and frightening work environments, not just because the virus is little understood, but because in most settings they are overworked, under-protected, and themselves become vulnerable to COVID-19 nosocomial infection. We need a holistic resolve to prevent our frontline "soldiers" becoming COVID-19 patients. We must do everything to support health workers who are directly confronting COVID-19's infection pathways to aid the afflicted and help control the virus's spread. We need to give these health workers all the support they need to do their work, be alive and stay safe.

**Fifthly**, Actions to address COVID-19 related social determinants of health (SDOH) [2] such as living conditions, household income, socio-cultural factors, and education which affect people's health and their access to services contribute in controlling the spread of the viral disease. Understanding how SDOH impact a person's overall health can facilitate health plans to tailor their programs from an evidence-based perspective to address the evolving needs of their members in this rapidly evolving time [8]. Particularly for individual African health plans, this valuable information can aid them to target specific individuals who may be at higher risk of contracting COVID-19, or those who may be experiencing health issues related due to food insecurity caused by job

losses and social isolation, and thus assist them with improving their health and wellbeing by providing the appropriate context-specific communications with actions that could keep them safe. It is worthy to note that, Rwanda is the most advanced country in Africa regarding UHC [9]. As for 2019, most of UHC prerequisites have been achieved in Rwanda except some persisting gaps, for instance poverty and stunting among others.

## **2. Conclusion**

Key quality COVID-19 related health services must be provided to the entire population even more during exceptional events. Strengthening African communities with active and passive surveillance systems built into primary health care (PHC); expanding insurance coverage, increasing public awareness, ensuring sufficient medicines, providing extra financial resources, ensuring diagnostics and equipment are available; hiring/recruiting more qualified healthcare staff are the essential steps towards UHC needed in many African countries to contribute significantly in controlling the COVID-19 spread. African governments should consider respecting the terms of the Abuja Declaration on health care expenditure and provide higher investments aimed at empowering the community health services, emergency preparedness/response, and epidemiological surveillance. This requires consistent management choices and a strong political commitment with a vision of a more resilient Pan-African society and sustainable health systems.

Lastly, the hazards of "Coro" as called locally by Africans to its economy including its sustainable health development agendas is more wrecking than it might look, thus the need for UHC bit part.

### Competing Interests

The authors declare that they have no competing interests.

### Author Contributions

FSW conceived and designed the study. FSW, DAAE, EKD, NLC and EVY contributed in writing the original manuscript. All authors read and approved the final manuscript.

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