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10-14.March.2025

THEME :

RESILIENT AND STRONG AFRICAN HEALTH SYSTEMS: CONTRIBUTION OF HEALTH ECONOMICS AND HEALTH POLICY

10th – 14th March 2025

Kigali Convention Centre



PROGRAM AND ABSTRACT BOOK

TABLE OF CONTENTS

AfHEA 2025 CONFERENCE PROGRAM AGENDA 01

ORGANIZED PARALLEL SESSION 1: 01

Advancing public health through evidence-informed priority-setting approaches in Africa (organized session) 01

The changing landscape of malaria prevention: new evidence on the cost of SMC delivery and cost-effectiveness implications for new interventions (organized session) 03

Advancing UHC and Health Security through Private Sector Engagement (organized session) 07

Community and local contributions to health funding and social assistance in Africa (organized session) 09

INDIVIDUAL PARALLEL SESSION 1: 15

Strengthening Public Financial Management Systems_1 15

Health System Reforms, Governance, and Policy Impact in Africa 21

Efficiency and Fiscal Dynamics in Health Expenditure Across West Africa and OPEC Countries 27

ORGANIZED PARALLEL SESSION 2: 31

Assessing the Challenges to Equitable Access to COVID-19 Vaccine Distribution: Case Studies of Selected African Countries (organized session) 31

Digital Innovations, Financing and Community Approaches to Health in French-Speaking Countries in Africa (organized session) 36

Financing for Universal Health Coverage: Lessons and Future Direction for African Countries (organized session) 27

TABLE OF CONTENTS

INDIVIDUAL PARALLEL SESSION 2: **46**

Health System Resilience, Local Manufacturing, and Service Challenges in LMICs 46

Economic Evaluations of HIV, Maternal Health, Anaemia, COVID-19, and Digital Health Interventions in LMICs 53

Gender, Policy, and Workplace Dynamics in African Health Systems 58

Community Engagement, Financing, and Accessibility in Health Systems Strengthening 65

ORGANIZED PARALLEL SESSION 3: **73**

Financing, Social Protection and Community Healthcare in French-speaking Africa (organised session) 73

Policy learning on health financing for UHC: could we do better? (organized session) 78

Factors Influencing Equitable Access to COVID-19 Vaccines: Synthesis of Scoping Review Studies and Qualitative Analysis in Selected African Countries (organized session) 79

INDIVIDUAL PARALLEL SESSION 3: **87**

Addressing Cancer Care Inequalities and Innovations in Africa 87

Improving Neonatal and Child Health: Management, Inequalities, and Policy Implementation in Africa 87 93

Political Economy and Leadership in Strengthening Health Systems in Developing Countries 100

Health Insurance Expansion and Willingness to Pay in Informal and Community Settings in Africa 106

TABLE OF CONTENTS

POSTER SESSION 1: 113

ORGANIZED PARALLEL SESSION 4: 127

Designing accessible health benefits: contextualizing priority-setting to country health financing and service delivery systems (organised session) 127

INDIVIDUAL PARALLEL SESSION 4: 132

Investing in Health systems Post COVID 132

Addressing Health Inequities and Financial Barriers in African Healthcare Systems 139

Healthcare Purchasing, Capitation, and Quality Improvement Strategies 145

POSTER SESSION 2: 160

ORGANIZED PARALLEL SESSION 5: 171

Financing Primary Health Care and Promoting Community-Based Health Insurance in Madagascar (organized session) 171

Governance Arrangements for Public Financing of Private Sector Engagement in Mixed Health Systems of Low and Lower-Middle-Income Countries: What Works and for Whom? (organized session) 176

ORGANIZED PARALLEL SESSION 5: 182

Strengthening Primary Healthcare Systems for Universal Health Coverage in Africa 182

TABLE OF CONTENTS

Workforce, Interventions, and Policy Impact in African Healthcare Systems 188

Economic and Health Impacts of Diabetes and Cancer in Africa 194

Linking Informal Health Systems, Subsidies, and Financial Barriers in African Healthcare 201

Improving Maternal and Reproductive Health through Quality Care and Strategic Interventions in Africa 208

ORGANIZED PARALLEL SESSION 6: 216

Health financing reforms for advancing Rwanda's Universal Health Coverage agenda (organized session) 216

The Impact of Public Financial Management [PFM] on Health Outcomes: What does the Evidence Say? (organized session) 222

INDIVIDUAL PARALLEL SESSION 6: 226

Integrated Patient Care 230

Innovations in African Healthcare: Decolonization, Policy, and Equity Initiatives 237

Innovative Approaches to HIV and TB Management in Africa 243

Measuring Quality of Life 249

ORGANIZED PARALLEL SESSION 7: 256

Finding the right level of financial autonomy of primary care service providers for responsive and people-centred health systems (organized session) 256

TABLE OF CONTENTS

INDIVIDUAL PARALLEL SESSION 7: **260**

Decision Models and Quality of Care 260

Health Financing, Efficiency, and Policy Impact in Sub-Saharan Africa 264

Cost-Effectiveness of Health Interventions and Disease Management in LMICs 270

Equity and Cost Analysis in Malaria Control Across Africa 276

Health Insurance Impact on Utilization, Inequalities, and Fiscal Strategies in Africa 282

Adolescent Health and Well-Being: Policies, Interventions, and Determinants in Sub-Saharan Africa 288

ORGANIZED PARALLEL SESSION 8: **297**

Trained but unemployed, underemployed and unpaid: empirical research on (and policy options to) incorporate the paradoxical surplus health workers in Africa (organized session) 297

Building resilient health systems for emergency preparedness: gender and health workforce intersections (organized session) 302

POSTER SESSION 3: **307**

INDIVIDUAL SESSION 8: **319**

Advancing Vaccine Equity and Primary Healthcare Access in Africa 319

TABLE OF CONTENTS

Addressing Maternal and Reproductive Health Challenges Through Financing, Infrastructure, and Outcomes in Africa 327

ORGANIZED PARALLEL SESSION 9: 335

Resource optimization and Priority Setting for Public Health Emergency Preparedness and Response in Africa (organized session) 335

Public financial management: help or hindrance to health facility financial autonomy (organized session) 339

INDIVIDUAL PARALLEL SESSION 9: 343

Community Health Systems and Stakeholder Engagement for UHC and Accountability in Africa 343

Equity, Social Determinants, and Health Inequalities in Africa 350

Challenges in Health Workforce Sustainability and Well-Being in Africa 358

Cost-Effectiveness of Surgical, Diagnostic, and Treatment Strategies for Health Conditions in Africa 364

INDIVIDUAL PARALLEL SESSION 10: 368

Overcoming Barriers to Maternal Health Access and Utilization in Africa 368

Innovative Strategies for Workforce and Health System Strengthening in Nigeria and Sub-Saharan Africa 372

TABLE OF CONTENTS

Economic Impacts of Non-Communicable Diseases and Health Decision-Making in Africa 378

Factors Shaping Enrolment, Equity, and Reimbursement in Health Insurance Across Africa 384

Health Financing, Policy Sustainability, and Regulatory Practices in Africa and Beyond 391

INDIVIDUAL ORGANIZED SESSION 11: 398

Economic Evaluations of Health and Nutrition Interventions in Africa 398

Governance and Financing Transitions for Universal Health Coverage in Africa 405

Economic and Behavioral Insights into Malaria and Related Health Burdens in Africa 409

Digital Health Innovations and Data-Driven Strategies for Health Equity and Access 415

Community-Based Health Financing and Primary Care Sustainability in Africa 423

MentalHealth 430

PRE-CONFERENCE EVENTS: MARCH 10 & 11, 2025

MONDAY MARCH 10, 2025

AD4	AD7	AD10	AD11	AD12	AD12
	09:00 - 16:30	08:00 - 16:00	08:00 - 17:00	08:00 - 10:00	14:30 - 16:30
	Pre-Conference Event: Finalization and launch of the harmonized curriculum in Health Economics developed by **AfHEA** and **Africa CDC**	**Pre-Conference Event:** How to strengthen public financial management to enable effective and sustainable health systems **(World Bank, WHO and UNICEF).**	**Pre-Conference Event:** Strengthening Community Health Systems for Universal Health Coverage in Low Resource Settings **(Financing Alliance for Health).**	**Pre-Conference Event:** Transforming and Investing in Africa's Health Workforce for Universal Health Coverage and Health Security through the Africa Health Workforce Investment Charter **(WHO-AFRO).**	**Pre-Conference Event:** Scaling up integration of HIV, TB and Malaria Service Delivery through Health Insurance Schemes: Early lessons from Global Fund Pilots **(Global Fund and WHO-AFRO).**

TUESDAY MARCH 11, 2025

AD4	AD7	AD10	AD11	AD12	AD12
	09:00 - 11:30	09:00 - 12:30	08:00 - 12:30	08:00 - 16t:00	14:30 - 16:30
	Pre-Conference Event: Sustainable Health Economics and Health Financing Capacity Strengthening in Africa **(CHAI, AfHEA, and SPHs - University of Rwanda and University of Ghana).**	**Pre-Conference Event:** Better Data for Better Policy: Emerging Experiences of Implementing and Utilising Digital Data Systems in Health Financing **(ODI, CHAI, Thinkwell, GHS, and Ministries of Health of Burkina Faso, Ethiopia and Uganda).**	**Pre-Conference Event:** How can Primary Health Care deliver Efficient, Effective and Equitable Outcomes for Communities? **(MSH, Africa CDC, and UNICEF).**	**Pre-Conference Event:** Financing Health for All in the African Region: Measurement Issues, Policy Responses and Learnings **(WHO-AFRO).**	**Pre-Conference Event:** Institutionalizing HTA in Africa: What Can We Learn from Real Life Examples of Low- and Middle-Income countries? **(MSH).**

FRENCH/MIXED SESSIONS | ENGLISH SESSIONS | ORGANISED SESSIONS

OFFICIAL OPENING CEREMONY

MH1+2: Tuesday March 11, 2025; 17:00-18:30

OFFICIAL OPENING CEREMONY

08:00-09:30	**MH1+2: Plenary Session** Wednesday March 12, 2025
09:30-10:00	Tea/Coffee break and Group photo session

Break-out sessions 1

	MH1	MH2	AD12	AD10	AD11	AD7	AD4
09:30-10:00	**1332:** Advancing public health through evidence-informed priority-setting approaches in Africa	**1244:** The changing landscape of malaria prevention: new evidence on the cost of SMC delivery and cost-effectiveness implications for new interventions.	**1303:** Advancing UHC and Health Security through Private Sector Engagement	**1343:** Strengthening Public Financial Management TSystems	**1346:** Health System Reforms, Governance, and Policy Impact in Africa	**1410:** Community and local contributions to health financing and social assistance in Africa	**1373:** Efficiency and Fiscal Dynamics in Health Expenditure Across West Africa and OPEC Countries"

09:30-10:00	Tea/Coffee break and Group photo session

Break-out sessions 2

11:30-13:00	MH1	MH2	AD12	AD10	AD11	AD7	AD4
	1323: Assessing the Challenges to Equitable Access to COVID-19 Vaccine Distribution: Case Studies of Selected African Countries	**1414:** Digital Innovations, Financing, and Community Approaches in Health in French-Speaking countries in Africa	**1248:** FINANCING FOR UNIVERSAL HEALTH COVERAGE: LESSONS AND FUTURE DIRECTION FOR AFRICAN COUNTRIES	**1345:** Health System Resilience, Local Manufacturing, and Service Challenges in LMICs	**1355:** Economic Evaluations of HIV, Maternal Health, Anemia, COVID-19, and Digital Health Interventions in LMICs	**1374:** Gender, Policy, and Workplace Dynamics in African Health Systems	**1398:** Community Engagement, Financing, and Accessibility in Health Systems Strengthening

13:00-14:00	Lunch

Break-out sessions 3

14:00-15:30	MH1	MH2	AD12	AD10	AD11	AD7	AD4
	1320: Factors Influencing Equitable Access to COVID-19 Vaccines: Synthesis of Scoping Review Studies and Qualitative Analysis in Selected African Countries	**1411:** Financing, Social Protection and Community Healthcare in French-speaking countries in Africa	**1306:** Policy learning on health financing for UHC: could we do better?	**1359:** Addressing Cancer Care Inequalities and Innovations in Africa	**1397:** Improving Neonatal and Child Health: Management, Inequalities, and Policy Implementation in Africa	**1391:** Political Economy and Leadership in Strengthening Health Systems in Developing Countries	**1376:** Health Insurance Expansion and Willingness to Pay in Informal and Community Settings in Africa

15:30-15:45	Tea/coffee break and Poster session 1

Break-out sessions 4

	MH1	MH2	AD12	AD10	AD11	AD7	AD4
15:45-17:15			**1317:** Designing accessible health benefits: contextualizing priority-setting to country health financing and service delivery systems	**1339:** Investing in Health systems Post COVID	**1368:** Addressing Health Inequities and Financial Barriers in African Healthcare Systems	**1344:** Healthcare Purchasing, Capitation, and Quality Improvement Strategies	**1412:** Economic Evaluation and Financing for Health in French-speaking Countries in Africa

17:15-18:45	Plenary session 2: MH1+2 (Nigeria SWAp)

THURSDAY MARCH 13, 2025

08:00-09:30	**Plenary session 3: MH1+2 (Rwanda)**
09:30-10:00	Tea/Coffee break and Poster session 2

Break-out sessions 5

MH1	MH2	AD12	AD10	AD11	AD7	AD4

	MH1	MH2	AD12	AD10	AD11	AD7	AD4
10:00-11:30	**1316:** Financing Primary Health Care and Promoting Community-Based Health Insurance in Madagascar	**1381:** Strengthening Primary Healthcare Systems for Universal Health Coverage in Africa	**1282:** Governance Arrangements for Public Financing of Private Sector Engagement in Mixed Health Systems of Low and Lower-Middle-Income Countries: What Works and for Whom?	**1347:** Workforce, Interventions, and Policy Impact in African Healthcare Systems	**1360:** Economic and Health Impacts of Diabetes and Cancer in Africa	**1369:** Linking Informal Health Systems, Subsidies, and Financial Barriers in African Healthcare	**1392:** Improving Maternal and Reproductive Health Through Quality Care and Strategic Interventions in Africa

Break-out sessions 6

	MH1	MH2	AD12	AD10	AD11	AD7	AD4
11:30-13:00	**1413:** Social Inequalities, Maternal Health and Resource Mobilisation in French-speaking Countries in Africa	**1331:** Health financing reforms for advancing Rwanda's Universal Health Coverage agenda	**1295:** The impact of Public Financial Management [PFM] on health outcomes: What does the evidence say	**1340:** Integrated Patient care	**1357:** Innovations in African Healthcare: Decolonization, Policy, and Equity Initiatives	**1364:** Innovative Approaches to HIV and TB Management in Africa	**1386:** Measuring Quality of Life

13:00-14:00 Lunch

Break-out sessions 7

	MH1	MH2	AD12	AD10	AD11	AD7	AD4

	MH1	MH2	AD12	AD10	AD11	AD7	AD4
14:00-15:30	**1385:** Decision Models and Quality of Care	**1350:** Health Financing, Efficiency, and Policy Impact in Sub-Saharan Africa	**1277:** Finding the right level of financial autonomy of primary care service providers for responsive and people-centred health systems	**1354:** Cost-Effectiveness of Health Interventions and Disease Management in LMICs	**1362:** Equity and Cost Analysis in Malaria Control Across Africa	**1377:** Health Insurance Impact on Utilization, Inequalities, and Fiscal Strategies in Africa	**1396:** Adolescent Health and Well-Being: Policies, Interventions, and Determinants in Sub-Saharan Africa

15:30-15:45	Tea/coffee break and Poster session 3

Break-out sessions 8

	MH1	MH2	AD12	AD10	AD11	AD7	AD4
14:00-15:30			**1278:** Trained but unemployed, underemployed and unpaid: empirical research on (and policy options to) incorporate the paradoxical surplus health workers in Africa	**1300:** Building resilient health systems for emergency preparedness: gender and health workforce intersections	**1351:** Cost-Effectiveness of Health Interventions and Financing in Africa	**1371:** Advancing Vaccine Equity and Primary Healthcare Access in Africa	**1393:** Addressing Maternal and Reproductive Health Challenges Through Financing, Infrastructure, and Outcomes in Africa

17:15-18:45t	Plenary session 4: MH1+2 (UNFPA)
19:30-22:00	Gala dinner

FRIDAY MARCH 14, 2025

08:00-09:30	Plenary session 5: MH1+2 (High-level Policymakers' Session)
09:30-10:00	Tea/Coffee break

Break-out sessions 9

	MH1	MH2	AD12	AD10	AD11	AD7	AD4
10:00-11:30	**1311:** Resource optimization and Priority Setting for Public Health Emergency Preparedness and Response in Africa	**1279** Public financial management: help or hindrance to health facility financial autonomy	**1399:** Community Health Systems and Stakeholder Engagement for UHC and Accountability in Africa	**1305:** Prioritizing assistive technologies for mobility: adapting priority setting methods for Rwanda.	**1366:** Equity, Social Determinants, and Health Inequalities in Africa	**1348:** Challenges in Health Workforce Sustainability and Well-Being in Africa	**1356:** Cost-Effectiveness of Surgical, Diagnostic, and Treatment Strategies for Health Conditions in Africa

Break-out sessions 10

	MH1	MH2	AD12	AD10	AD11	AD7	AD4
11:30-13:00	**1394:** Overcoming Barriers to Maternal Health Access tand Utilization in Africa	**1353:** Innovative Strategies for Workforce and Health System Strengthening in Nigeria and Sub-Saharan Africa	**1358:** Economic Impacts of Non-Communicable Diseases and Health Decision-Making in Africa	**1375:** Factors Shaping Enrollment, Equity, and Reimbursement in Health Insurance Across Africa	**1372:** Equity, Social Health Financing, Policy Sustainability, and Regulatory Practices in Africa and Beyond		

13:00-14:00	Lunch

Break-out sessions 11

	MH1	MH2	AD12	AD10	AD11	AD7	AD4
14:00-15:30	**1352:** Economic Evaluations of Health and Nutrition Interventions in Africa	**1380:** Governance and Financing Transitions for Universal Health Coverage in Africa	**1361:** Economic and Behavioral Insights into Malaria and Related Health Burdens in Africa	**1389:** Digital Health Innovations and Data-Driven Strategies for Health tEquity and Access	**1382:** Community-Based Health Financing and Primary Care Sustainability in Africa	**1404:** 1404: Mental Health	

15:30-15:45	Tea/coffee break
15:30-15:45	Closing ceremony: MH1+2

ORGANIZED PARALLEL SESSION 1

10:00 AM–11:30 AM Wednesday, 03 March 2025

Advancing Public Health Through Evidence-Informed Priority-Setting Approaches in Africa (Organized Session).

Josephine Gatua, Africa CDC, Stéphane Verguet, Harvard T.H. Chan School of Public Health, Lumbwe Chola, University of Bergen/University of Oslo

Description

This organized session discusses how to advance public health and ultimately improve population health via the development and implementation of priority setting approaches. It is articulated around three illustrative presentations.

First, Dr. Josephine Gatua, from the Health Economics & Financing Programme of Africa CDC, will present and discuss a framework for evidence-informed priority setting for the African continent. Second, Dr. Fentabil Getnet Yimer, Head Decision Science Unit, National Decision Management Center for Health at the Ethiopian Public Health Institute, will give concrete illustrations in an Ethiopian setting, with an example of modelling efficient and equitable pathways toward national scale-up of tuberculosis control programs in Ethiopia. Third, Dr. Richmond Owusu and Dr. Genevieve Aryeetey from the University of Ghana School of Public Health, will give concrete illustrations in the context of Ghana, in describing priority setting processes for HIV/AIDS, TB, and malaria in the country. Lastly, Prof. Lumbwe Chola, from the University of Oslo, will provide remarks on the three presentations.

The session will be chaired by Prof. Stéphane Verguet, from the Harvard T.H. Chan School of Public Health, and Dr. Josephine Gatua, Principal Health Economist, Health Economics & Financing Division, Africa CDC.

Continental Framework for Evidence Informed Priority Setting

Josephine Gatua *Africa Centre for Disease Control and Prevention*

The Africa Centres for Disease Control and Prevention (Africa CDC) is an autonomous technical agency of the African Union with a mandate to safeguard Africa's public health. The Africa CDC Health Economics and Financing Division (HEF) within Africa CDC was established to facilitate the generation and use of health economics and financing evidence for decision-making at the continental, regional and member state levels in support of the African Union's Agenda 2063 and the New Public Health Order.

In Africa, evidence-informed priority setting is gaining traction as countries strive to achieve universal health coverage (UHC). However, progress in implementation toward UHC varies due to differences in technical capacity, financing, access to information, and political support. Challenges include limited awareness, data, and fragmented research efforts.

To help African Union member states meet these ambitious goals within the resource-constrained context, the HEF seeks to strengthen their capacity for evidence-informed priority setting particularly leveraging health economics and financing evidence for public health decision-making.

Part of the challenge in making evidence-informed resource allocation decisions is lack of contextually relevant guidance and/or framework for evidence-informed priority setting in Africa. To bridge this gap, the HEF has recently developed a continental framework with the aim of enhancing public health through institutionalization of systematic evidence-informed priority setting approaches. Therefore, this framework plans to provide guidance and options for African Union member states to institutionalize evidence-informed priority setting approaches. In addition, the framework would serve as a platform for sharing research findings and raise awareness to facilitate capacity development, and foster collaboration between key stakeholder within and across countries on the continent.

Exploring Priority Setting Processes for HIV/AIDS, TB and Malaria Programs in Ghana: Perspectives from key informants

Richmond Owusu

Department of Health Policy, Planning and Management, School of Public Health, University of Ghana, Legon, Ghana

Worldwide, countries have the challenge of meeting the ever-increasing demand for healthcare amidst limited resources. While, priority setting is necessary in all settings, it is especially critical in low- and middle-income countries because of their often-low budgetary allocations for health. Despite the long history of disease programs supported by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFTAM) in Ghana, there is limited evidence on the processes used for priority setting. This study explores the priority setting processes employed for GFTAM-supported programs in Ghana.

In-depth interviews of ten key informants were conducted online and face-to-face. Interviews were transcribed and analysed both inductively and deductively to identify key themes. We structured our results to describe: (1) identification of health needs, (2) stakeholder participation; (3) transparency of processes; and (4) contextual factors. Priorities were identified through national health strategies and mandates, development partners and global mandates and internally generated data and surveillance.

The main actors in the priority setting were ministries and agencies, development partners, research institutions, committees and working groups. Actors had varying influence and power in the process with limited public involvement. The process was often documented and disseminated through various mediums. Contextual factors reported were mainly barriers that affected the process, and these included inadequate funding, aligning priorities with funders and interruptions in the priority setting process.

While formal and explicit priority setting mechanisms are being expanded globally to support resource allocation decisions in health more generally, stakeholders in this study indicated that their use in the three GFTAM supported programmes was limited.

Modelling Efficient and Equitable Pathways Toward National Scale-Up: A Case Study of Tuberculosis Control in Ethiopia

Fentabil Getnet Yimer *Ethiopian Public Health Institute, Addis Ababa, Ethiopia*

A few studies have indicated that the addition of tuberculosis (TB) services into health extension workers' (HEWs) tasks – that is "task-shifting" – improved case detection and treatment outcomes in Ethiopia. Given resource and operational constraints, only a limited number of areas can be targeted by an expanded task-shifting program in the country. We applied data analytic methods to assess the distributional disparities in TB services across regions and districts in Ethiopia, and to model both efficient and equitable pathways toward national scaling up of community-based TB case detection and treatment services in Ethiopia.

Data sources were multiple and heterogeneous and included: Ethiopia's health information management systems (i.e. District Health Information Software 2), demographic and geospatial data, and the relevant published literature. Disparities in TB services coverage were quantified across districts ("woredas") in the whole country, including in terms of: diagnosis coverage; health centre reach adequacy (i.e., population captured by health centre); and spatial access (population with access within 2-hour walking). Subsequently, districts with the largest equity gaps could be prioritized to benefit from task-shifting at the community level.

TB diagnosis coverage, health centre reach adequacy, and spatial access adequacy were estimated to vary substantially across districts and regions across the whole country of Ethiopia. A TB task-shifting program implemented in priority districts with inadequate access could substantially raise the national TB case detection and TB treatment success rates in Ethiopia.

Current access to TB services presents substantial disparities across districts and regions in Ethiopia, which can be attributed to both health system- and TB-specific deficiencies. Adding and expanding TB detection and treatment services into the tasks of health extension workers in priority districts with poor coverage could substantially address equity gaps in Ethiopia.

The changing landscape of malaria prevention: new evidence on the cost of SMC delivery and cost-effectiveness implications for new interventions (organized session)

Justice Nonvignon, University of Ghana, Fadima Yaya Bocoum, National Centre for Scientific and Technological Research

Description

Seasonal Malaria Chemoprevention (SMC) has been recommended by WHO for malaria prevention in areas of the Sahel and sub-Sahel with high seasonal transmission since 2012. Two vaccines, RTS, S/A S01 and R21/Matrix-M, have been recommend since 2021 and 2023, respectively.

New interventions such as monoclonal antibodies for malaria (mAbs) are also under development and present a promising new approach.

However, global funders and domestic malaria control programs are faced with limited resources for malaria control and prevention and therefore must examine the relative cost-effectiveness of available interventions and their delivery. Questions around safety, effectiveness, cost of delivery, and appropriate use cases of each intervention are key factors for consideration.

Panellists from the University of Ghana, Burkina Faso's National Centre for Scientific and Technology Research, the University of Western Australia, Medicines for Malaria Venture, and Management Sciences for Health will reflect on recent cost and cost effectiveness findings in the seasonal malaria prevention landscape, including results from three new costing studies of SMC, a systematic review of SMC, and an impact and economic modelling study for malaria prevention.

The panellists will explore the latest effectiveness and cost effectiveness findings in existing prevention interventions and discuss:

- Given country's needs around malaria control and prevention and the growing suite of interventions, amidst worsening economic situations, what is the future of malaria control in countries?
- What are the opportunities, and implications of new technologies for malaria prevention?
- What are the unknowns when comparing these new technologies against current practices?
- How cost-effective is current delivery of SMC against future technologies and what is the impact of delivery costs?
- How cost-effective is current delivery of SMC against future technologies and what is the impact of delivery costs?

Potential cost-effectiveness of anti-infective monoclonal antibodies for seasonal malaria prevention

Thiery Masserey[1] **Narimane Nekkab[1]** **Lydia Braunack-Mayer[1]**

Justice Nonvignon[2] **Colin Gilmartin[3]** **Anika Ruisch[3]** **Melissa Penny[4]**

(1) Swiss Tropical and Public Health Institute, Allschwil, Switzerland,
(2) Department of Health Policy, Planning and Management, School of Public Health, University of Ghana, Legon, Ghana,
(3) Management Sciences for Health, Arlington, VA,
(4) University of Western Australia, Perth, Australia

Anti-infective monoclonal antibodies (mAbs) are in development to protect against infection, with the potential to be efficacious against clinical malaria for several months in children under five years. Seasonal malaria chemoprevention (SMC) with sulfadoxine-pyrimethamine plus amodiaquine (SP+AQ) is highly cost-effective for protecting children in seasonal settings. Determining the cost-effectiveness of mAbs for seasonal deployment, including a comparison with SMC, will depend on several factors, including the effectiveness of mAbs, economics costs, alongside SP-resistance.

Using an individual-based model of malaria, we assessed conditions under which mAbs might be comparably or more cost-effective than SMC. We considered four mAb profiles: two base cases with a 120-day half-life and 80% initial efficacy, and two upside cases with a 180-day half-life and 98% initial efficacy, both with exponential or sigmoidal efficacy decay. SMC provided a prophylactic period (PP) of 20, 25, or 31 days. Every year, children under five receive either a mAb alone or combined with an antimalarial treatment at the beginning of the transmission season or four monthly cycles of SMC. We estimated the cumulative number of cases averted by each intervention. The literature informed ranges of annual economic costs per child for SMC (3-20$) and mAbs (7-30$). For each combination of interventions, we estimated the economic cost ratio at which mAbs would reach a lower cost per case averted than SMC.

Our results indicated that the economic cost of upside case mAbs with exponential or sigmoidal decay needs to be 20-25% and 8-12% cheaper, respectively, than SMC conferring a PP of 31 days to be cost-effective as they prevented fewer clinical cases. However, in some scenarios, upside case mAbs with sigmoidal decay could prevent more cases than SMC and be cost-effective at a higher economic cost than SMC. The economic costs of these mAbs could equal those of SMC that provide only a PP of 20 days due to resistance. When these mAbs are combined with a drug, their economic cost could be 7-20 % higher than SMC depending on the PP of SMC. However, the economic cost of base case mAbs needs to be at least 20% cheaper than SMC to be cost-effective across all compared scenarios. Overall, to be cost-effective compared to SMC the economic cost of mAbs with low efficacy need to be much cheaper than SMC, while highly effective mAbs deployed with a drug have more flexible economic requirements but will depend on levels of SP resistance.

The cost of delivering seasonal malaria chemoprevention: A systematic review

Anika Ruisch[1], Miranda Heilweil[1], Ishani Mathur[1], Sara Harris[1], Damian G Walker[1], Richmond Owusu[2], Justice Nonvignon[2] and Colin Gilmartin[1]

(1)Management Sciences for Health, Arlington, VA,
(2)Department of Health Policy, Planning and Management, School of Public Health, University of Ghana, Legon, Ghana

Seasonal malaria chemoprevention (SMC) is a cost-effective intervention for preventing malaria in children. SMC includes monthly doses of antimalarials during high transmission periods and has been implemented in 17 countries. Limited evidence exists on the costs for SMC delivery including the impact on households and caregivers, for example the cost of time spent staying home for drug administration to children instead of going to work. To inform future planning and resource allocation, there is a need to understand the cost of SMC delivery, especially as new malaria preventive technologies are being adopted.

This systematic review aims to determine the financial and economic costs of SMC delivery from provider and patient perspectives.

Six databases were reviewed in accordance with the PRISMA guidelines. We included studies published between 2012 and 2023 which focused on the cost of SMC delivery and included a defined costing methodology. Two authors reviewed each study to ensure criteria were met and extracted relevant cost data. Results were adjusted for inflation and study quality was assessed using the CHEERS checklist.

We identified 4,034 studies, of which six met the inclusion criteria, including results from nine countries. The number of children targeted for SMC varied from 104,225 to 2,020,597. The total financial cost per child covered by SMC ranged from $1.71 to $12.46 and the total economic cost from $2.11 to $29.06. The Incremental cost-effectiveness ratio (ICER) per clinical case averted ranged from $5.41 to $138.03, ICER per DALY averted from $24.51 to $182.88, and ICER per death averted from $688.86 to $18,418.81.

While some components (e.g. training, drugs and supplies) were universally costed, others (e.g. transport, per diem) were only incorporated into some calculations, leading to discrepancies in aggregate cost estimates for SMC delivery. Costing methodologies, reporting, and the intervention scale varied by study, limiting comparability. As most studies only captured SMC costs from a provider perspective, important household costs may have been overlooked; studies also lack a consistent approach regarding inclusion of SMC integration costs with existing pathways. Adopting a standardized costing approach for mature SMC programs could provide a better understanding of resource requirements and costs, increasing comparability across studies and informing future resource allocations. Given emerging malaria preventive technologies (e.g. monoclonal antibodies and malaria vaccines), understanding SMC cost implications is critical to ensure sustainable delivery strategies and enable evidence-based decision-making surrounding malaria prevention.

Estimating the Opportunity Cost of Seasonal Malaria Chemoprevention mplementation in Mali, Burkina Faso, Mali and Senegal

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(5)Cheikh Anta Diop University of Dakar, Dakar, Senegal

Seasonal malaria chemoprevention (SMC) for children under 5 years of age is one of the most common malaria prevention interventions implemented at scale in the Sahel and sub-Sahel regions of Africa. The intervention uses health system, community and household resources, creating opportunity costs. Previous studies have often estimated costs from health system perspective, largely ignoring costs from community and household perspectives. The objective of this study was to estimate the opportunity cost of SMC implementation in Mali, Burkina Faso, and Senegal.

A repeated descriptive cross-sectional design was used to collect cost data during the first and third monthly cycles of the SMC administration between February - August 2022 in the three countries. We used an ingredients approach to collect direct and indirect cost data from central, regional, district, health facility and community levels using structured questionnaire. Overall, a total of 1,147 caregivers were interviewed. In addition, 265 community health volunteers and 234 health workers were interviewed. In each study country, data were collected from 16 health facilities in 4 districts spread across 2 regions. Both financial and economic costs were analysed. For direct economic costs, capital and recurrent costs were analysed. Capital items were annualized and discounted at 3%. For indirect or productivity costs, the time (in hours) contributed by volunteers and caregivers was calculated and valued using local agriculture wage rate or minimum wage rate for each country. All costs are reported in 2022 US dollars at an exchange rate of CFA594 = US$1.00. Sensitivity analyses were conducted by varying relevant parameters.

The financial cost per dose was estimated to be US$0.99 in Mali, US$1.42 in Burkina Faso, and US$1.51 in Senegal. Economic cost per dose was US$3.02 in Senegal, US$3.14 in Burkina Faso, and US$2.96 in Mali. These translate into total annual financial and economic costs per fully dosed child of 4 monthly cycles of US$3.97 – US$6.05 and US$11.85 – US$12.57 respectively. The economic costs in all countries were dominated by indirect costs ranging between 50% - 66% of total economic cost. SMC administration cost, district level cost and caregivers cost were the main cost drivers.

SMC implementation is associated with economic costs largely driven by productivity losses to caregivers, volunteers, and health care workers. Previous studies have largely overlooked these costs, which are crucial inputs to decision-making and evaluation of malaria control programs.

Advancing UHC and Health Security through Private Sector Engagement (organized session)

David Clarke, World Health Organisation, Geneva, Kingsley Addai Frimpong, WHO Country Office for Ethiopia, Gordon Abekah-Nkrumah, University of Ghana

Description

Private sector engagement is the meaningful inclusion of private providers for service delivery in mixed health systems. Private sector engagement requires that governments focus on governance of the whole health system – both private and public – to ensure quality of care and financial protection for patients, irrespective of where they seek care. It requires that the private sector aligns with public sector health goals and commits to working to support the government agenda.

Health systems around the world were overwhelmed by the coronavirus disease 2019 (COVID-19). The pandemic, which was a surprise to many countries, resulted in several challenges including a high burden on intensive care unit (ICU) beds, overstretched health workforce, a lack of COVID-19 tools including ventilators and personal protective equipment (PPE), economic hardship and mental health issues amongst the population.

This session builds upon research findings and offers critical insights to inform future private sector reforms in health service delivery.

The session will feature a technical introduction, summarizing research findings, followed by country-specific presentations (focused on Ghana) that will delve into implementation challenges. An interactive discussion with the audience will explore opportunities to enhance private sector engagement {PSE} through optimized governance behaviours. Additionally, two discussants will summarize the discussions and offer insights into practical ways forward for policymaking and research.

Engaging the private health service delivery sector through governance in mixed health systems

Anna Cocozza *World Health Organisation, Headquarters, Geneva, Switzerland*

WHO has the potential to play a pivotal role in supporting UHC through private health sector service delivery governance. A resolution to engage the private sector in providing essential health services was adopted in the Sixty-third World Health Assembly (WHA). Since then, WHO has made progress towards recognizing and engaging the private health sector, but a more system-wide shift is necessary to catalyze action for UHC. Leveraging on work to date, WHO is supporting Member States to strengthen governance of mixed health systems and assure alignment of the private sector for UHC, to promote equity, access, quality and financial protection for the population.

In this presentation, COCOZZA, Anna, Technical Officer with the World Health Organization, will examine consensus around the means and strategies for engaging the private sector in health care delivery. Additionally, the Advisory Group on Governance of the Private Sector for universal health coverage (UHC) has recommended a strategy for WHO that will support a new way of doing business for health system governance. This strategy will also be examined, specifically emphasizing how a well-governed health system can facilitate service delivery by both public and private actors in realizing the goals of UHC.

Engagement of the Private Health Sector in the Delivery of Ghana's Covid-19 Emergency Response

Kingsley Addai Frimpong *WHO Country Office for Ethiopia, Addis Ababa, Ethiopia*

In this presentation, Kingsley ADDAI FRIMPONG, a health economist with the World Health Organization, will examine the critical role of the private sector in the delivery of Covid-19 Emergency Response.
This practice paper examines how the private sector was engaged by the Ghanian government to implement the national COVID-19 emergency response. The study drew on qualitative research using a thematic analytical approach.

The findings suggest that the government demonstrated leadership in mobilising, resourcing, and collaborating with the private health sector to deliver its pandemic response via a defined emergency response plan, a coordinated pandemic response structure and a robust platform for information gathering and sharing. However, the government fell short of providing the enabling environment for the private health sector to expand their capacity to meet increased demand for health services during the pandemic. There were also challenges related to the overconcentration of resources in the public health response and national level structures to the detriment of clinical care and sub-national level structures. Generally, the findings also indicate a fragmented private health sector that is not only unattractive for the government to engage and collaborate with, but also weak in terms of capacity (financial and human resources) to partner with government and respond to any major health emergency.

Improving the readiness of Ghana's health system for future health emergencies

Maureen Martey *Ministry of Health, Ghana, Accra, Ghana*

In this presentation, Dr. Maureen Martey, Head of Private Sector and Resource Mobilization department of the MOH, will discuss how gaps identified and lesson learnt from implementing the pandemic response are being addressed through the development of a private sector engagement strategy to improve the readiness of Ghana's health system for future health emergencies.

This presentation will reflect on how policy makers are putting in place an appropriate policy framework that will help in organising, engaging, and collaborating with private health entities in Ghana.

Community and Local Contributions to Health Funding and Social Assistance in Africa (Organized Session)

Engaging Local Elected Officials in the Increased Mobilization of Domestic Resources: Contributions of Local Authorities to Health Financing in Senegal.

10:00 AM–11:30 AM
Wednesday, 03 March 2025

Farba Lamine Sall *Health Economist - Open Development, Dakar, Senegal*

Context

In Senegal, the Ministry of Health and Social Action (MSAS) and the Union of Associations of Locally Elected Officials (UAEL) are working together to strengthen the involvement of local authorities in health management and increase their financial contributions to the sector.

As part of the decentralisation process, local authorities (communes and départements) receive various funds from the State, such as the Fonds de Dotation de la Décentralisation (Decentralisation Endowment Fund) and the Fonds d'Équipement des Collectivités Territoriales (Local Authority Equipment Fund). They also have their own resources from local taxes and receive funding from technical and financial partners, decentralised cooperation, donations and the private sector.

Objective

Evaluate the local authorities' contributions to health financing for the period 2022-2023 in order to optimise the mobilisation of internal resources.

Method

Data collection forms based on the national health accounts classification were sent to the 601 Local Authorities. A workshop was held to summarise the results, check the quality of the data, and follow up with the LAs to complete any missing information. A summary model was created to itemise the data by volume, region, source of funding, type of expenditure, year and beneficiary.

Results

Out of the 601 expected LAs, 600 filled out the forms. They contributed to health financing to the tune of 50,420,099,995 FCFA (84 million USD), including 20,385,368,616 FCFA in 2022 and 30,034,731,379 FCFA in 2023. This contribution increased by 9,649,362,763 FCFA, or 19% compared to 2022. In 2023, the contributions from the LA(local authorities) (exceeded the forecasts of the National Health and Social Development Plan 2019-2028 by 26,076,266,280 FCFA.

State transfer funds account for 47% of local authority funding, followed by own funds at 36.4% and other sources (PTFs, decentralised cooperation, private sector, etc.) at 16.8%. Health expenditure breaks down into 52% for operations and 48% for investment, with 56% of investment expenditure devoted to construction, followed by medical equipment and rehabilitation at 24.74% (the remainder includes technological equipment, mobile logistics, etc.). Among operating expenditure, salaries account for 37.6%, relief for the needy 24.79% and expenditure on medicines 20.46%. In terms of beneficiaries, 77% of local community expenditure is allocated to health facilities.

Conclusion

The evaluation made it possible to assess the contributions made by local and regional authorities to health financing. The collaboration between MSAS and UAEL optimises the exploitation of the potential of local authorities to increase their contributions to financing the sector. It also aims to strengthen health governance and facilitate the integration of health into all policies at decentralised level in order to move towards UHC.

Analysis of funding mechanisms and strategies for community health programmes: the case of the Central African Republic (CAR)

Gloire Mongue Kosspe, Parfait Sebuolo, Noelly Douma, Birindabagabo Pascal

Background

The financing of community health in the Central African Republic (CAR) is still a concern, as there is no government budget line for community activities. Considerable efforts have been made by technical and financial partners (TFPs) in this sector, but these remain insufficient.

Objectives

To analyse community health funding mechanisms and strategies in CAR. The specific objectives are:

- To trace the different sources of funding for community health and
- To analyse innovative funding mechanisms for community health programmes.

Methodologies

This is a cross-sectional study that used mixed methods to collect and analyse data from different sources of funding in the health sector in CAR. The data collected are for the 2022-2023 batches. The Excel tool will be used in the analysis to produce trend parameters.

Results

The result reveals that there is a funding gap of 77% of all community health programme needs in 2022 and 2023. In addition to the gap, funding for community health programmes in general and community health workers in particular is predominantly external, at 99.8%, with the government contributing only 0.2%. The government should mobilise an average of USD 26,226,426 per year.

Recommendations

In view of the above results, we recommend that the CAR government prioritise community health programmes in its budget by creating a budget line for community health; strengthening the effectiveness of the use of resources by encouraging Technical and Financial Partners to draw up action plans to improve the traceability of mobilised resources.

Conclusions

To reduce maternal and infant mortality, which remains a major concern for CAR, the government should prioritise community health programmes and CHWs, hence the importance of investing in them by increasing the budget envelope, as well as improving primary healthcare functions, including community health workers.

Dynamics of achieving Sustainable Development Goal 3 (SDG3) in Senegal: contribution of community organizations (COs) in the Diourbel commune.

Christine Awa Diouf[1], Abdoul Aziz Ndiaye[2], Mamadou Saliou Mbengue[2], Thierno Madiou Diallo[1] and Maty Thiam[3]

(1) Centre Régional de Recherche et de Formation à la prise en charge clinique de Fann (CRCF)/ Regional Center for Research and Training in Clinical Care of Fann (CRCF), Dakar, Senegal
(2) Université Alioune Diop (Alioune Diop University) (UAD), Bambey, Senegal
(3) District sanitaire de Diourbel (Health district of Diourbel), Senegal

Context

As part of the implementation of the 2030 Agenda, which sets out the Sustainable Development Goals (SDGs), governments around the world are planning to involve communities in all development programmes. In Senegal, community organisations (COs) are involved in health development strategies in order to contribute locally to achieving Sustainable Development Goal 3 (SDG 3), which is specifically dedicated to health.

Objective

The aim of this study is to analyse the participation of COs in the Diourbel commune in achieving MDG 3.

Methods

This is a mixed study with a sequential estimate carried out in the Diourbel commune. The quantitative part was carried out using a questionnaire administered to representatives of 39 COs. The qualitative study was carried out with the COs and health structures in the commune through 10 individual interviews and 01 focus group of 08 targets to supplement the results obtained through the questionnaires. Semi-structured interview guides and a focus group guide adapted to the targets were used. The interviews were recorded, transcribed and analysed for content. The data from the questionnaires was entered, processed, presented in the form of tables and graphs using Excel software and then analysed.

Results

A total of 39 COs, including 12 community watch and alert committees (CWACs), 09 health development committees (HDCs), 09 community health mutuals (CHMs) and 09 community-based organisations (CBOs) took part in the study. With disparities according to the type of community organisation, the respondents were predominantly male (72%), with an average age of 50. All of the respondents were in education, with the majority working in teaching (30.8%) and health/community development (28.2%). The study revealed limited knowledge and low appropriation of the SDGs by COs. According to their activities, which are mainly carried out in the health and socio-economic fields, the role of CBOs in health can be situated at three levels: prevention and health promotion, early and equitable access to quality health services and social protection.

Conclusions

This study shows that the COs in the Diourbel commune play a vital role in local and sustainable health development. Their activities are perfectly aligned with the targets of the national health objectives, which are in line with those of MDG 3. However, the lack of financial resources hinders their proper fulfilment.

Social assistance (in health) in low- and middle-income Sub-Saharan African countries: what lessons can be learned from the Belgian experience in social assistance?

Bart Criel *Institute of Tropical Medicine, Antwerp, Kruibeke, Belgium*

Social health protection is a key element in Universal Health Coverage (UHC) policies. A comprehensive social protection policy is based on three central functions: a prevention function (for example, social health insurance), a promotion function (for example, improving the capabilities of individuals and households), and a social assistance function (for example, support for the most disadvantaged). The author of this abstract is an emeritus professor in the Department of Public Health at the Institute of Tropical Medicine in Antwerp, Belgium. He has 30 years of experience in research, teaching, and service in the field of health system management and social health protection in developing countries. At the same time, he held the political position of director of the Public Centre for Social Action (CPAS) in his municipality in Belgium for 8 years.

In this presentation, he briefly describes the history and functioning of the social assistance system in his country. He then draws parallels with the social assistance arrangements that exist (often still in their embryonic state) in Sub-Saharan Africa. He finally presents a series of lessons for social assistance systems in the Global South: 1) the relevance of prioritizing the use of specifically trained social work professionals; 2) avoiding the consideration of poverty as a permanent status; 3) taking into account the structural determinants of poverty and social exclusion; 4) ensuring the respect for the dignity of individuals and households in need of social assistance; and 5) giving a voice to social assistance beneficiaries in the functioning of social assistance systems.

In Senegal: Are HIV-infected patients resistant to COVID-19 vaccination?

Ndeye Fatou Senghor *Centre National de Recherche et de Formation à la Prise en Charge Clinique de Fann/ Fann National Centre for Research and Training in Clinical Care (CRCF), Dakar, Senegal*

The aim of the study was to analyse the acceptability of Covid-19 vaccines among people living with HIV (PLHIV) in Senegal.

Methods and Materials

A mixed analysis study was conducted from 10 November to 23 December 2022 in the regions of Dakar, Kaolack and Ziguinchor. As part of the qualitative approach, 76 individual interviews were conducted, including 22 with the general population, 24 with men who have sex with men (MSM), 09 with drug users (DU) and 21 with sex workers (SW). As for the quantitative survey, 60 questionnaires were administered to 29 people from the general population, including 13 MSM, 10 SW and 8 DU. Their ages ranged from 19 to 58, with an average of 41. The majority (80/135) had been vaccinated against Covid-19, including 35 SW, 29 MSM and 16 DU. Data were analysed and processed using Dedoose and SPSS software.

Results

Vaccinated PLWH (80) expressed a feeling of fear before accepting the vaccines. Initially, they were wary of vaccines because of the weight of the misinformation. Some of them changed their minds because they felt vulnerable (25/80), had direct experience of Covid-19 (26/80) and had been made aware of the issue by health workers (29/80). Unvaccinated PLHIV (55/80) said they had limited knowledge of the Covid-19 vaccine. Added to this are the rumours circulating through social networks and peer groups. Non-adherence to vaccination is explained by a lack of information about vaccination and the occurrence of side effects among vaccinated peers. In addition, some PLHIV had more confidence in the Johnson and Johnson vaccines because they were a single dose and were perceived as being of good quality because they came from the United States.

Conclusion

This study shows that PLHIV expressed an initial fear of vaccines, influenced by misinformation and rumours circulating on social networks. However, three factors contributed to a change in decision for some of them: a feeling of vulnerability, experience of the disease and the quality of awareness-raising by health workers. These results underline the importance of strengthening vaccination education to encourage greater acceptability of the vaccine among this vulnerable population.

Strengthening Public Financial Management Systems_1

What can a ministry of finance do for health spending? A public finance perspective on enhancing health spending efficiency

Tom Hart, ODI, London, United Kingdom and Ms. Danielle Serebro, Masters in Development Economics, Collaborative Africa Budget Reform Initiative, Johannesburg, South Africa

Investing more in health ought to be a priority for all governments – high-quality health spending supports the economy by strengthening human capital; reduces poverty and income inequality; and strengthens health security to mitigate against the macro-economic shocks associated with epidemics and pandemics. However, budgetary space for health is severely constrained – low- and middle-income country governments are confronted with stagnant or low economic growth, limited capacity to mobilise revenue, rising inflation and higher debt-service costs.

Despite widespread knowledge of this fiscal squeeze, there continue to be unrealistic expectations from the ministry of health and health financing community of how much more funding the ministry of finance can or will allocate to the health sector. If it is not reasonable to expect a finance ministry to accede to every demand for additional funding from the ministry of health, what can a ministry of finance feasibly do to improve the efficiency and effectiveness of health spending?

We suggest 10 ways in which the MoF can be a better partner to the health sector: (1) supporting resource-constrained health benefit packages through accurate medium-term forecasting; (2) enabling bottom-up budget inputs for greater allocative efficiency; (3) supporting better budget development through the MoF challenge function; (4) institutionalising spending review processes to identify health inefficiencies and new priorities; (5) reviewing procurement policies and processes which impede health sector efficiency; (6) increasing budget credibility and execution through enhanced cash management; (7) utilising the PFM system and direct financing to enable greater facility financial autonomy; (8) ensuring the fiscal decentralisation system supports effective and equitable health spending; (9) leveraging digital financial tools for improved information access and efficiency; and (10) raising revenue and reducing health spending pressures through health taxes.

A qualitative study of the impact of context, decision-space, organisational capacity and stakeholder power on financing for Primary Health Care in Greater Accra, Ghana

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(5) Policy, Planning, Monitoring and Evaluation Directorate, Ghana Health Service, Accra, Ghana

Background

Decentralization policy affects how municipal and metropolitan local governments finance health systems to deliver Primary Health Care (PHC) for Universal Health Coverage. Though the law in Ghana implies political decentralization or devolution, conflicting laws call for the establishment of a health service and imply administrative decentralization/reconcentration. It is unclear how local governments/municipal or metropolitan assemblies in Ghana provide financing to support urban PHC in the context of current conflicting decentralization policies.

Aims and Objectives

To understand trends and patterns of municipal assembly financial support to the health system, we analysed sources and amounts of financial resources for PHC in one municipality in Greater Accra and examined the influence of organisational capacity, contextual factors, decision space, and stakeholder power on their allocation and disbursement.

Methods

The Study Design is a single case study using mixed methods for data collection. We focused our analysis on the funds given by the local government to the Municipal Health Directorate (MHD). We analysed the municipal assembly's annual plans, composite budgets and financial reports over six years (2018-2024) and reviewed the MHD's expenditure records and cashbooks. Sixty-one (61) hours of non-participant observations of the 2024 planning and budgeting process were also completed. Fifteen (15) stakeholders were interviewed, including assembly members, public representatives, and heads of departments. Field notes and transcripts were thematically analysed. Analysis of sources, trends of fund inflow and expenditures was completed in Excel.

Key Findings

The decision space of the Municipal Assembly for disbursement of financial resources for PHC is influenced by several factors including: the limited financial capacity of the Municipal Assembly, competing needs between departments, the incomplete decentralisation of the Municipal Health Directorate (MHD), stakeholder power and interests, and central government guidelines, policies and mandates. On average, the local government disbursed only 2.3% of its total revenue to the MHD, which represents only 31% of the total funds budgeted for the MHD. Within both budgetary allocations and disbursement decisions, capital projects are prioritised over programmatic investments.

Conclusion

Primary Health Care is under-financed by the Municipal Assembly. Capital expenditures for PHC receive

more focus than programmatic expenditures. The disbursement of funds by the Municipal Assembly to the Municipal Health Directorate is influenced by the organizational capacity of the Municipal Assembly to disburse resources, the decision space of the Municipal Assembly under the model of decentralization in implementation, the power of and use of power by stakeholders, and political context.

Strengthening Public Financial Management (PFM) at the subnational levels in Kakumiro and Kassanda Districts, Uganda

Lawrence Were[1], Aliyi Walimbwa[2] Yewande Kamuntu[1], Fahadi Mawanda[2], Charity Kirabo Nagemi[1], Briony Pasipanodya[1] & Eoghan Brady[1].

1. Clinton Health Access Initiative, Kampala, Uganda
2. Ministry of Health

Background

Uganda implements a model of decentralization that involves devolution of political and administrative authority to District Local Governments (DLGs) with the district as a unit, below which are the lower-level local governments, including health units. Districts therefore oversee the planning/ budgeting processes and the delivery of health services at health facilities.

In 2023, Clinton Health Access Initiative (CHAI) collaborated with the Ministry of Health (MOH) to conduct a Bottleneck Analysis (BNA) to establish financing and service delivery constraints in six project districts. The BNA identified low budget absorption and inefficient use of the available resources as key public financial management (PFM) constraints at sub-national levels with suboptimal PFM practices and the lack of budget visibility at the district local government level as the root causes.

Objective

To build capacity in financial management at district and facility levels for improved planning, budgeting, accountability and reporting (BAR) of funds flowing to health facilities.

Methodology

CHAI worked with the MOH and district local governments of Kakumiro and Kassanda to develop a district budget performance tracking Tool and financial management dashboard to tie the workplans to the expected allocations for the year and track the planned quarterly disbursements and expenditures. District teams were trained on the Primary Health Care Grants Guidelines and Chart of Accounts (CoAs) and the use of the district budget tracking tools and dashboard to track funds flows and utilization for health service delivery. Health facility In-charges were also trained on annual work planning, budgeting, and reporting.

Results

The capacity of Health Facility managers was built to use financial management tools for budgeting, work planning, accountability, and reporting. District dashboards are in place in the two districts to help districts help the team to monitor budget utilization at health facility level in real time and make corrective actions as necessary.

Next Steps

The next phase of the study will report on the gains in skills and knowledge in financial management by service providers and district health management teams and the subsequent impact on service delivery in intervention facilities. The findings will be used to inform scale up of this capacity building approach to other key districts in Uganda.

How Public Financial Management processes influence the amount and timeliness of government's payments for vaccines in Madagascar and Sierra Leone

Noemi Schramm Ndao, CESAG Université Dakar, Dakar, Senegal, Laima A. K. Dumbuya, Government of Sierra Leone, Freetown, Sierra Leone and Tsihory Ravakiniaina Raharison, Government of Madagascar, Antananarivo, Madagascar

Vaccination has long been considered one of the foundations of an effective healthcare system. Recent calculations (Sim, Jit, Constenla, Peters, & Hutubessy, 2019) have found that for every dollar spent on vaccines, the return on investment can be as high as $54, higher than that of many other public interventions such as community health workers, pre-school education or public infrastructure (Ozawa, 2016). However, every year, governments struggle to pay vaccines. This research aims to investigate how public financial management processes influence government's ability to pay on time and in full for vaccines. Understanding how and why governments pay for basic health interventions on time and in full will help to better formulate not only advocacy but also health benefit packages and budgets both within government and external donors.

Through Key Informant Interviews in Madagascar completed between August 2023-February 2024 and Sierra Leone between June 2021-December 2022, reviewing Public Financial Management laws, regulations and budget laws, as well as other relevant secondary literature, the authors have mapped the budgeting and budget execution process for vaccines in detail. Budget requests and allocation for vaccines are erratic, while actual expenditures follow mostly the estimated need. In Sierra Leone, it takes 27 steps from payment initiation to actual payment. The payment process is largely completed manually, increasing opportunities for human error. In Madagascar, it takes twelve steps for vaccine payments to be made, but they have to be approved by the Ministerial Council, presided by the Prime Minister. It has taken, on average, 8.7 months in the last five years for the government of Madagascar to pay its vaccines, and it took Sierra Leone also nine months to pay in 2023. In 2024, the government has digitalized key steps to

to improve budget execution. In both governments, public financial management processes are used to ration cash - by delaying processing payment requests, or increasing the number of steps, the payment is delayed. Transaction costs have been tracked and measured in Sierra Leone, estimating a total of 163 hours spent processing and tracking the payment, the equivalent of 20 workdays. Furthermore, due to depreciating exchange rates, the delays in paying vaccines increased the cost of vaccines to the government of Sierra Leone by 30% in local currency. In summary, public financial management processes have an influence on the timeliness and amount of vaccine payments in Sierra Leone and Madagascar.

Effect of Government-to-Government Funding on Public Financial Management and Service Delivery: Experience from Zomba and Mangochi District of Malawi

Mark Akanko Achaw[1], Atamandike C Chingwanda[2], John Limited[2] and Dominic Nkhoma[3]

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(2) PROPEL Health Project-Palladium, Lilongwe, Malawi,
(3) Kamuzu University of Health Sciences, Malawi

Background and Objective

Amid macroeconomic challenges and shrinking fiscal space, many countries, including Malawi, are focusing on budget efficiency to counteract declining health development assistance. Studies have identified that low budgets executions are often due to factors like poorly implemented and restrictive Public Financial Management (PFM) systems. A 2020 World Bank PFM assessment in Malawi highlighted issues such as insufficient and delayed district budget releases, which negatively impact the PFM system and health sector goals, particularly in service delivery. To address these challenges, USAID piloted a government-to-government (G2G) financing mechanism in the Mangochi and Zomba districts in Malawi. The mechanism provides direct funding for district health activities. As part of a broader Public Expenditure Review, the PROPEL Health Malawi Project evaluated the G2G mechanism's performance in these districts, focusing on its impact on district health financing, governance, and service quality improvements.

Methods

We employed a mixed-methods approach, combining policy document reviews, budget data analysis, and key informant interviews with district officials and community representatives. Our sample included 28 health facilities across Mangochi and Zomba districts. We assessed PFM service delivery goals and budget credibility using the PEFA methodology and indicators. Additionally, we analysed health sector budget trends from 2016/17 to 2020/21 and evaluated the effectiveness of PFM in the health sector at both district council and facility levels, comparing these findings with national-level data.

Results

The study found that the G2G mechanism increased health resources in the districts and improved the quality of services, particularly in maternal and child health. As a results-based mechanism, G2G introduced performance-based financing, enhanced financial management and procurement capacities, and implemented systematic, evidence-based programming. Overall, the G2G mechanism has strengthened the public finance management system's contribution to service delivery goals, including accountability, equity, quality, and transparency. While impactful, the mechanism is currently limited to a few programs and interventions. Expanding its scope could yield even greater benefits.

Conclusion and Policy Recommendations

The G2G mechanism is an important step to strengthening decentralized local systems and improving service delivery outputs but its effect is limited by its earmarked expenditure controls.

Does public financial management enhance the effectiveness of development assistance for health in low-and middle-income countries? A cross-country panel study.

Newton Chagoma, Center for Health Economics, University of York, York, United Kingdom, Julia Hatamyar, Center for Health Economics, University of York, United Kingdom, Sumit Mazmudar, Center for Health Economics, United Kingdom and Marc Suhrcke, marc.suhrcke@york.ac.uk

Background

Public Financial Management (PFM) practices govern the use and administration of public funds, aiming to enhance operational and allocative efficiencies in public service delivery. By doing so, PFM systems hold the potential to enhance health service delivery and facilitate progress towards Universal Health Coverage. They also provide an operational pathway for harmonisation and alignment principles of the Paris Declarations on aid effectiveness driven to enhance the quality and impact of development assistance. While many low-and middle-income countries (LMICs) rely to a large extent on donor assistance, there is scant evidence on how PFM—DAH dynamics affect population health. This study contributes to the growing evidence base on how PFM and DAH may enhance the effectiveness of health aid and improve population health outcomes. It also examines how the effectiveness of DAH has changed before and after the Paris Declaration on aid effectiveness.

Methods

We employ panel fixed effects regressions to identify how DAH and the quality of PFM systems affect population health. The sample consists of 67 countries, covering the years 2005 to 2021, Data were drawn from publicly available sources: the World Bank Development Indicator, Public Expenditure and Financial Accountability (PEFA) secretariat and the Creditor Reporting System databases. Our primary outcome variable is infant mortality, and the PEFA and Country and Policy Institutional Assessment scores represent the quality of PFM systems– our key independent variable of interest. We control for economy size, institutional quality, and public health expenditures.

Results

Our findings reaffirm the beneficial impact of DAH and suggest that countries with stronger PFM systems hold greater potential to improving population health. A unit increase in the quality of PFM systems marginally reduced infant mortality by 0.10% (P<0.01). The combined effect of PFM and DAH was also apparent, and significantly reduced infant mortality by nearly 0.035% (P<0.05). Regarding the Paris Declaration on aid effectiveness and Accra Agenda for Action (AA), landmark events in aid programming, the post-Paris/AAA era was associated with a 0.28% (P<0.01) reduction in infant mortality. Overall, these findings reaffirm the health-enhancing effects of well-functioning PFM system and DAH flows.

Conclusion

While vertical aid flow is on the rise, the use of recipient countries' PFM system – also viewed as "on budget" donor support – appear as a promising pathway for enhancing the impact of DAH in recipient countries. These countries must therefore strive to strengthen PFM systems to incentivise donors use a unified approach to deliver aid other than fragmented mechanisms. Simultaneously, donors should intensify efforts to building resilient system to support effective healthcare delivery. These actions are crucial for effective use of healthcare resources and accelerate progress towards achieving health-related Sustainable Development Goals, and overall health system objectives in LMICs.

Health System Reforms, Governance, and Policy Impact in Africa

10:00 AM–11:30 AM Wednesday, 03 March 2025

Health system strengthening to improve governance in the health system in Chad

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Introduction and Objective

The 12-year Health District Support Programme in Chad (PADS), implemented by the Swiss Tropical and Public Health institute (Swiss TPH) in partnership with the Centre de Support en Santé Internationale (CSSI) and funded by the Swiss Agency for Development and Cooperation (SDC), aims to improve health system governance and access to quality healthcare in Batha and Moyen Chari provinces. In May 2022, an impact study of PADS phase 2 (2018-2022) was conducted to evaluate its effects on healthcare management, quality of care, and community perceptions.

Methodology

The study used a mixed-methods approach to collect data. The quantitative component focused on service providers, surveying 78 health facilities—36 in Batha and 42 in Moyen Chari. The qualitative component targeted community members, conducting 24 focus group discussions with women, men, and community leaders in both nomadic and sedentary communities.

Results and Discussion

The quantitative analysis revealed improvements in management and quality of care across most quality indicators. However, the utilization rates for curative care, especially for children under 11 months and women over 15, remain below expectations. Both provinces also show low trends in antenatal consultations, births attended by qualified personnel, family planning, and contraceptive use. These shortfalls may be linked to the COVID-19 pandemic and related restrictions, as community feedback highlighted difficulties in accessing services during the crisis. Despite improvements in health facilities, communities generally perceive the quality of care as ineffective, often attributing this to shortages of qualified staff and lack of equipment. The qualitative findings suggest that access to quality care could be enhanced by promoting greater equity, particularly in terms of gender and towards nomadic communities. There is also a need to strengthen the involvement of female and pastoralist representatives in health committees to ensure they play an active role in planning health activities.

Conclusion

The study indicates significant improvements in most qualitative indicators during phase 2 of PADS, despite the challenges posed by the COVID-19 pandemic. However, a gap persists between the actual improvements in quality of care and the community's perception of it, as well as in equitable access to health services. Further efforts are needed to address these disparities and enhance community involvement in health planning.

Global Health in the Grip of Neoliberalism: A Comparative Policy Analysis Using the Stages Heuristic Model

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Background

The COVID-19 pandemic revealed critical weaknesses in global health systems, many of which have roots in the neoliberal policies that have dominated global health governance since the 1980s. Neoliberalism, characterized by market-driven policies, privatization, and reduced government intervention, has profoundly impacted healthcare access, equity, and quality worldwide.

Objective

This study aims to analyze the impact of neoliberal reforms on health systems in various countries, focusing on the interplay between governance, policy formulation, and stewardship in the health sector. By examining the outcomes of these reforms, the study seeks to understand how different approaches to neoliberalism have shaped health system performance and equity.

Methods

The study employs the Stages Heuristic Model (SHM) to conduct a retrospective comparative analysis of health policy reforms in ten countries, including the United States, Chile, New Zealand, Ecuador, and China. The research synthesizes data from peer-reviewed articles, government reports, and health system evaluations to assess the outcomes of neoliberal policies on healthcare systems.

Results

The analysis reveals that in countries such as the United States and Chile, neoliberal reforms led to increased health inequities and a tiered healthcare system, where access to quality care became increasingly dependent on socioeconomic status. In contrast, countries like Taiwan, which balanced neoliberal reforms with strong public health initiatives, managed to maintain more equitable health systems. China and Venezuela, which adopted more interventionist policies, also demonstrated better health outcomes and reduced inequities.

Conclusion

The study underscores the need for governance models that prioritize equity and public health in healthcare systems. It suggests that while neoliberal policies can drive economic efficiency, they often do so at the cost of health equity, necessitating a re-evaluation of global health governance and policy approaches in the post-pandemic era.

Understanding health system responsiveness to public feedback at the sub-national level in Coastal Kenya

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(4) Kilifi County Department of Health, Kilifi, Kenya

Background

Responsiveness, a broad multi-faceted health system goal is thought to be important to building people-centred and resilient health systems. However, many studies examining responsiveness report a composite satisfaction index or proportions of patients describing satisfaction with responsiveness dimensions (e.g. dignity, autonomy, prompt attention). Consequently, responsiveness is predominantly based on collation of service users' feedback and could be termed health service responsiveness. We thus conceptualised broader health system responsiveness as comprised of three interrelated processes – receiving, processing, and responding to public feedback – and occurring in, 'processing spaces' within the health system. We set out to answer the research questions: How is public feedback received, processed, and responded to, and what influences the practice of responsiveness at sub-national level.

Methods

We adopted a multiple case study design, and collected qualitative data (35 interviews, four focus group discussions, observations, and document review). Drawing on our conceptualisation of responsiveness combined with Ortiz Aragon's insights on organisational capacity we explored responsiveness practices at the sub-national level in a county at the Kenyan Coast. In our study, the cases were the 'processing spaces' and included Health Facility Committees and Sub- County Health Management Teams. These governance structures were purposively selected to support examination of system-level interactions towards responsiveness to public feedback.

Findings

There were multiple feedback mechanisms through which the health system could receive public feedback, but these mechanisms had limited functionality, often worked in isolation, and inadequately represented vulnerable groups. These challenges contributed to the emergence of informal feedback with mixed effects on responsiveness. We also found organisational capacity gaps that constrained responsiveness ranging from inadequate funding and staffing of feedback mechanisms (hardware), through absence of clear procedures and guidelines (tangible software), to norms, actor relationships and power dynamics (intangible software elements).

Discussion and Conclusion

A broader health systems perspective on responsiveness incorporates various feedback channels and forms, including the health system's capacity to effectively respond to public feedback. This capacity relies on hardware elements like funding for functional feedback mechanisms, human resources for processing feedback, and tangible software components such as procedures for collecting and analysing feedback. Intangible software elements like power dynamics, provider norms, and communication also play a crucial role. Our findings highlight the relevance of integrating diverse feedback mechanisms and considering system capacities in low- and middle-income contexts. This approach strengthens health system resilience and responsiveness.

Institutionalisation of Health Financing Progress Matrix in Mauritius: Immediate impacts on policy making

Ajoy Nundoochan, World Health Organization, Port Louis, Mauritius, Hema Bhunjun-Kassee, Ministry of Health and Wellness, Port Louis, Mauritius, Mathew Jowett, World Health Organization, Geneva, Switzerland, Faizal Shaikh, World Health Organization, Ethiopia and Prof. Laurent Musango, World Health Organization, Antananarivo, Madagascar

Background

The pursuit of universal health coverage (UHC) in Mauritius, with every individual accessing high-quality health services without running the consequences of financial hardship, is deeply enshrined in the country's long-standing tradition of a welfare state with free provision of health care from primary to tertiary services. Public health care services in Mauritius are almost exclusively funded through tax revenue receipts. While per capita government expenditure on health has been rising, the UHC Service Coverage Index has been stagnating around 66-68.

Aims and Objectives

In an uncertain world beset by external shocks impacting on economic growth and the capacity to generate revenue through taxation and fund the national health services, and on the other hand, the need to accelerate the progress towards UHC, it is essential to evaluate the health financing system in Mauritius and identify priority areas to be addressed to steer progress towards UHC by 2030. To that effect, the WHO's Health Financing Progress Matrix (HFPM) was implemented. The HFPM framework provides a set of evidence-based benchmarks hovering around nineteen desirable attributes upon which progress can be assessed. Each attribute represents a critical element of a health financing system and guides institutions, policy development to accelerate UHC.

Methods

A mapping of the health financing landscape comprising a description of key health coverage schemes followed by a detailed assessment based on thirty-three questions of health financing policy was undertaken. A national steering committee oversaw the HFPM process, which entailed desk review of published documents, exit interviews and working sessions with national stakeholders. WHO, internal and external assessors, reviewed and validated the assessment as well as update information where necessary and provide scoring.

Key Findings

Mauritius achieved Advanced status in four Assessment Areas, namely revenue raising, benefits and entitlements, public financial management and public health functions and programmes. In terms of achieving UHC goals the health financing systems was found to be Advanced stage in three domains (Equity in finance, Service use relative to need and Health security) while Established in the remaining five domains (Efficiency, Equity in resource distribution, Transparency and accountability, Financial protection and Quality).

Conclusion

The assessment confirmed that distribution of public health expenditure are pro-poor. The HFPM assessment informed a high-level national health financing dialogue and influenced the position statement adopted thereafter with commitments to increase Efficiency (Strengthen existing institutionalised structure to better evaluate, improve policy development and implementation); Equity in resource distribution (Elaborate a new health financing strategy which will consider ways and means to sustain provision of free health services); Transparency and accountability (Sustain the implementation of recommendations from the Audit Office and Internal Control); and Financial protection(Better understand the drivers of out of pocket payments and catastrophic health spending).

Referral Experiences of Service Users in Nigeria Urban Slums

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Background

The referral patterns within the Nigerian health system is sub-optimal due to various reasons such as insufficient knowledge among healthcare providers, patient non-compliance, preferences, financial constraints, and inadequate support, weakening the health system.

Aim of Research

Although health provider perceptions have been documented, little is known about service user experiences, which requires clearer understanding for improvement. Hence, this paper provides new knowledge on referral experiences of healthcare consumers in urban slums in southeast Nigeria

Method

Data was generated from a cross-sectional study using a pretested interviewer-administered questionnaire that was used to interview the representatives of 1025 households in eight slums that have primary health care (PHC) centres in Enugu and Anambra states, southeast Nigeria.

Key Findings

The findings showed that only 7.4% of consumers were referred to other facilities, mostly by patent medicine vendors, private clinics, and PHC centres, with referrals mostly to private clinics and laboratories. Verbal referrals dominated, while few appointments were booked. The types of referrals varied significantly between facilities that initiated referral and between states.

Main Conclusion

Our study showed that there is poor referral practice in urban slums in Nigeria and as such poor effect on the continuum of care. This highlights the need for innovative solutions to integrate informal health providers into the PHC system to enhance improved referrals for better health service provision and reduction in inequity in urban slums.

Keywords

Healthcare system, healthcare consumers, healthcare providers, referral, urban slums, informal health providers.

Efficiency and Fiscal Dynamics in Health Expenditure Across West Africa and OPEC Countries

10:00 AM–11:30 AM Wednesday, 03 March 2025

The determinants of the efficiency of health spending in West Africa: two step approach by truncated Bootstrap method

Abdoulaye Balde *Universite Cheikh Anta Diop, Dakar, Senegal*

The purpose of this article is to assess the determinants of the efficiency of public health spending in West Africa.
The analysis is made from a two-step DEA approach. In the first step, the efficiency of public health expenditure is estimated in a non-parametric way, by running a VRS (output of variable scales) model with output orientation, while distinguishing the pre-MDG periods (1995-1999) and MDGs (2000-2015).

A total of eight efficiency models are estimated, four multi-output models and four mono-output models. The efficiency scores obtained in this first step are regressed, in the second step, on a set of environmental variables by following the bootstrap truncated procedure of Simar and Wilson (2007), more robust than conventional approaches based on Tobit regression or ordinary least squares.

The results on the first step highlight, on average, an inefficiency of public health spending in all countries except Cape Verde. However, efficiency levels have increased in all countries during the implementation period of MDG-related programs.

Regarding the determinants, the post - DEA results show that the variables external resources, population density, food prevalence, government effectiveness and political stability have a positive and significant effect on the level of public health expenditure efficiency. As for the variable representing per capita income, its coefficient has a positive sign, but it is not significant. on the other hand, the variables public health expenditure, interaction between public and private health expenditure, urbanization rate, infant mortality rate and CO2 emitted have a negative and significant influence on the level of efficiency of public health expenditure in west Africa.

These results highlight the need to strengthen funding policies, in particular through the extension of universal health coverage (insurance), improvement in the quality of governance and better targeting of health spending

Increasing public resources for the implementation of the free health care program "Gratuité" in a perspective of budgetary space for health in Burkina Faso

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Since 2016, a free healthcare program "Gratuité (Free of charge)" has been initiated by Government in Burkina Faso to achieve universal health coverage. The implementation of this health financing reform has led to an increasing access to healthcare services and a decrease in the burden of out-of-pocket payments. However, the resources dedicated to this health program are still low, in addition to the inefficiency pockets leading to several wastes and including administrative red taps, medicine stock-outs, debts to the central purchasing agency and the induced demand healthcare services. This paper initiates quantitative research to estimate the additional resources that could be mobilized for the "Gratuité (Free of charge)" and then defines the most sustainable options for strengthening the program funding. The evidence points out a conducive macroeconomic outlook that could allow for mobilizing additional domestic and public resources for the program, not enough to cover the expected costs of this program. In addition, despite their low expected level, these additional resources will be significantly higher than the program's funding commitments of government. This suggests to strengthen the budget planning and execution through a better public financing management and to improve the efficiency of peripheral health facilities by reducing inequities in bed distribution and drug stock-outs, while strengthening the integrated supervision of health facilities.

Asymmetric effects of oil price on health expenditure in some selected OPEC countries

Olaide Sekinat Balogun *Tai Solarin University of Education, Nigeria*

Oil prices have effect on economic activities, especially for countries that rely on oil revenue for budgeting. Whenever the price of oil is affected in such country, expenditure on economic activities is affect through budgetary allocation. A negative change in price of oil not only affects allocation in the economy but also may lead to deficit financing and other sectors of the economy may suffer this effect.

Therefore, this study examined the asymmetric effects of oil prices on health expenditure in some selected OPEC (United Arab Emirates, Saudi Arabia, Iraq, Nigeria and Algeria) countries. These countries are the top oil producers in the world and spend less than 6% of their Gross Domestic Product (GDP) on healthcare sector in their various countries.

The study relied on demand for health theory to structure models for estimation. Data was retrieved between the period of 2000 and 2022 from World Development Indicators (WDI, 2023) and World Bank Commodity Price Data (WCPD, 2023) for empirical analysis. The study used Welch's T-test, panel Autoregressive Distributed Lag (ARDL) and panel Non-linear Autoregressive Distributed Lag (NARD) to estimate models.

The results showed that burden of health expenditure was felt more on households in Nigeria and Iraq. Also, there exist symmetric and asymmetric relationship between oil price and the two types of health expenditures used in the long run. Specifically, reduction in oil price has negative effect on both government health expenditure (-0.0096) and out of pocket health expenditure (0.0091). This implies that reduction of health expenditure by the government is due to fall in oil price.

Based on these results, government of these countries should be sensitive and pay keen attention to health expenditure during oil boom and crunch in order to achieve healthy economy as proposed in the SDGs. Specifically, increasing government health expenditure will help to improve their health sector activities during oil boom and crunch.

Unlocking Efficiency: Budget Impact of HIV and CVD Care Integration and Task Shifting Learnings from Nigeria's MAPIT Study

Emmanuel Ndenor Sambo *UKS Consulting Ltd, Abuja, Nigeria*

Background

As the longevity of people living with HIV improves, so does the prevalence of dual burdens—HIV and cardiovascular diseases, particularly hypertension. In Nigeria alone, approximately one in every three adults grapples with hypertension. Yet, resource-limited settings grapple with persistent health workforce shortages and inadequate access to care.

While there remains a persistent health workforce shortage and deficient access to healthcare in resource-limited settings, one strategy that serves as a stop-gap measure is the Task Shifting and Sharing (TASSH) being implemented in several countries to efficiently utilize existing health workers to improve the populations to quality health services.

Integrating care yields twofold benefits. From the provider's perspective, it streamlines efficiency, resulting in cost savings. Simultaneously, from the demand side, it reduces expenses associated with hospital visits and related costs.

The synergy of TASSH and service integration amplifies these advantages, closing human resource gaps and making care more accessible.

The NIH-funded MAPIT Study in Nigeria's Akwa-Ibom State, evaluated the feasibility and effectiveness of practice facilitation on the integration of a task strengthening strategy for Hypertension control into the HIV care platform in 30 PHC Clinics.

Aims and Objectives

This study estimates the budget impact of integrating hypertension and HIV care and assesses the impact of Task Shifting on the personnel cost for the delivery of integrated HIV and Hypertension care.

Methodology

Using a cross-sectional approach, primary data was gathered from 15 participating PHC Clinics for the following: personnel time and cost, diagnostics and medicines cost for both HIV and Hypertension. Analysis was done using a customized excel-based model to estimate the individual and combined impacts of service integration and task shifting on the cost of delivering care to individuals with the dual burden of HIV and Hypertension.

Key Findings

While TASSH reduced Human Resource Costs by up to 23%, Integration reduced the overall treatment cost for Hypertension and HIV by 30%, a combination of Integration and TASSH further reduced the total costs by an additional 2 percentage points.

Main Conclusion

As Countries look to improve the efficiencies of their investments in health, innovations such as the Task shifting, and the integration of major health interventions present viable opportunities for leverage at the PHC level especially in resource deprived settings.

11:30 AM–1:00 PM Wednesday, 03 March 2025

Assessing the Challenges to Equitable Access to COVID-19 Vaccine Distribution: Case Studies of Selected African Countries (organized session).

Daniel Malik Achala, AfHEA, Accra, Ghana, Senait Alemayehu Beshah, AfHEA, Addis Abeba, Ethiopia, Grace Njeri Muriithi, AfHEA, Nairobi, Kenya, John Ataguba, AfHEA, Fadima Yaya Bocoum, Institut de Recherche en Sciences de la Santé (IRSS), Ouagadougou, Burkina Faso, Chijioke O. Nwosu, University of the Free State, Bloemfontein, South Africa

Description

Vaccines play crucial role in promoting and advancing preventive health and overall health outcomes. However, stark inequities in the production, distribution, and accessibility of vaccines have burdened developing countries who are disproportionately impacted by these inequities. The COVID-19 pandemic further reinforced these existing inequities and prompted the re-emergence of debates on scaling up research and development (R&D) capacity for vaccines in Africa. To address this, a roadmap for achieving 60% vaccine manufacturing target by 2040 was launched under the Partnerships for African Vaccine Manufacturing (PAVM). Several other initiatives such as the Saving Lives and Livelihoods initiative, Africa Medical Supplies Platform (AMSP), African Vaccine Manufacturing Accelerator (AVMA), COVAX among others, are being implemented in Africa to ensure improved and equitable access to vaccines in the continent. In contribution to efforts that address inequitable access to vaccines in Africa, a collaborative titled "Equitable Access to the COVID-19 vaccines in Africa (ECOVA)" is being implemented jointly by the African Health Economics and Policy Association (AfHEA), Africa Centres for Disease Control and Prevention (Africa CDC), and the United Nations Economic Commission for Africa (UNECA).

As part of the ECOVA project, several country level studies have been commissioned to address key questions of inequitable access to vaccine in Africa and to explore the solutions for overcoming the challenges with equitable access especially for vulnerable populations in Africa. The studies are combination of synthesized evidence on barriers, hesitancy, uptake and patterns in access to the COVID-19 vaccines qualitative analysis of the observed inequities and the underlining reasons for the inequities. Furthermore, the studies explore potential mitigating mechanisms for overcoming the inequities and improving equitable access to vaccines especially for vulnerable populations in Africa.

An organized session is proposed to be held at the 7th AfHEA conference to share the findings of these studies. The study will feature findings of both scoping review and qualitative analysis studies from four African countries (Democratic Republic of Congo, Ghana, Kenya and Mozambique) on equitable access to vaccines in Africa including vaccine hesitancy, barriers to access and uptake as well as distributional mechanisms and challenges and strategies to improve equitable access.

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A scoping review and qualitative analysis of COVID-19 vaccines access, equity, hesitancy and uptake in Kenya.

Vincent Okungu *University of Nairobi, Nairobi, Nairobi, Kenya*

Introduction

The global rollout of the COVID-19 vaccines was hampered by vaccine hesitancy even as the pandemic gained momentum between 2019 and 2022 and called for an urgent need to intensify vaccination efforts to reach most of the population. In Kenya, poor vaccine uptake and inequity were associated with a lack of transparency, including poor coordination and a lack of timely response and strategy to address rumors and misconceptions. The main objective of this review was to identify the critical barriers to equitable and timely access to and uptake of vaccines in Kenya and how these barriers can be mitigated. Ultimately, we draw essential lessons for mitigating the impacts of future pandemics similar to COVID-19.

Method and Materials

A digital search for peer-reviewed publications was conducted on March 17, 2024, using four databases: PUBMED, Google Scholar, Cochrane Library, and Africa Journals Online. A total of 60 articles were reviewed. The search terms were as follows: COVID-19 vaccine +Access +Kenya; COVID-19 vaccine +Uptake+ Kenya; COVID-19 vaccine +Equity+ Kenya; COVID-19 vaccine +Hesitancy+ Kenya. The search was restricted to studies published from 2020 when the first vaccines were rolled out. Primary data involved 25 purposively selected key informants. The data were analyzed thematically, focusing on the key enablers and barriers to COVID-19 vaccine rollout and uptake in Kenya.

Results and Recommendations

Among the critical determinants of COVID-19 vaccine uptake, confidence in the vaccine's efficacy and safety was a significant consideration eliciting 90% of the responses. Geographic access to vaccination sites hampered uptake, where only 14% of the population was vaccinated in hard-to-reach counties. Sociodemographic factors, including age, gender, level of education, occupation, and co-morbidity, significantly influenced vaccine uptake in Kenya. Above all, the failure of the Ministry of Health to mount a convincing response to myths and misconceptions about the COVID-19 vaccine ultimately affected vaccination coverage countrywide. The main highlights of the qualitative findings include the lack of a well-packaged information strategy on COVID-19 vaccines and poorly coordinated efforts to combat rumours and misinformation about the vaccine. The findings highlight important factors that made it difficult for Kenyans to access vaccines. Careful planning and consideration of areas and people who are most disadvantaged will enhance a more equitable uptake of vaccines among Kenyans.

Results and Recommendations

The study has highlighted vital policy lessons that countries can consider before rolling out new vaccination programs. This ensures better preparation for future pandemics.

Equitable Access to COVID-19 Vaccines: A Case Study in Ghana

James Akazili *School of Public Health, C. K. Tedam University of Technology and Applied Science*

Background

The coronavirus disease (COVID-19) pandemic has been recognized as one of the world's most serious pandemics, that had affected global health systems, economies and the population. In the African region, many countries were affected with more than 4.8 million confirmed cases and 130,000 mortalities by June 2021. Ghana recorded about 171,657 confirmed cases of COVID-19 and 1,462 deaths by July 7, 2023. Vaccines are considered one of the most efficient means and cost-effective tools for preventing diseases and maintaining population health. Vaccination programs often seek to achieve herd immunity and reduce morbidities and mortalities. Although there were strenuous efforts to facilitate the procurement and distribution of the COVID-19 vaccines for all populations around the world, available evidence suggests that several factors hindered access, acceptance and use of the COVID-19 vaccines. In Ghana, only 15.9% of the eligible population was fully vaccinated as of April 2022. Thus, this study explored factors influencing COVID-19 vaccines distribution, access and uptake as well as appropriate strategies to improve equitable access and uptake of vaccines especially for the vulnerable populations in Ghana.

Method

The study employed a qualitative research approach involving desk review and primary data collection through in-depth interviews with relevant stakeholders in Ghana. We reviewed published and unpublished articles, existing national policy documents linked with views of stakeholders to understand factors affecting equitable access, hesitancy and uptake of COVID-19 vaccines in Ghana. Data from stakeholders' interviews was coded using QSR Nvivo 12 software to aid thematic content analysis.

Findings

The findings suggest that a wide range of factors including perceptions about the COVID-19 disease and vaccines; role of the media and prominent members of society; personal idiosyncrasies; health system, international and political factors influenced distribution, equitable access and uptake of COVID-19 vaccines. Similarly, doubts about the clinical safety and efficacy of the vaccines, inadequate information about possible side effects, socio-cultural and religious factors as well as misinformation linked to reduced fertility with the view to reducing the African population were the main reasons cited for vaccine hesitancy in Ghana.

Conclusion

The study concludes that an intersectoral communication and educational campaign strategies involving key private and public health sector players as well as international partners could improve the distribution, equitable access and uptake of COVID-19 vaccines. Similarly, effective community engagement through community structures and leadership focusing on promoting the benefits of vaccination could address the issue of misinformation and vaccine hesitancy in Ghana.

Factors contributing to vaccine hesitancy and approaches to improve vaccine acceptance in Mozambique: a scoping review and qualitative assessment

Mariana E Posse *Mariana Posse Consultoria*

Background

The delay or refusal of vaccination is amongst the main challenges to equitable and timely access and uptake of COVID-19 vaccines. We conducted a scoping review to examine factors that contributed to vaccine hesitancy in Mozambique and the approaches to improve vaccine acceptance. The review is complemented with a qualitative analysis of the COVID-19 vaccine rollout response

Method

The scoping review was conducted following the five-stage analytic framework of Arksey and O'Malley. We searched PubMed, The Cochrane Library, African Journal Online and LitCovid from January 5 to 22, 2024. Representatives of organizations that have been key players in the COVID-19 response are participating in face-to-face interviews for the qualitative analysis.

Results

Seven out of 53 studies identified were included in this review. The most common study design was quantitative and cross-sectional (71%). COVID-19 vaccine acceptance ranged from 59% to 89%. The most frequently reported predictors that have a positive correlation with vaccine acceptance were being male and having higher levels of institutional trust. Concerning age, mixed results were reported. While two studies found that older adults were more willing to accept vaccination, one study found that those under 25 years were more accepting of vaccination if compared to those 55 years and over. Regarding the reasons for vaccine hesitancy, the most reported were uncertainty about vaccines safety and efficacy. No study has specifically addressed vulnerable populations in Mozambique. Studies emphasized the implementation of demand promotion interventions about COVID-19 vaccination and its importance, as an approach to reduce vaccine hesitancy. Regarding results from the qualitative analysis, contributions such as the following are expected: insights on necessary investments in the vaccine supply chain, in strategies to increase demand of vaccines, to improve public-private partnerships and to ensure the involvement of geographically, culturally and economically isolated populations in debates on the development, implementation and evaluation of the response to outbreaks and pandemics.

Conclusion

Our review demonstrates that in Mozambique people are vaccine hesitant because of low trust in both vaccines and institutions. To address vaccines inequity and to prepare for future epidemics, policymakers should focus on rebuilding institutional trust by engaging communities in an equitable and transparent manner. The results of the review and the qualitative analysis will guide the response to future health emergencies

The Reasons for Hesitancy and Acceptance of the Covid-19 Vaccine among the Congolese

Genese Lolimo Lobukulu *AfHEA's ECOVA, Democratic Republic of Congo*

Context

More than 9.6 billion doses of Covid-19 vaccine have been injected worldwide. Countries in North America and Western Europe have vaccination rates of over 50%. By contrast, African countries are struggling to vaccinate their populations, with a rate of less than 10%. What are the reasons for the low Covid-19 vaccination rate among the Congolese population?

Method

We carried out a scoping review on one hand using the Arksey and O'Malley framework. Searches were performed on PubMed, ProQuest and Scopus. Inclusion criteria were quantitative, qualitative or mixed studies (published reviews) between 2019 and 2023 primarily discussing or assessing Covid-19 vaccine acceptance, fair and timely access hesitancy. In addition, in-depth key informant interviews were conducted.

Results

A total of 430 articles were identified in the databases. Of these, only 6 articles were included in the review (5 cross-sectional studies and 1 cohort study) and 25 in-depth interviews were conducted. Despite the strong desire of the Congolese to be vaccinated, only 2.7% of them are fully vaccinated. The main reasons for hesitancy to vaccinate were: fear of side-effects (83.3%), lack of confidence in the vaccine (60.0%), and fear that the vaccine was new and experimental (84.4%). Conversely, a history of Covid-19 vaccination among parents, a higher level of perceived susceptibility to Covid-19 within the family, fear of contacting Covid-19, belief in the existence of Covid-19, belonging to the medical profession, and knowledge of the vaccination strategy and priority groups are factors favouring the acceptance of Covid-19 vaccination among the Congolese.

Results

Analysis of the literature and in-depth interviews shows that the main reason for Congolese people's reluctance to be vaccinated against Covid-19 is a lack of confidence in the vaccine, its efficacy and its safety. It is therefore necessary for the health and political authorities to boost the Congolese population's confidence in the vaccine and their level of knowledge about the benefits of vaccination in the community.

Digital Innovations, Financing and Community Approaches to Health in French-Speaking Countries in Africa (organized session)

11:30 AM–1:00 PM Wednesday, 03 March 2025

Health and community involvement' strategy: an innovative approach to oral health care in rural areas in Côte d'Ivoire

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Context

In Côte d'Ivoire, there are numerous inequalities between urban and rural areas regarding access to dental care. This situation is partly explained by the almost non-existent availability of modern dental care in rural areas. However, oral health issues affect all populations indiscriminately, including those living in rural areas. Faced with this situation, the public health principle of equity means that these populations should be able to benefit from appropriate care. Hence initiatives such as the Community Health Education Strategy (CHES), which aims to empower communities and enable them to take ownership of development initiatives, are therefore becoming an opportunity. The aim of this study was to show how it can be used to manage the oral health of people living in rural areas of Côte d'Ivoire.

Methods

Our study, which is a sharing of experience, describes the six steps of implementing the CHES strategy, namely:

- (i) awareness "sharing the vision,
- (ii) mobilization "development road,
- (iii) community diagnosis "identification of problems,
- (iv) situational analysis "seed project,
- (v) training of stakeholders,
- (vi) development activities/health and hygiene promotion, and the results obtained.

Results

Situational analysis of oral health at multiple levels: Mobile consultation (Kodjokro 92.5% never had a consultation, Kouassiblekro 90.6%), Collection of data from consultation registers (Edjambo 1780 records, Frambo 1240), Household survey (Frambo 78 households, Kouassiblekro 59). Involvement of Community Health Workers (ICHW) (Kodjokro 3, Kouassiblekro 4, Frambo 5). Capacity building of healthcare personnel (Edjambo 5, Frambo 3) and the CHES committee (Kodjokro 7, Kouassiblekro 7, and Frambo 7).

Conclusions

The CHES strategy opens up the possibility of integrating oral health at the community level. It is an innovative approach due to its methodology for determining the needs for oral health care and the involvement of communities in managing their health within an empowerment framework.

Keywords

Oral health, rural area, community health, empowerment, Côte d'Ivoire.

Digital health and user perception of digital tools: preliminary results of the evaluation of the implementation of the "Minimal Digital Ecosystem (MDE)" project in Burkina Faso

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Introduction

Since July 2023, Burkina Faso has been experimenting with the "Minimal Digital Ecosystem (MDE)" project in its health system to improve governance, efficiency, and quality of primary health care and free healthcare policy. The MDE integrates eight digital tools: E-financial flow, E-Free, E-Quality, e-Santage, Individual Digital Free Care Sheet (FIS), NetSIGL2.0, REC-Maternity and REC-PCIME. This study presents the users' perception of these tools after the preliminary evaluation of the MDE.

Methods

It was a descriptive cross-sectional study, with data collection in four health districts (Ziniaré, Ténado, Manga, and Sapouy) between December 2023 and January 2024. A total of 72 health facilities were visited and 603 users were interviewed, ranging from 18 users for E-Quality to 170 users for REC-PCIME. The descriptive data were analyzed using Excel software.

Results

The proportion of trained agents varied from 52% for REC-Maternity and REC-PCIME to 97% for E-financial flow. The perceived complexity of the tools varied from 4% for e-SantéCom to 65% for NetSIGL2.0. For NetSIGL2.0 and E-qualité, it was noted that despite high training rates (92% and 94% respectively), these tools were deemed complex by a majority of users (65% and 59% respectively). The attitude towards the tools was mostly positive, ranging from 72% for E-Qualité to 100% for E-flux financier and e-SantéCom.

Conclusion

This study shows contrasting perceptions in the use of MDE tools, highlighting the need for continuous improvement mechanisms to facilitate its adoption and maximize its benefits for the healthcare system.

Improving adherence to Universal Health Coverage (UHC) in Côte d'Ivoire: a Fuzzy Delphi approach to effectively integrate social networks into the communication strategy

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(2) OBALE

Summary

Since 2015, improvements in health service coverage have stagnated, and the world is facing a real challenge in implementing Universal Health Coverage (UHC). In Côte d'Ivoire, implementation of the Universal Health Coverage (UHC) policy is a challenge despite the massive enrolment of 10 million people in four years. The low take-up rate of the Universal Health Coverage, barely 10% by the end of 2023, highlights the need to explore new strategies to increase the effectiveness of the programme. Against this backdrop, this research aims to examine the conditions required to effectively exploit and integrate social networks, such as Facebook and TikTok, which are widely used in Côte d'Ivoire, as a potential means of communicating about the Universal Health Card in order to encourage and improve enrolment and effective use of the health services covered.

Our methodology comprises three stages. Firstly, we draw up a questionnaire based on interviews with experts in public health, health economics, health system administration and political communication. The questionnaire aims to identify the essential components of a communication strategy for the UHC that incorporates social networks. The questionnaire is then administered to about twenty health experts with proven experience in implementing health interventions. Finally, the data was analysed using the Fuzzy Delphi method to identify the components on which there was consensus and those on which the experts had divergent views.

The results of this study will be essential in informing policymakers on how to effectively use social networks to promote the use of UHC in Côte d'Ivoire. By fully exploiting the potential of social networks, it will be possible to overcome current barriers and increase access to healthcare for the entire population.

Keywords

UHC, Côte d'Ivoire, Social networks, Fuzzy Delphi

Factors associated with the use of digital tools by healthcare professionals: the case of the Digital Minimal Ecosystem (DME) (l'Ecosystème Digital Minimal (EDM) in Burkina Faso

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Context

The rate of digital health usage in the healthcare sector is low in many countries. The use of digital tools by healthcare professionals is a factor that facilitates the successful implementation and adoption of digital health. Burkina Faso has recently adopted a Minimum Digital Ecosystem (MDE) in the health sector. The MDE is a basket of eight digital innovations designed specifically to facilitate, among other things, electronic consultation, the management of free healthcare, the management of medicines and the evaluation of the quality of care.

Objective

Identifying the factors associated with the use of MDE tools among healthcare professionals.

Methods

This was a cross-sectional study involving four health districts in Burkina Faso: Ziniaré, Ténado, Manga and Sapouy. Moran autocorrelation was used to select a representative set of health facilities in these districts. A non-probability convenience sampling procedure was used to recruit health professionals. T-tests and logistic regression models were used to analyse the data.

Results

We found that 548 of the 799 (that is 68.6%) healthcare professionals, including [67(93.1%) facility managers; 218(72.7%) healthcare providers; 73(93.6%) essential drug depot managers; 3(60.0%) district managers; 2(40.0%) cashiers; 30(51.7%) management committee treasurers and 155(55.2%) community-based healthcare workers] actually used the MDE tools.

Use of the tools was significantly associated with user profiles. Compared with facility managers, care providers were less likely to use the tools (aOR: 0.12; 95% IC 0.04-0.35). Women were also less likely to use the tools than men (aOR: 0.45; 95% IC 0.25-0.78). However, tool use was positively associated with age (aOR: 1.05; 95% CI 1.00-1.11). No significant difference in tool use was found in relation to education level (p=0.354).

Conclusion

The results of this study should encourage policy makers to motivate healthcare providers, particularly women, to use digital tools to improve primary healthcare in Burkina Faso.

Keywords

Digital health, Healthcare professionals, Usage, Burkina Faso.

Innovative financing of reproductive health in Senegal: Experiences of civil society and local Community-based organisations

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Context

In Senegal, a small proportion of current health expenditure is devoted to reproductive, maternal, newborn,

child and adolescent health (SRMNIA), even though it is considered a priority area.[1]. One of the major challenges in this area is sustainable financing. To meet this challenge, civil society and community-based organisations (CSOs/CBOs) have put in place a number of innovative and alternative domestic financing strategies, which the CRCF has capitalised on as part of the NIP EXPAND project.

Objective

The aim of this work is to share, through an inclusive process, experiences of domestic financing of the SRMNIA and to identify good practice from these implemented experiences in order to popularise them with a view to making them sustainable.

Methods

A three-day capitalisation workshop held in September 2022 in Dakar brought together 30 participants, including 10 CSOs/CBOs from the regions of Dakar, Diourbel, Kolda and Sédhiou, who had previously been trained in capitalising on experience and knowledge management.

The methodology combined PowerPoint presentations, group work and discussions. The presentations covered the generalities of SRMNIA funding and the funding experiences of these CSOs/CBOs.

Results

A total of 10 experiences were shared. From savings and credit communities to community health centres, community granaries and professionalised mutual health organisations, these innovative strategies focus mainly on women, adolescents/young people and children to ensure sustainable access to quality healthcare at lower cost.

Among the shared experiences, 02 themes were selected, documented and popularised through policy briefs. These are the community polyclinics run by Action Développement/Development Action (AcDev) and the « taxawu ndaw ni »[2] project run by Pikine town council.

Conclusion

In response to the shortfall in funding for the SRMNIA in Senegal, it is essential to make the most of domestic resources to ensure the sustainability of health initiatives. This workshop identified alternative and innovative domestic financing strategies and popularised them with a view to scaling them up.

[1] 2 MSAS Stratégie Nationale de Financement de la Santé.pdf [Internet]. [cité 8 déc 2023]. Disponible sur/ MSAS National Health Financing Strategy.pdf [Internet]. [cited 8 Dec 2023]. Available on: https://www.sante.gouv.sn/sites/default/files/2%20MSAS%20Strat%C3%A9gie%20Nationale%20de%20Financement%20de%20la%20Sant%C3%A9.pdf

[2] Wolof expression which means supporting young people.

Financing for Universal Health Coverage: Lessons and Future Direction for African Countries (organized session)

Beverley Essue[1], Juliet Nabyonga-Orem[2]

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2. *World Health Organization*

Description

Introduction

Health financing is a core requirement for the health system to function and advance universal health coverage (UHC). The World Health Organization's (WHO) 2010 World Health Report highlights how health financing reforms could influence the embodied health system goals and intermediate objectives. In recent years, UHC established as a global priority, reinforced by the United Nations Sustainable Development Goals, calls for sustainable and equitable health financing policy as integral to moving towards UHC. Health system reforms need to improve the coverage and intermediate objectives linked to it explicitly. Several countries have taken necessary health financing reforms to progress towards the UHC goals. However, it's not clear if the common funds allocation presents the appropriate way to use the resources. Furthermore, it is important to distil how health financing policies are improving the equity, effectiveness, and resource distribution in countries in Africa.

Session Objective

To amplify and socialize evidence and key lessons on Africa's UHC resource levels, approaches to resource generation, and financial policies aimed at protecting the population.

Learning Objectives and Impact

This is the most relevant platform to disseminate and discuss evidence on how to generate and utilize resources from different sources of funds in Africa drawing lessons from UHC health financing policy reforms, particularly user fee exemption policies. The session will further analyze how the financing policies are impacting financial risk protection using an equity lens. The session discussions will contribute to filling the knowledge gap about health financing policies and the UHC financial risk protection goal which will stimulate further discussions and research on the topic area. We aim to spark further discussion and collaboration on new research opportunities to examine the lessons from our research in other low-income country settings progressing toward UHC in Africa. At the end of the session, we will include an evaluation poll to understand the impact of the session on the achievement of our learning objective and to identify attendees' perspectives on priority areas for further work on this topic.

Target Audience

Academia/researchers, development partners, civil society organizations, policymakers, and implementers.

Financing Health System Elements in Africa: A Scoping Review

Humphrey Karamagi *WHO Regional Office for Africa, Brazzaville, Congo*

Introduction

Countries that are reforming their health systems to progress towards Universal Health Coverage (UHC) need to consider total resource requirements over the long term to plan for the implementation and sustainable financing of UHC. However, there is a lack of detailed conceptualization as to how the current health financing mechanisms interplay across health system elements. Thus, we aimed to generate evidence on how to utilize resources from different sources of funds in Africa.

Methods

We conducted a scoping review of empirical research following the six-stage methodological framework for Scoping Review by Arksey & O'Malley and Levac, Colquhoun & O'Brien. We searched for published and grey literature in Medline, Cochrane Library, PubMed, WHO database, World Bank, and Google Scholar search engine databases and summarized data using a narrative approach, involving thematic syntheses and descriptive statistics.

Results

We included 156 studies out of 1,168 studies among which 13% were conceptual studies while 87% were empirical studies. These selected studies focused on the financing of the 13 health system elements. About 45% focused on service delivery, 13% on human resources, 5% on medical products, and 3% on infrastructure and governance. Studies reporting multiple health system elements were 8%, while health financing assessment frameworks were 23%. The publication years ranged from 1975 to 2021. While public sources were the most dominant form of financing, global documentation of health expenditure does not track funding on all the health system dimensions that informed the conceptual framework of this scoping review.

Conclusion

There is a need to advocate for expenditure tracking for health systems, including intangibles. Further analysis would inform the development of a framework for assessing financing sources for health system elements based on efficiency, feasibility, sustainability, equity, and displacement.

Free Healthcare Policies and the Achievement of Universal Health Coverage: A Systematic Review

Prossy Kiddu Namyalo *Institute of Health Policy, Management, and Evaluation, Dalla Lana School of Public Health, University of Toronto, Toronto, ON, Canada*

Introduction

Free healthcare policies are vital financing and service policies to advancing universal health coverage (UHC) as they promote financial risk protection, reduce catastrophic health expenditures (CHE) and impoverishment due to out-of-pocket (OOP) payments. Although equity is not a natural consequence of implementing a free healthcare policy, it needs to be analysed as an outcome of financial protection because it is inherent in UHC and its pursuit.

Methods

The systematic review assessed how free healthcare policies have impacted the advancement of financial risk protection. Medline, EMBASE, and HealthSTAR were searched for studies that assessed free healthcare policies and FRP, published after 2005-2023. The web-based platform Covidence was used for de-duplication, screening, and data extraction. Two authors independently extracted data and 33 articles were included in the review.

Results

Most of the articles (64%) were published between 2016 and 2021. Three-quarters (75.8%) of articles focused on targeted policies particularly on population groups and services with the majority (82%) conducted in the AFRO region of WHO. The majority (68%) of targeted policies examined maternal and child health services. Ninety percent of the studies included an equity analysis with 72% examining differences between socio-economic groups (wealth income quintiles). CHE incidence was higher for targeted policies compared to policies that covered all services and all population groups. There was mixed evidence on patients' residence and the incurrence of CHE and OOP costs. In general, when primary healthcare facilities were utilized, households incurred lower OOP. The treatment and provider fees constituted the biggest proportion of the medical direct costs and transport fares of non-medical costs. The wealthier seem to have benefited more from the free healthcare programs than the poor.

Conclusion

CHE incidence and impoverishment were identified in all included studies. The focus of free healthcare policies is easing financial access to healthcare services, included studies should, in principle, have demonstrated a high degree of financial risk protection. However, even with free care, patients experience significant CHE and are pushed into poverty from both direct medical and non-medical costs, especially the poorest groups. This is likely to halt the progression towards UHC indicator 3.8.2 at the country level.

Financial Protection in Uganda: Reflections from WHO's Health Financing Progress Matrix

Christabel Abewe *WHO, Kampala, Uganda*

Introduction

:Financial protection is an intrinsic part of universal health coverage (UHC) and, together with service coverage, is one of the health systems' goals. Uganda has doubled its UHC service coverage from 22% to 50% between 2000 and 2020 and inequalities in coverage of essential services tracked in the UHC index across quintiles have reduced in this period. However, it has failed to make similar progress in financial protection and has very high catastrophic health spending affecting 13.6% of the population at the 10% threshold and 3.6% at the 25% threshold in 2020. Further, there has not been significant progress in catastrophic expenditure over the past two decades in Uganda, with progress made around 2000-2002 later lost. Using the WHO Health Financing Progress Matrix (HFPM) assessment and structure, we identified health financing policies and policy shifts that have significantly influenced financial protection in Uganda.

Methods

The assessment relied on WHO's HFPM which hypothesizes a set of linkages between health financing policies and health system performance, and explicitly maps these; in the case of financial protection, twelve questions or areas of health financing policy were assessed as important influencers of financial protection. Data was gathered through a desk review of published and unpublished materials, additionally, key informant interviews were conducted to provide primary data and validate the information collected through secondary sources.

Results and Conclusions

The root causes of the poor financial protection in Uganda are inadequate resources to provide the essential health care package, lack of user confidence in the quality of the health services provided in the public sector, high household expenditure on medicines, informal/under the table fees/payments, high use of private sector facilities, and inequitable access to health services. The key required policy shifts to address poor financial protection include: i) Increasing domestic resource allocation to the health sector through strengthened, targeted, and evidence-based advocacy efforts. The Uganda Revenue Authority should expand the tax base by strengthening tax administration to increase the funds collected from motor third-party insurance, sin taxes, and trust funds in addition to introducing new taxes such as the airline tax. ii) Creating more fiscal space for health through efficiency gains, including better tracking of performance against spend, and addressing the inefficiencies of vertical programs through integration. iii)Quality incentives, which can be promoted through a mix of payment mechanisms and improved tracking of services delivered about public resources.

Health System Resilience, Local Manufacturing, and Service Challenges in LMICs

Advancing the Agenda on Local Manufacture of Medicines in Africa: Opportunities for Enhancing Domestic Ownership and Sustainability

Frances Ilika

USAID Health Policy Plus (HP+) Project of Palladium International Development Company – Abuja, Abuja, Nigeria

Background

Despite very high burden of infectious disease, many African countries access medicines including Antiretroviral therapy from international sources. The Government of Nigeria with the support of the USAID-funded Health Policy Plus Project assessed the feasibility of manufacturing medicines, using Antiretroviral (ARV) drugs manufacturing in Nigeria as a sustainable financing mechanism.

Method

A three-step approach was adopted that included desk reviews of relevant literature, key informant interviews with major stakeholders from government, pharmaceutical associations and manufacturers, regulatory agencies, donor, private, partner and civil society organizations, and a market assessment to determine economic benefits. Stakeholders were chosen based on their technical and political knowledge and involvement in the manufacturing and implementation landscape along the value chain. The multisectoral approach enabled exploration of the needs, constraints, risks, and benefits.

Results

The baseline assessment and market analysis showed feasibility of local manufacturing of HIV commodities under enabling factors; approximately 2.16 billion USD could be gained in 10 years. Some key enablers identified include multisectoral engagements with various stakeholders from across the government, creating an enabling environment and securing market commitments, technical assistance for WHO and FDA approvals, quality control, making appropriate capital and human resource investments and regulatory support to agencies, and pharmaceutical companies to secure all necessary approvals and secure financing at favourable terms.

Discussion/Conclusion

Using evidence from above; an actionable roadmap was developed that details a comprehensive approach to commence local production of HIV commodities in Nigeria, outlining the key stakeholders, key steps, and a way forward for implementation.

Advancing local manufacturing in Africa is critical and momentous to help improve access to life-saving treatment, attain self-sufficiency, improve local ownership and sustainability. This serves as an improved body of knowledge for the government, policymakers, and other critical stakeholders to advance conversations on creating an enabling environment for in-country manufacturing of essential commodities in Africa.

How the introduction of an innovative tool is enhancing access to essential medicines and quality of healthcare delivery: a case study of Liberia's foremost tertiary hospital

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Background

Using evidence from above; aAccess to medical products including essential medicines, is critical to the delivery of quality healthcare services. However, in most low-and-middle-income countries, especially in the sub-Sahara, health facilities at all levels are faced with the challenge of frequent stock out of essential commodities, consequently resulting in poor health outcomes of the population. Several factors ranging from financing to information systems have been described as key drivers. This abstract showcases how the introduction of an innovative tool is helping a country's largest hospital strengthen its health information system in overcoming this problem.n actionable roadmap was developed that details a comprehensive approach to commence local production of HIV commodities in Nigeria, outlining the key stakeholders, key steps, and a way forward for implementation.

Methodology

Taking Liberia's foremost hospital as case study, an assessment of the facility's supply chain system was conducted in collaboration with the hospital management team using the Institutional Architecture (IA) framework for health systems. The framework focuses on the actors/people, processes, and tools that interact to bring about health system improvement. A mix of structured Key Informant Interviews, Focus Group Discussions, process observation and document reviews were used to unearth gaps in the hospital's governance, inventory, and logistics management information system. Notably, policies/guidelines were lacking, commodity inventory and storage processes were poorly managed, and non-standardized paper-based Logistics Management Information System (LMIS) tool was being used. Over a 3-year period, leveraging the Institutional Architecture, a co-creation approach was utilized to develop and implement contextualized solutions including adaptation of the Combined Report, Request, Issue and Receipt Form (CRRIRF) and development of a Google-based Stock Management Tool to address the "tools" component

of the framework. Similarly, training and mentoring/coaching were used to build capacity of "actors" while policies/guidelines were developed and rolled out to strengthen the "processes".

Results

The capacity building and mentoring/coaching support bolstered proficiency in the actors to pivot to use of standardized LMIS tool, improving inventory management practices. This fostered routine generation and real time reporting of reliable stock data, enhancing visibility. Additionally, routine consumption pattern analysis per service point is now being conducted with insights used to guide forecasting/quantification of essential commodities. The management team now makes informed decisions regarding procurement planning, consequently mitigating commodity stock outs to better serve over 3 million people of Liberia.

Conclusion

In similar contexts, introduction of similar tools should be considered and implemented within context and understanding of Institutional Architecture as it would prove helpful to determine key drivers of poorly performing health systems while leveraging co-creation approach to curate local and adaptable solutions that will contribute significantly to improving health systems.

Impact of Surgery on Economic Development in Low- and Middle-Income Countries: A Dynamic Panel Data Analysis

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Background

Access to surgery remains limited in low- and middle-income countries (LMICs) where it has historically been considered prohibitively expensive. There is a growing consensus that robust surgical systems are necessary for national economic well-being, but the direct impact has not been quantified.

Objective

The study explored the impact of surgery on the economic development of LMICs using panel data spanning years 2000 to 2022.

Methods

Economic development was measured using per capita Gross Domestic Product (GDP). The volume of surgical activities in a country was proxied by the volume of sutures (in kilogrammes) imported into the country per 100,000 population, obtained from the United Nations Comtrade. Considering that local production of sutures could affect the GDP per capita through other ways than health improvement, countries that produce sutures locally were excluded. The effect of surgery on GPD per capita was assessed using the Generalized Method of Moments system dynamic panel data estimation technique under the framework of the augmented Solow growth theory.

Results

A total of 95 LMICs were included in the study.

The analysis showed that a one-unit increase in the volume of imported sutures (kg per 100,000 population) leads to a 0.001 unit increase in GDP per capita across the studied LMICs (p-value: 0.001). In a disaggregated analysis, a stronger impact was found in low-income countries, with a one-unit increase in imported sutures resulting in a 0.043 unit increase in GDP per capita (p-value: 0.000), while the results for high-income countries remained consistent with the overall findings.

Conclusion

This study provides quantitative evidence of a significant positive impact of surgery on the economic prosperity of LMICs, with a remarkably stronger effect in low-income countries. Beyond direct health benefits, the results provide strong economic argument for investments in surgical systems, to scale up access to safe, timely and affordable surgeries for all in LMICs.

Determinants of Medication Stockout and Medical Expenditures among Kenyan Refugees During the COVID-19 Pandemic

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Background

The COVID-19 pandemic remains one of the major health and development challenges that the world ever faced. Globally, the need for medical services significantly increased during the pandemic, while existing inequality in access to medical services was further aggravated by dwindling human resources. Increasing demand for healthcare services widened the existing inequality in healthcare access, with situations among refugees becoming more deplorable.

Aim and Objective

This paper analysed the determinants of medication stockout and medical expenses among Kenyan refugees during the COVID-19 pandemic.

Methods

The data were collected using stratified random sampling by the UNHCR in five panel waves, comprising 1328 respondents in wave 1, 1699 in wave 2, 1483 in wave 3, 1371 wave 4 and 1556 in wave 5. The UNHCR's registered refugees formed the sampling frame. Adult households' members were the respondents to the interviews which were conducted bimonthly between May 2020 and June 2021. The data were initially analysed with consideration of their panel nature, but the likelihood ratio statistics were insignificant ($p>0.05$). Therefore, ordinary Probit and Instrumental Variable (IV) Tobit regressions were used.

Key Findings

The results showed that 15.56% of the respondents needed medications but could not access them, while 14.86% visited healthcare centres. Average monthly healthcare expenditure was KSh 212.30. The probability of medication stockout was significantly influenced ($p<0.05$) by NGO assistance, government assistance, age, sold livestock, sold other assets, and the number of hospital visits, but declined with household size, male household headship, and the number of enterprises. The IV Tobit regression was conducted with medication stockout being instrumented by hospital visitation (. The Wald test of exogeneity statistics (19.75) was statistically significant, implying that medication stockout was endogenous. Medical expenditures increased significantly ($p<0.05$) with medication stockout (KSh 2735.55), access to loans (KSh 618.25), NGO assistance (KSh 349.24), household size (KSh 79.96), sold other assets (KSh 388.40), the number of enterprises (KSh 895.72) and urban residence (KSh 383.54), but declined with male household headship (KSh 260.11).

Conclusion

It was concluded that medications were inaccessible by the most economically vulnerable refugees who sought medical services, and there was a gender difference in demand for medical services. Efforts to promote access to healthcare services and health among refugees should target the most economically vulnerable and female headed households.

Keywords

Medication Stockout; Medical Expenditures; Refugees; COVID-19; Kenya.

Crime in urban areas inhibits provision of health services in Primary Healthcare Centres: a qualitative study in Nigeria.

Pamela Adaobi Ogbozor[1], Tochukwu Charles Orjiakor[2], Obinna Emmanuel Onwujekwe[2], John Eze[3], Nicola Bowes[4]

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(3) University of Nigeria, Nigeria
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Introduction

Recent estimates reveal a fast-urbanizing globe, especially for low-income countries. With the stiff competitive tendencies and the spatial differences in access to scarce resources, crimes are likely to increase and impact the wellbeing of urban residents. Access to- and provision of essential healthcare services in Primary Health Centres is also affected. We explored how crime inhibits provision and access to health services in two urban centres in South east Nigeria.

Method

Eight urban neighborhoods in two large urban cities in the Southeast Nigeria were selected for the study. Key stakeholders were engaged either with in-depth interviews or Focused Group Discussions (FGD). The pool of participants for the in-depth interviews includes 52 key stakeholders comprising 8 Health Policymakers, 10 formal health managers, 10 security personnel, 6 Informal providers coordinators, 8 Informal health providers and 10 community leaders. The Focused Group Discussions involved. female (n = 4) and 4 (n =4) male service users. Data was analysed thematically using Nvivo 12.

Building a Resilient Public Health Emergency Management System: Findings from USAID/Ethiopian Health Resilience Activity Baseline Evaluation

Tefera Alemu[1], Elsabet Megersa[2], Kassa Hailu[1], Asaminew Girma[1], Veronica Triana[3], Muluken Melese[3], Elke Konings[3], Floride Niyuhire[3], Lemma Belay[4], Helena Hailu[4], Daniel Gebremichael[4]

1. USAID/Health Resilience Activity, Management Sciences for Health (MSH)/Ethiopia Country Office
2. USAID/Health Resilience Activity, Ethiopian Red Cross Society (ERCS)/Head Quarter
3. USAID/Health Resilience Activity, Management Sciences for Health (MSH)/Global Office
4. U.S. Agency for International Development | Ethiopia

Background

Ethiopia is facing ongoing and escalating emergencies, with its current preparedness and early warning systems insufficient for early detection and effective response. To address these gaps, USAID has started "Ethiopia Health Resilience Activity" project being implemented by MSH and ERCS as the major sub-partner.

Objective

This assessment evaluates the local-level International Health Regulation (IHR) 2005 core capacities in alignment with the project result areas.

Methods

In September 2023, a baseline assessment was conducted across 15 Woreda Health Offices (WrHOs), 48 health centres, 38 health posts, 7 hospitals, and 10 private health facilities. Data were collected using surveys and simple random sampling techniques, with face-to-face interviews and record reviews conducted via the ODK app. Analysis was performed using Microsoft Excel 365.

Results

Each WrHO has a full-time Public Health Emergency Management (PHEM) officer, and all health centers and hospitals have designated PHEM focal persons. Of the 15 surveyed woredas, 10 (66.7%) have developed Vulnerability, Risk Assessment and Mapping (VRAM), and 5 (33.3%) have updated Emergency Preparedness and Response Plans (EPRP) for the 2022/23 fiscal year. However, only one woreda has allocated a contingency budget for anticipated emergencies in its EPRP. Disaster Risk Management (DRM) councils, Rapid Response Teams (RRTs), and Technical Working Groups (TWGs) were established in 15 (100%), 14 (93.3%), and 8 (53.3%) of the woredas, respectively. However, functionality rates were 66.7% for DRM councils, 86.8% for RRTs, and 40% for TWGs. The Community and Event-Based Surveillance (CEBS) system was being piloted in 10 kebeles of Ayehu Guagusa and 5 kebeles of Jabi Tehnan woredas in the Amhara region and the District Health Information System 2 (DHIS2) for PHEM is implemented in Dire Dawa Administration.

Weekly surveillance reporting completeness and timeliness rates were 89.7% and 87.8%, respectively. Only one-third of the woredas analysed and utilized their Early Warning, Alert, and Reporting System (EWARS) data. Out of 21 outbreak events in the previous year, 16 (76.2%) were detected within 7 days of onset, all were notified within 24 hours, and 14 (66.7%) had early response actions completed within 7 days. Most woredas had limited and irregular review meetings, supportive supervision, and feedback mechanisms. Three woredas (20%) lacked computers, eight (53.3%) had no laptops, and nine (60%) had no internet access.

Conclusion

While the Government of Ethiopia (GoE) has established a local level surveillance and response mechanisms, their implementation and functionality vary across woredas. Local capabilities in community and event-based surveillance, EWARS data analysis and utilization, emergency preparedness and coordination remain insufficient and immature.

Recommendation

Project implementers and their stakeholders should focus on addressing identified gaps to enhance local-level IHR core capacities. This includes implementing regular mentorship, conducting review meetings

and action reviews, organizing simulation exercises, providing tailored training, and facilitating experience-sharing visits. Additionally, it is crucial to provide essential gadgets like laptop computers, dongles, and Wi-Fi services to empower Woreda Health Offices (WrHOs) to become centres of excellence.

Economic Evaluations of HIV, Maternal Health, Anaemia, COVID-19, and Digital Health Interventions in LMICs

11:30 AM–1:00 PM Wednesday, 03 March 2025

The Costs of Implementing Anaemia Reduction Interventions Among Women Fish Processors in Ghana

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(2) University of Ghana School of Public Health, Accra, Ghana,
(3) Department of Health Policy, Planning and Management, School of Public Health, University of Ghana, Legon, Ghana

Background

Anaemia among women of reproductive age (WRA) remains persistently high in Ghana, affecting 41% in 2022. Women in low-income communities in Ghana engaged in fish processing activities are at increased risk of anaemia due to inadequate diets, exposure to infectious pathogens, and pollutants. The Invisible Fishers (IFs) project was implemented among women fish processors in their reproductive age in Central and Volta regions of Ghana to mitigate anaemia. Despite the efficacy, feasibility and scalability of the intervention, the cost of implementing the intervention is unknown.

Objective

The objective of this study was to estimate the costs of implementing the IFs project in Ghana.

Methods

We used micro-costing approach to analyse the costs of implementing the IFs project. Data were collected as part of a pilot randomized control trial with three interventions: Behaviour Change Communication (BCC), Strengthening Market Engagement of fish processors plus Behaviour Change Communication (SME+BCC), and Fish Smoking Technology and Practices plus Behaviour Change Communication (FST+BCC). The BCC taught participants about the causes of anaemia and risk reduction strategies, while the SME addressed the problem of inadequate storage facilities, physical distance from markets, entrepreneurship skills, and access to credit facility among women fish processors.

Finally, the FST introduced and promoted an improved fish-smoking oven designed to reduce women fish processors' exposure to airborne pollutants. The interventions were delivered to 60 women fish processors in the Central region and 60 in Volta region. The cost of the intervention was estimated from the societal perspective. Economic costs were categorized as direct costs (i.e. personnel, transportation, meetings, training, monitoring, administrative, oven, computer, stationeries, and furniture) and indirect cost (i.e. value of productive time lost by women and volunteers).

Results

The FST+BCC had the highest average cost per beneficiary (US$11,898.62), followed by the SME+BCC (US8,962.93). The least expensive was the BCC (US$4,651.93) over the intervention period of 18 months. Recurrent costs constituted the largest component of economic costs (98%). Key drivers of direct costs were personnel (58%), administrative expenses (14%), and transportation (7%).

Conclusion

There is a high cost for implementing interventions included in the IFs project in a small population compared to similar large-scale studies conducted in Kenya (US$110), and Burundi (US$770). Planning and scaling-up of the interventions across larger populations could bring about economies of scale to reduce the average cost of the interventions.

A cost-effectiveness analysis of COVID-19 critical care interventions in Addis Ababa, Ethiopia: a modelling study

Senait Beshah *AfHEA, Addis Abeba, Ethiopia*

Objective

To estimate and compare the cost-effectiveness of COVID-19 critical care intervention approaches: non-invasive (oxygen without intubation) and invasive (intubation) management in Ethiopia.

Methods

A Markov model is used to compare the costs and outcomes for non-invasive and invasive COVID-19 clinical interventions using both primary and secondary data sources. Healthcare provider costs (recurrent and capital cost) and patient-side costs (direct and indirect) were estimated and reported in United States Dollars (US$), 2021. The outcome measure used in this analysis was DALYs averted. Both the average cost-effectiveness ratio (ACER) and incremental cost-effectiveness ratio (ICER) were reported. One-way and probabilistic sensitivity analyses were applied to assess the robustness of the findings. The analysis is conducted using Tree Age pro health care software 2022.

Results

The average cost per patient per episode for mild/moderate, severe, non-invasive, and invasive critical management was $951, $3449, $5514, and $6500, respectively. According to the average cost-effective ratio (ACER), non-invasive management resulted in $1991 per DALY averted, while invasive management resulted in $3998 per DALY averted. Similarly, the incremental cost-effective ratio (ICER) of invasive compared to non-invasive management was $ 4948 per DALY averted. Conclusion Clinical management of critical COVID-19 cases in Ethiopia is associated with a significant financial burden. Invasive intervention is unlikely to be a cost-effective COVID-19 intervention in Ethiopia compared to non-invasive critical case management using a willingness to pay threshold of three times GDP per capita.

Keywords

COVID-19, Cost, Cost-effectiveness, Critical. Invasive, Non-invasive.

A country-led approach to leveraging digital technology for tracking resource flows to improve health sector resource planning and allocation: Rwanda's Success Story

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(3) USAID, Rwanda

Background

Health systems in most African countries are financed through a mix of sources, including external funds, government budgets, and out-of-pocket payments. In these contexts, ministries of health often face challenges in aligning spending from external sources with their domestic planning and budgeting processes, therefore increasing the scope for inefficient allocation of resources. Enhanced tracking and visibility of interventions and services funded through external funding is therefore necessary.

The Government of Rwanda (GOR) previously invested in an externally developed digital system for tracking domestic and external funds for health. Due to limitations in autonomy around adapting the functionality of this system, in 2017 the GOR halted this system and reverted to manual tracking of expenditure using Excel files. The GOR has now successfully developed a homegrown digital Health Resources Tracking Tool (HRTT) that provides accurate up-to-date information on the flow of resources (current and budgeted) in the health sector from both domestic and external sources. HRTT identifies the specific source of funds, where these funds are being spent by domain of intervention, level of care, type of healthcare service, and geographic location.

Aims

The objective of this presentation is to outline Rwanda's journey from an externally developed system to a home-grown automated web-based system that allows remote data entry of Development Partners' budget and expenditure data, and collation of financial data from public databases. HRTT blends the System of Health Accounts (SHA) methodology with the country's planning and budgeting process, facilitates the generation of timely annual health expenditure reports, and is less resource intensive. The tool produces reports and dashboards that are easily used for health financing policy dialogue and decision making, which is especially critical for under-resourced health services and programs. HRTT's functionality allows the ministry of health to generate various summary statistics and trend analysis of key health financing indicators. HRTT is currently used by the Ministry of Health and over 100 development partners. This has proven to be an important tool for supporting the equitable and efficient allocation of external funding to relatively underfunded priority areas and vulnerable populations.

Findings

This presentation provides key lessons learned in the development of HRTT. Among these lessons are the enabling factors for the success of HRTT. These include ownership of source codes and availability of financial databases in digital format. The presentation will also highlight key challenges faced, and processes that are fundamental for developing this innovative resource tracking system.

Cost Analysis of Implementing a Digital Tool (DISC-Mali) for Community Health Care in Ségou, Mali

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(1) National Institute of Public Health, Bamako, Mali,
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(4) United Nations Children's Fund, Bamako, Mali,
(5) United Nations Children's Fund

Introduction

The Ministry of Health in Mali has initiated a digital health strategy at the community level, leading to the development and deployment of the DISC-Mali tool. This study evaluates the cost of developing and implementing DISC-Mali over two years in the Ségou region, considering the perspectives of both the Ministry and the local community.

Materials and Methods

The evaluation included health structures and partners at all three levels of the health system. A purposive sampling approach was used to select the national and regional health structures and professionals involved in DISC-Mali. A representative sample of health districts (6 out of 8) and community health worker (CHW) sites (184 out of 220) was randomly chosen. For comparison, 184 CHW sites in the Sikasso region, not using the tool, were also evaluated. Data collection employed both top-down and bottom-up approaches, including interviews with selected professionals and CHWs, with resource usage data sourced from financial reports.

Findings

The total cost of implementing the DISC-Mali tool was 273,018,864 XOF (445,635 USD), with direct costs accounting for 195,176,086 XOF (318,576 USD), or 71% of the total. The direct cost per CHW was 319,961 XOF (522 USD), while the indirect cost was 127,611 XOF (208 USD). CHW site-level costs comprised the majority of the expenses, representing 54% of the total cost (147,552,983 XOF, 240,844 USD). The primary funding sources were UNICEF (37% of total costs), the government (32%), and PACSU (29%).

Conclusion

The DISC-Mali tool, with its relatively low direct unit cost compared to Mali's GDP per capita, is an efficient intervention. Given its positive impact on CHW activities and its affordability, scaling up DISC-Mali nationwide is recommended.

Keywords

Cost, digitalization of health, community health worker, DISC-Mali.

Cost-effectiveness and budget impact of introducing a new uterotonic for the prevention of postpartum haemorrhage in India, Nigeria and Uganda

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(2) CHAI-Nigeria
(3) Department of Obstetrics and Gynaecology, Makerere University College of Health Sciences

Background

In 2018, the World Health Organization first recognized heat-stable carbetocin, a uterotonic, for

postpartum haemorrhage (PPH) prevention.

Objective

This health-economic analysis supports public sector introduction decision-making by assessing the cost-effectiveness, budget and health impact of HSC compared to current prophylactic standards, with India, Nigeria and Uganda as use-cases.

Method

A decision-tree model was developed to compare heat-stable carbetocin versus oxytocin and misoprostol among women giving birth in public sector healthcare facilities in India, Nigeria and Uganda. The model accounted for differences in PPH risk and costs based on mode of delivery, healthcare setting and provider behaviour to mitigate quality concerns of oxytocin. Model outcomes included the number of PPH events, DALYs due to PPH, deaths due to PPH, and direct medical care costs. The budget impact was estimated based on projected uterotonic uptake between 2022–2026 in the Indian context and 2024-2028 in the Nigerian and Ugandan contexts.

Key Findings

Compared to oxytocin, heat-stable carbetocin for prophylactic use avoided more PPH events, severe PPH event, deaths and DALYs per 100,000 births across the three countries. Projected direct medical costs to the public healthcare system were also lower per 100,000 births. Health and cost benefits were even greater when compared to misoprostol in India and Uganda, while health benefits were greater in Nigeria. In the budget impact analysis across a 5-year period, all three country public health systems were projected to see considerably fewer PPH events and save millions as the penetration for heat-stable carbetocin, as a prophylactic uterotonic, grows.

Main Conclusions

Greater adoption of heat-stable carbetocin for the prevention of PPH could advance country efforts to achieve their maternal health targets of reducing PPH, increase efficiency of its public health spending, contribute toward Universal Health Coverage goals and support climate resiliency and health equity agendas.

Gender, Policy, and Workplace Dynamics in African Health Systems

11:30 AM–1:00 PM Wednesday, 03 March 2025

Assessment of prevalence and determinants of workplace violence among nurses in public tertiary hospitals in Enugu State, Nigeria

Nwanneka Chidinma Ghasi[1], Daniel Ogbuabor[2]

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(2) University of Nigeria Enugu Campus, Enugu, Nigeria

Background

Nurses are three times more likely to experience workplace violence (WPV) than other healthcare professionals. Nonetheless, studies of factors that predict verbal violence, physical violence, and sexual violence against nurses are scarce. Furthermore, relatively little is known about how WPV influences nurses' burnout and intent to leave their jobs.

Objectives

This study assessed the prevalence and determinants of workplace violence among nurses in public tertiary hospitals in Enugu State, Nigeria. We also assessed the influence of workplace violence on nurses' burnout and intent to leave their job.

Methods and Materials

The study adopted a cross-sectional survey design. Data was collected from nurses (n= 450) working in four public tertiary hospitals in Enugu State Nigeria. Proportional stratified random sampling technique was used to select respondents in each hospital. We collected data using a validated, interviewer-administered, structured questionnaire. The questionnaire investigated nurses' experiences of workplace violence in the past 12 months, scored as yes or no. Workplace violence included verbal, physical, and sexual violence. The independent variables included sociodemographic factors and organizational characteristics. Additionally, we collected data on intent to leave and burnout. We used the Maslach burnout inventory scale comprising depersonalization, emotional exhaustion and personal accomplishment. We analyzed the data using descriptive statistics, cross-tabulations and binary logistic regression. Statistical significance was set a p-value of 0.05.

Results

The results showed that prevalence of verbal, physical and sexual violence was 91.1%, 13.3%, and 2.0%. Overall, the reporting rate of WPV was 16%. Nurses' marital status, qualification and tenure predicted physical violence. Being a female nurse increased the likelihood of verbal violence (OR=2.84, 95%CI: 1.09-7.42, p=0.033). Nurses' qualification (OR=2.03, 95%CI: 1.03-4.00, p-value=0.04), direct contact with patients (OR=50.50, 95%CI: 2.99-853.77, p-value=0.007), working in accident and emergency units (OR=5.42,95%CI: 1.97-14.85, p-value=0.001) increased the likelihood of physical violence against nurses. Direct contact with

patients (OR =72.39, 95%CI: 2.19-2397, p-value=0.016) increased the odds, while working with male clients (OR = 0.04, 95%CI: 0.0-0.76, p-value=0.032) decreased the odds of sexual violence. Verbal violence predicted burnout (OR = 2.09, 95%CI:1.03-4.23, p-value=0.040), emotional exhaustion (OR = 2.60, 95%CI:1.26-5.38, p-value=0.010), and intention to leave (OR = 8.32, 95%CI:1.12-61.58, p-value=0.038). Physical violence predicted depersonalization (OR = 2.29, 95%CI:1.31-4.02, p-value=0.004) among nurses in this study.

Conclusions

Our finding highlights a need for safer work environment and policies incorporating the factors predicting WPV and strategies to mitigate the influence of WPV on nurses' burnout and retention is warranted.

Understanding health policy agenda setting, formulation and implementation in Nigeria: the case of a maternal and child health reform program

Chinyere Cecelia Okeke[1], Benjamin Chudi Uzochukwu[2]

(1) University of Nigeria, HPRG, Enugu, Enugu, Nigeria
(2) University of Nigeria Enugu Campus, Enugu, Nigeria

Background

Poor maternal and child health indicators have been reported in Nigeria since the 1990s. Different interventions for improving maternal, neonatal and child health (MNCH) activities in Nigeria have been in place, yet MNCH indices remain poor. MNCH reforms adopted by the federal government to improve MNCH indices have traditionally focused on broadening access to healthcare, but they do not achieve the expected large impacts. Yet there has been little effort to understand how these decisions are made.

Aims and Objectives

This study aimed to explore the actors and the implementation processes through which policy actors operate in Nigeria.

Methods

This was an exploratory, descriptive study using a mixed methods approach. The study population were policy makers at the Federal and State levels, community members, civil society organizations, health workers, media and academia who were purposively drawn due to the role they played and for proper representation of sectors in the study population. Data was collected through review of 13 documents; mapping of MNCH policies and advocacy events; 46 in-depth interviews and 5 focus group discussions. Data was analysed using Leichter's macro context framework; Stakeholders and Forcefield analysis for the

actors involved, the Walt and Gilson Policy triangle framework, Shiffman and Smith's policy analysis framework and social network analysis. NVivo version 12 was used for coding and organizing data under common themes, and for interpretation.

Key Findings

Four primary themes influenced the policy-making process for MNCH reform programs in Nigeria: situational factors such as poor maternal and child health indices, recovery of funds from debt relief, and having a decentralized health system; structural structures such as the top-down approach of these MNCH reforms, the weak nature of the PHCs, lack of dissemination and understanding of program protocols at subnational level; socio-economic factors such as lack of sufficient funds, weak accountability structures, weak participation of the citizens and corruption on part of public office holders.; international factors such as role of the donor partners, setting of international health agenda and controlling the funds and location for implementation. MNCH policy actors were identified, and three groups of actors played crucial roles, namely policymakers, development partners and civil society organizations.

Main Conclusion

Adopting findings principles, which include understanding power dynamics, advocating for stakeholder involvement, enhancing capabilities, ensuring transparency and accountability, prioritizing evidence-based decision-making, and promoting empowerment and ownership, is crucial for developing MNCH policies that are responsive, fair, and efficient.

Gender Dynamics, Economic Empowerment, and Health Outcomes: Insights from Yobe State, Nigeria

Vera Niniola, Precious Nwadire, Nkata Chuku, Alozie Ananaba and Oyinyechi Obih

Health Systems Consult Limited, Abuja, Nigeria

Background

In Yobe State, Nigeria, deeply rooted traditional gender norms and cultural expectations have long been a driving force behind gender-based disparities in power, decision making, and health outcomes, particularly affecting women and girls.

Aims and Objectives

This study aimed to unravel the intricate gender dynamics within the community, focusing on the influence of traditional norms on women's economic power, and health outcomes. It also sought to examine the

actors involved, the Walt and Gilson Policy triangle framework, Shiffman and Smith's policy analysis framework and social network analysis. NVivo version 12 was used for coding and organizing data under common themes, and for interpretation.

Key Findings

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Adopting findings principles, which include understanding power dynamics, advocating for stakeholder involvement, enhancing capabilities, ensuring transparency and accountability, prioritizing evidence-based decision-making, and promoting empowerment and ownership, is crucial for developing MNCH policies that are responsive, fair, and efficient.

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Aims and Objectives

This study aimed to unravel the intricate gender dynamics within the community, focusing on the influence of traditional norms on women's economic power, and health outcomes. It also sought to examine the

potential of men as allies in advancing gender equality and enhancing health outcomes within this context.

Methods

Through a comprehensive qualitative study, we engaged community members, religious and traditional leaders, state-level stakeholders, and local organizations in Yobe State. Employing in-depth interviews and focus group discussions, we delved into the nuances of gender dynamics, women's economic empowerment, decision-making processes, and access to healthcare services. Thematic coding was used to extract vital insights from respondents' perspectives.

Findings

Our findings uncovered the pervasive impact of harmful norms, perpetuating a culture of silence around Gender-Based Violence (GBV). The fear of stigma, retaliation, and damage to family reputation discourages reporting. Traditional gender norms not only limit women's political participation and public engagement but also influence their roles in household decision-making. Men often wield greater authority in substantial financial matters, while women exercise more autonomy over daily needs, contributing to gender disparities. Harmful norms favouring men in inheritance laws exacerbate gender-based economic imbalances, deeply rooted in patriarchal values. Sociocultural and religious norms that endorse early marriages for girls often lead to adverse consequences for their well-being and reproductive health. Additionally, cultural beliefs opposing comprehensive sexual education hinder adolescents' access to vital sexual and reproductive health information, further impeding their agency and decision-making.

Conclusion

Within households, power imbalances persist, particularly in financial decisions, where male approval is necessary for women to access healthcare. To address these challenges, our study emphasizes the urgency of shifting harmful social norms. Initiatives promoting awareness, community-based approaches, and collaboration with non-governmental organizations (NGOs) are essential for a comprehensive response to GBV. Furthermore, this study highlights the pivotal role of men as allies in the journey towards challenging and reshaping these harmful norms, ultimately advancing gender equality, and promoting better health outcomes.

Keywords

Gender-Based Violence (GBV), Cultural Norms, Women's Empowerment, Health Access, Decision-Making.

Gender integration in the fight against HIV to reduce barriers to access to healthcare in the Fatick region and island areas

Fatim SyFatim Sy *Bokk Yakaar, Fatick, Senegal*

Description of the Problem:

In the context of caring for people infected with HIV, and given the socio-cultural realities, men also have a great deal of influence over women and their families to prevent them from accessing treatment. During activities to locate lost patients or resume treatment, most of the women express their husbands' refusal to travel frequently to the facilities, leading to arguments between couples and sometimes even divorce. The aim was to strengthen gender inclusion in social relations by preventing and reducing gender-based violence, particularly against women and women living with HIV in the Fatick region.

Activities Carried out and Results Achieved

The project ran from January to December 2023 and targeted people living with HIV. A number of community activities were carried out, including advocacy with religious and traditional leaders, discussions with local authorities, talks and focus groups with men and women, and visits to couples. These activities were organised even on islands with difficult geographical access. These activities were carried out with the support of relays trained in gender and HIV. A total of 45 focus groups, 12 dialogues, 45 chats, 20 pleas and 35 couple visits were carried out, reaching 1,722 people, of which 1,051 were women and 671 men. These activities enabled men and women to openly share their experiences and discuss discriminatory gender norms. The community dialogues established a shared understanding and consideration of the gender aspect in care, stimulating positive changes in behaviour and contributing to the creation of more respectful and equitable environments.

Lessons Learned and Future Steps

The distinctive feature of these community strategies was the involvement of religious leaders, the guardians of tradition and local authorities. This has led to a significant change in behaviour, taking account of the gender aspect and helping to reduce gender-based violence.

Keywords

HIV- Gender - VBG

An Assessment of Gender Intentionality in the Design and Implementation of the AM-ARCH Scheme in Benin-A qualitative study

Nihad J.E. Agoligan Tometin[1], Hashim Hounkpatin[1], Jean-Paul Dossou[1], Kefilath Bello[1], Aimé Yedenou[1], Lizah Nyawira[2], Moreen Mwenda[2], Joseph Githinji[2], Christelle Boyi[1] and Boniface Mbuthia[3]

(1)CERRHUD, Cotonou, Benin, (2)Amref Health Africa, Nairobi, Kenya, (3)ThinkWell Global, Nairobi, Nairobi, Kenya

Introduction

Benin, like many countries, has committed to achieving universal health coverage (UHC). To this end, it has launched the Health Insurance for Human Capital Strengthening (AM-ARCH) program. However, gender inequalities pose a significant challenge in implementing such initiatives. This study assesses the extent to which the AM-ARCH scheme integrated gender needs into its design, to understand the implementation experiences of the AM-ARCH scheme through a gender lens, and to identify opportunities for enhancing gender intentionality in AM-ARCH and future health financing reforms.

Methods

We employed a descriptive single case study design to examine gender intentionality in the design and implementation phases of the AM-ARCH scheme. Data collection took place from August to December 2024, including a document review and key informants' interviews. A stakeholder workshop was conducted at the end of the data collection stage to enhance the validity and reliability of the findings. This also helped to initiate the data analysis, guided by an analytical framework adapted from the World Health Organization's (WHO) Gender-Responsive Assessment Scale (GRAS) for program and policy evaluation, from the International Union for Conservation of Nature's (IUCN) gender-responsive criteria for assessing gender intentionality in Nationally Determined Contributions (NDCs) and from the Strategic Purchasing Africa Resource Centre (SPARC) Strategic Health Purchasing (SHP) progress tracking framework.

Findings

The study reveals that despite a supportive political environment for gender integration in Benin, the AM-ARCH program demonstrates gaps in its gender intentionality. During the program's design phase, no gender-specific needs assessment was conducted, with efforts limited to evaluating previous reforms. While women hold significant influence within governance structures, their representation is not equal. In terms of AM-ARCH implementation, efforts to address women's needs are evident in the benefit package's composition, which favors women. However, gender-responsive budgeting and expertise are insufficient. Beneficiary involvement prioritizes women's participation in targeting committees but remains limited overall. Targeted actions to reduce gender inequalities primarily focus on provider sensitization and training. Finally, although sex-disaggregated data is available for monitoring and evaluation, its utilization and the overall information system require strengthening to improve gender equity outcomes

Conclusion

Benin offers a favourable context to integrate gender into health financing reforms supported namely by existing legal frameworks, and political commitment. However, strengthening gender-responsive budgeting, governance, and broader stakeholder engagement is crucial to fully capitalize on this context and promote gender equity in healthcare access.

Keywords

Gender equity, gender integration, gender intentionality, AM-ARCH, health financing, Benin.

Community Engagement, Financing, and Accessibility in Health Systems Strengthening

11:30 AM–1:00 PM Wednesday, 03 March 2025

Expansion of HIV Self-Test Kits via Rwanda's community Pharmacies Enhances Availability, Yet Affordability Challenges Persist

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Background

The World Health Organization (WHO) has recommended HIV self-testing (HIVST) as an additional method to complement existing HIV testing services. Consequently, Rwanda approved the over-the-counter sale of oral fluid HIV self-testing in community pharmacies, enabling home testing and addressing accessibility issues like long waiting times at public health facilities. However, there have been no studies on whether HIVSTs are widely available and economically priced for Rwandans preferring community pharmacies. Thus, this study aimed to determine the availability and affordability of HIVSTs in Community Pharmacies in Rwanda.

Methods

This cross-sectional study involved 220 licensed community pharmacists who were randomly selected nationwide between February and May 2023. Using the Statistical Package for the Social Sciences (SPSS) version 25.0, Chi-square test was used to determine whether HIVST availability differed across regions, and ANOVA followed by a post-hoc test was used to determine whether HIVST prices differed significantly across regions. A standardized methodology developed by the WHO and Health Action International (HAI) was used to analyse whether HIVST is affordable for the Rwandan population.

Results

Of the 220 community pharmacies visited, 76% had HIVST, of which 53% were fingerstick HIVST. Though the capital city (Kigali) had a high availability of 45%, Chi-square test found no significant association between the availability of HIVST and pharmacy location ($x2=4.734$, $p=0.316$).

However, one-way ANOVA showed a significant variation in the price of oral fluid HIV self-test based on pharmacy location (F=11.349, p-value>0.0001), with post hoc test showing a significant variation between the capital city, and two provinces, Southern (p>0.001) and Western (p=0.004). The average cost of blood-based and oral fluid HIVST in Rwanda was unaffordable for the lowest-paid employees earning 1,000Rwf daily.

Conclusion

HIVST is available in community pharmacies but is not economically priced for Rwandans.
Interestingly, no association was found between HIVST availability and the location of pharmacies. However, there is a price variation between different locations. Reduced-profit mark-ups or partners providing HIVST through social marketing at a lower cost can make HIVST more affordable.

Keywords

community Pharmacies, HIV-Self tests, availability, affordability.

The adoption of health-seeking behaviour in Primary healthcare settings as a move towards Universal Health Coverage in relation to household socioeconomic Status: A case study from two district councils in Tanzania

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Background

Primary Health Care (PHC) practice in Tanzania was founded in 1983, primed on the delivery of Essential Health Intervention Packages (EHIP) and treatment-seeking behaviour (TSB) of beneficiaries: - individuals, families and communities who pursue providers at facilities in one of the three levels of the national healthcare referral hierarchy. Recent studies indicate that globally, over 80% of people's health needs across a lifetime can be solved within the framework of comprehensive Primary Health Care (PHC). Unlike the current coverage of less than 50% and high out-of-pocket expenditure. A model of comprehensive PHC health-seeking behaviour and practice (HSB&P) can affordably and effectively expedite transformation for the attainment of the goals of Universal Health Coverage (UHC) and a Resilient and Sustainable System for Health (RSSH) by 2030. However, limited evidence supports adapting comprehensive PHC health-seeking behaviours and practices.

Objective

To determine the association between PHC health-seeking behaviour and practices (HSB&P) and

socioeconomic status (SES) in selected district councils in Tanzania and how it can facilitate the move towards UHC.

Methods

This study was designed as a hospital-based cross-sectional study, employing a quantitative approach to collect and analyse data from two district councils (DCs) in Tanzania. The study population included out-patient clients who visited the health facilities on the interview date. A pre-tested questionnaire was used to collect data on different aspects. Data cleaning and all statistical analysis were performed using STATA version 17.0. We used Principal component analysis to create a socioeconomic status which was then grouped into 20% wealth quintiles from the poorest to the richest. We finally ran a logistic regression to assess the factors associated with health-seeking behaviours.

Results

73% of respondents were female and the majority were married (63%). Over 27% had at least one household member with chronic illness while over 21% visited the facility for check-up purposes. When health-seeking behaviour was analysed across SES, we found a significant difference among those with seeking behaviour compared to those without. Again, multivariate regression suggests that seeking behaviour increases with wealth and there is a strong association between SES and HSB across all the quintiles compared to the first poorest quintile. Gender (female), age, household size and insurance status are associated with health-seeking behaviour.

Conclusion

Findings suggest that health-seeking behaviour is strongly associated with socioeconomic status of households, and health insurance. Hence efforts to improve people's wellbeing and provide financial protection are crucial.

Strengthening health security at community level in Nigeria: Examining what multi-sectoral contributions exist

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Introduction

Multi-sectoral plans and actions at community level are one of strategies deployed in the Primary Health-care (PHC) system for improving health and well-being of the people. Also, a means of addressing social

Multi-sectoral actions are also means of implementing the Health in All Policies (HiAP) policy, which Nigeria has committed to implement. However, there is paucity of knowledge on level of multi-sectoral involvement to ensure health security and promotion at community level. This paper provides new insights on multisectoral activities for health, at community level and what can be done to strengthen them, towards achieving universal health coverage (UHC) in Nigeria.

Methods

A qualitative cross-sectional case study of three contextually different states (Akwa Ibom, Anambra and Kano) in Nigeria. Data were collected through review of relevant documents, 90 in-depth interviews with policymakers (health and non-health sectors), formal and informal health providers, community leaders and 12 focus group discussions with community members. Analysis was guided by the Expanded Health Systems framework (EHSF), which recognises combinations of collaborations between non-health sector and other societal partnerships (CSOs, NGOs, community groups and informal health providers), to contribute directly to community health or indirectly through one or more SDHs; and by the WHO PHC operational framework which proposes multisectoral action as one of three key approaches to UHC.

Results

Several community and household activities, supported by multisectoral actions on health, were identified. Most activities were primarily initiated by health sector stakeholders, whilst few others were by non-health sectors (Education, Environment, Agriculture, Security, Women Affairs, Social Welfare, Nutrition, Water, Sanitation and Hygiene-WASH), or communities. Activities contributed to health security of communities directly, or indirectly, through improving one or several SDHs. However, most collaborative engagements with non-health sectors were not backed by formal sectoral policies or guidelines, but, rather, were organically initiated. Support of community leaders and groups facilitated initiation and sustenance of multi-sectoral activities whilst inadequate formal policy backing and funding were major constraints.

Conclusion

Multi-sectoral collaboration (MSC) for health at the community level is important for harnessing resources outside the health sector that will be used to enhance health security of communities. Such MSC is potentially a powerful tool for strengthening primary health care, towards UHC and achieving SDG3 as shown from our findings. However, entrenched and sustained MSC should be undertaken through explicitly intentional policy reforms and their implementation, through identifying, promoting, and financing MSC actions.

Engaging Community Leaders to Improve Young People's Utilization of Primary Health Centres for Sexual and Reproductive Health Care in Nigeria: Lessons from Action Learning

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Background

Despite the implementation of numerous health programs designed to enhance Primary Health Care (PHC) services, including specialized training for health workers in youth-friendly service provision, young people continue to face significant challenges in utilizing PHCs for sexual and reproductive health (SRH) services. A critical limitation of these programs has been the lack of community involvement and this has impeded the ability to harness valuable local insights, resources, and support, which are essential for achieving sustainable and impactful outcomes.

Aim

This study aims to engage community leaders in collaboration with healthcare providers to address and overcome community-specific barriers affecting young people's utilization of sexual and reproductive health (SRH) services.

Methodology

Building on a previous intervention that trained health workers in Ebonyi State, Nigeria, to provide Youth-Friendly Health Services (YFHS), this study extended training to community leaders, including religious leaders, youth leaders, president generals, and women leaders, using a Gender Transformative Approach. The leaders were recruited from six Local Government Areas (LGAs) and were equipped to support health workers in overcoming cultural and structural challenges to healthcare access. An action-learning approach facilitated collaborative problem-solving among health workers and community leaders. The participants were interviewed at the end of the exercise.

Findings

Using the Actional Learning process, health workers identified several challenges that hinder the delivery and utilization of SRH services in PHCs. Firstly, the increased workload among healthcare providers led to poor treatment of young people seeking SRH services at PHCs. In response, the team decided to extend training to volunteer health workers who were not originally trained in youth-friendly SRH services, aiming to alleviate the burden on existing staff. Community leaders supported this initiative by committing to provide stipends for the volunteers, who, despite being qualified health workers, were not formally employed by the government. Second, health workers noted that many young people were unaware of available contraceptives or had misconceptions about their side effects. In response, community leaders facilitated the dissemination of accurate information through community meetings and mobilized youth for sensitization sessions led by health workers. Finally, cultural barriers to the utilization of SRH services were

also addressed, with community leaders committing to working alongside health workers to engage influential community members. Six months after, through document review and interviews with health workers, the findings revealed remarkable improvement in the utilization of PHCs for SRHs by young people. One major area of evidence is the frequent stockout of contraceptives and increased youth seeking SRH counselling. Moreover, parents were reportedly more involved in the sexual health of their children and often accompanied them to the health facility for counselling.

Conclusion

The findings suggest that the action learning process is an effective strategy for identifying challenges and mobilising community resources to address them. The increased utilization of PHCs also represents a better return on investment in PHC infrastructure and training, demonstrating the benefits of community engagement in healthcare delivery.

Achieving the END-TB Strategy: The role of civil society and community gate keepers in improving community TB case finding

Husna Baffa[1], Mustapha Musa Tukur[1], Mamman Bajehson[1], Abdulrazaq Dikko1, Michael Sheshi[2], Ogoamaka Chukwuogo[2], Musa Said[1], Ibrahim Aliyu[3] and Bethrand Odume[2]

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(3) State Tuberculosis and Leprosy Control Program, Kano, Nigeria

Background

Tuberculosis remains a significant global health challenge, particularly in underserved communities where access to healthcare services is limited. TB treatment notification remains at 59%, despite advancements in treatment, TB control efforts often face hurdles in achieving sustainability. Civil society plays a crucial role in TB advocacy, awareness-raising, community engagement, and support for those affected by the disease. The World Health Organization recognizes the importance of civil society engagement in the fight against tuberculosis and aligns its End TB Strategy with the Sustainable Development Goals (SDGs) to emphasize the role of communities and civil society in ending the TB epidemic by 2030. We present results highlighting the role of civil society and community gatekeepers in promoting community centred sustainable TB control efforts.

Method

KNCV Nigeria, under TB local organization network (LON) 1 and 2 project implements active case finding in kano Nigeria, through Community based organizations to carry out community screening across 44 Local governments.

This approach involves house to house screening targeting women and children as well as screening of men that congregate in informal gatherings around the communities. In 2021, passive advocacies were conducted through Local government TB supervisors to the community leaders. By 2022, in addition to active advocacies, these community leaders serving as the gatekeepers were further engaged to participate in the screening activities while sensitizing and improving awareness about TB in the communities acting as TB Champions going forward. Patients diagnosed in these communities are linked to treatment through a referral system monitored by the CBOs. Data from January 2021 to December 2023 was collated and analysed.

Results

Prior to actively engaging the community leaders, contribution from community activities to case finding in the state was 49%, however this rose to 62% in 2022 reaching a peak of 72% in 2023. Again, the TB yield in 2021, from the community activity was just 4% this increased to 6% in 2022 and a further increase to 8% in 2023 showing community acceptance.

Conclusion

Engaging community-based organizations and community leaders serving as TB champions has yielded notable results in improving community TB case finding, this approach helps to advance social inclusion and building sustainable health systems to prevent and end TB in our communities. We recommend active engagement and provision of support for community leaders as TB champions in promoting community-centred and sustainable TB control efforts.

Improving Access to Basic Health and Nutrition Services by Training and Supporting CHWs in Conflict Affected Northwest and Southwest Regions of Cameroon

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Cameroon Baptist Convention Health Services, Bamenda, Cameroon

Background

Cameroon's hospitals and clinics are critically short-staffed with just 0.1 doctor per 1,000 people, and 0.2 midwives and nurses. This shortage is more acute in the North West and South West regions who continue to suffer severe consequences of a protracted crisis that was exacerbated by COVID-19 as the two regions had case fatality rates higher than that of the whole country with many healthcare personnel losing their

lives. The conflict; characterized by destruction of the economy, massive pendular displacements within host communities or bush hard-to-reach areas, and loss of livelihood, has rendered many people vulnerable. Healthcare needs are exacerbated as IDPs live in crowded and unhygienic conditions in host communities or bush hard-to-reach areas in make shift settlements; a breeding ground for infectious diseases. Additionally, access to healthcare is compounded further by insecurity with the destruction of about 27% of health facilities, most healthcare personnel vacating their areas of work leaving the few surviving facilities mostly run by Community Health Workers (CHWs), who for the most part were unskilled, thus unable to adequately respond to health needs in an emergency humanitarian context. Many humanitarian organisations with Cameroon Baptist Convention Health Services (CBCHS) inclusive responded by; strengthening the capacity of CHWs and supporting them to respond to the needs of the affected populations and ensure a continuum of care in remote/hard-to-reach areas, enhance service delivery and address the healthcare workforce shortages.

Aims and Objectives

The aim of this study was to review the services provided by the CHWs nagged by the CBCHS and ascertain if they were addressing the healthcare needs.

Methods Used

The study was a retrospective study of the reports of the CHWs work from June 2019 - June 2024 and this was done from July 1st to 31th 2024.

Key Findings

CHWs closed the health work force gap by providing timely treatment for malaria, ARIs and diarrhea and vaccinating children against vaccine preventable diseases and vitamin A. They detected malnutrition early in children 6-59months, managed SAM cases promptly and prevented malnutrition through IYCF-E education of mothers/caregivers. Prevented WASH related diseases like COVID -19 and Cholera through hygiene promotion and sensitization on essential family practices.

Main Conclusions

Trained and supported CHWs can enhance healthcare delivery by improving access to basic healthcare and nutrition services thus contributing to solving the acute healthcare work force shortages which is usually exacerbated in conflict and fragile settings.

Financing, Social Protection and Community Healthcare in French-speaking Africa (organised session)

Alex Okolouma, University of Dschang, Dschang, Cameroon

Since the adoption of the Sustainable Development Goals (SDGs) in 2015, social protection has become both an end and a means of development (SDG 1.3). According to the International Labour Organisation (ILO), only 8.7% of Cameroonians received at least one social protection benefit in 2015. Although Decree No. 2014/2377/PM of 13 August 2014 provides for voluntary affiliation in Article 4 for all informal workers, a large majority of these informal workers (90.5% in 2010) remain uncovered by the institutionalised social protection system. So, in the absence of social security, how do workers in the informal sector protect themselves against social risks in Cameroon?

The main objective of this research is to analyse the social protection mechanisms developed by informal workers to cope with perceived social risks in Cameroon. Specifically, the aim is firstly to identify the social protection mechanisms of informal workers, secondly to determine the factors influencing the choice of social protection mechanisms, and thirdly to establish the interdependence existing in the adoption of social protection mechanisms. The results of this research show that of the 493 informal workers surveyed, the rates of adoption of preventive and protective measures for insurance, deferment (credit, savings), local solidarity, traditional solidarity and other means of protection are 32.86%, 55.98%, 58.82%, 70.39% and 90.87% respectively. The main results of our multivariate Probit model show that the adoption of these social protection mechanisms is complementary and guided by several common factors. These factors have a positive and highly significant effect. They include age, level of education, financial education, sector of activity, media, state of health, interest in informal help and family altruism. This research concludes that, in order to extend social protection in Cameroon, insurance mechanisms need to be backed up by existing social norms or social groupings, taking into account the individual preferences of informal workers.

Performance-based financing in the Democratic Republic of Congo: analysis of its contribution to reducing wealth-related inequalities in health outcomes

Louis Tshituka, Papa Yona Mane *Université Gaston Berger, Saint-Louis, Senegal*

To accelerate progress in reducing maternal and child mortality, a framework for accelerating the reduction of maternal and child mortality - MDGs 4 and 5 (CAO 4&5) based on the purchases has been

adopted and implemented since 2008 in the Democratic Republic of Congo (DRC) in accordance with the commitments and resolutions of the Millennium Summit. Evaluations of performance-based financing programmes in sub-Saharan Africa in general and in the DRC in particular have focused on quantifying the impact of these programmes on maternal and child health outcomes, provider satisfaction and quality of care. Very few studies have considered assessing the effectiveness of these programmes from a distributional point of view. This study examines the role of financial incentives, particularly performance-based financing, in access to healthcare from the perspective of social inequalities in coverage, using data from the impact evaluation of performance-based financing (PBF) in the health sector in the DRC. To this end, concentration indicators, linear regression and the double-difference approach will be used to quantify and examine the impact of the PBF programme on inequalities in maternal and child health outcomes and access. These methods will be complemented by the composite vaccine equity measurement approach developed by Vaccine Economics Research for Sustainability & Equity (VERSE) and derived from the literature on measuring socio-economic inequality combined with measures of direct inequity in access to healthcare. The results obtained will be of great importance in terms of policy anchored in the international community's commitment to end child mortality by 2030 according to the United Nations MDG through equitable access to healthcare.

What is the contribution of this article?

- We know nothing about the impact of the FBR programme on equality of health outcomes and access in the Democratic Republic of Congo.

How this article may influence practice?

- The results obtained will have significant implications for public health policies aimed at improving access to maternal and child health services, rooted in the international community's commitment to ending maternal and child mortality by 2030 according to the UN SDGs through equitable access to healthcare.

Oral - Dental Health Status of a Rural Community Through the Records of Curative Consultations at Primary Health Care Facilities

Mamadi Traore

UFR Odonto-Stomatologie /Université Félix Houphouët-Boigny/ Félix Houphouët-Boigny University Abidjan, ABIDJAN, Côte d'Ivoire

Context

Despite the recommendation of primary odonto-stomatological healthcare by the WHO, the availability of dental care services is not effective for populations living in rural areas such as the villages of Frambo and Edjambo, in the Tiapoum health district, Côte d'Ivoire. Regardless of the nature of the health problem,

including oral health, the populations primarily rely on Primary Health Care Facilities (PHCF). However, the proportion of consultations for reasons related to oral health conditions or diseases is not known. This is what justifies this study, the results of which should provide an idea of the needs for dental care based on the data available in the curative consultation records in the Tiapoum district.

Goals and Objectives of the Research

Evaluate the needs for oral-dental care based on data from curative consultations in the health centers of Frambo and Edjambo.

Methods Used

It was a cross-sectional study with a descriptive aim. The study population consists of all consultations in the ESPCs of the villages of Frambo and Edjambo during the year 2021. The data collection took place from November 17 to December 9, 2022. It concerned the information recorded in the consultation registers for the entire year of 2021. The data extracted from these records included: sociodemographic characteristics (sex, age, profession, social protection), the reason for consultation, and the diagnosis. For the statistical analysis, the counts and proportions were calculated.

Principal Findings

A total of 2834 consultations recorded in 57 registers were analysed. Missing data in the records due to lack of information exist. For almost as many women (50.9%) as men (49.1%), consultations were significant for the age groups [0-4], [5-9], and [25-49] years with 24%, 18.6%, and 20.7% respectively. 36.9% of the patients were students and 21.5% were workers. Only 9 people, or 0.3% of the consultants, had social protection (private insurance, Universal Health Coverage). For 11 reasons for dental consultations out of 2834, the diagnosis showed that oral-dental problems accounted for 15 consultation cases, or 0.6%, including 40% for oral candidiasis, 40% for dental eruptions, and 20% for cavities.

Key Findings

Under-reported information on oral problems shows the lack of primary dental health care in the ESPCs. Hence the need for staff training in oral information system and capacity building.

Increase Funding for Primary Health Care to Progress Towards UHC: Senegal Leverages its Health Expenditures to Mobilize and Allocate Resources Efficiently.

Farba Lamine Sall *Health Economist- Open Development, Dakar, Senegal*

Context

Senegal has committed to various international agreements, including the Astana Declaration of 2018, which encourages countries to strengthen primary health care (PHC). PHC, being the first level of contact for populations with the healthcare system, constitute one of the pillars of the country's health policy. In 2023, Senegal evaluated its National Health Financing Strategy for Universal Health Coverage 2017-2021 with the aim of developing a new strategy. This evaluation revealed that significant financial resources were mobilized and invested during the implementation period, thereby achieving notable results in almost all strategic areas of the strategy. In order to ensure budget allocations aligned with sector priorities, the Ministry of Health and Social Action (MHSA), through the Health Economics Unit (HEU), analyzed the National Health Accounts (NHA) from 2017 to 2021 to examine the sources and use of health expenditures.

Objective

Analyse healthcare expenditures and their utilization, as well as draw the attention of MHSA decision-makers to sector priorities and optimize budget allocation, while convincing the Ministry of Finance and Budget to increase the allocated budget to better address them.

Method

The data collection covered the period from 2017 to 2021 from stakeholders in health financing such as the MHSA and other ministerial departments, the universal health coverage agency, local authorities, mutual societies and private insurance, and Technical and Financial Partners (TFPs). After verification, the data were processed in pre-established matrices.

Findings

Households bear a large portion of current health expenditures, accounting for 52% of the total, which exposes them to the risk of catastrophic spending and impoverishment. The WHO recommends no more than 20%. In comparison, the State only covers 22% of these expenses, the TFP 19%, and businesses and NGOs 7%. This trend is particularly pronounced in primary healthcare (PHC), where households cover an average of 55.9% of the expenses, while development partners and the public administration contribute 23.9% and 15.2%, respectively. NGOs and businesses contribute only 5% of the expenditures on primary health care. Expenditures in SSP are mainly dedicated to the purchase of pharmaceuticals (43.5%), with the remainder allocated to other operational expenses such as salaries and the purchase of consumables (56.5%). Moreover, expenditures related to non-communicable diseases (NCDs) account for more than a third of current health expenditures (37.6%), nearly double that allocated to infectious and parasitic diseases (20.5%). However, less than one percent of the expenditure on NCDs is allocated to prevention, with almost all of it dedicated to medications (54.6%) and curative care (42.2%). Households also bear the heaviest burden for NCDs, covering 75.4% of the expenses, mainly through direct payments, while the contribution from the public administration (17.7%), the private sector (6.7%), and the TFP (less than 1%) remains relatively low.

Conclusion

Despite the evolution of public health expenditures, Senegal remains far from the 15% recommended by the Abuja Declaration, and direct household payments remain high, well above the 20% recommended by the WHO. These direct payments impoverish households and delay their access to care. To remedy this situation, Senegal must increase its public health funding, currently at 9.4%, well below the 15% recommended by the Abuja Declaration, and strengthen social protection systems for better coverage. The MHSA should also align its budget allocations with public health priorities, particularly primary healthcare, which is essential for UHC. With 45% of deaths in 2022 due to non-communicable diseases, it is urgent to mobilize resources for their prevention and alleviate the financial burden on households.

The impact of financial inclusion on universal health coverage in Sub-Saharan Africa: the role of healthcare quality

Relwendé Nacanabo[1], Relwendé Sawadogo[2]

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Context

In 2015, the United Nations adopted seventeen Sustainable Development Goals, including universal health coverage and financial inclusion. The role of the quality of healthcare is little highlighted in empirical studies that have examined the link between financial inclusion and health outcomes in Sub-Saharan Africa. The objective of this paper is to analyse the effects of financial inclusion on universal health coverage in Sub-Saharan Africa, highlighting the role of the quality of healthcare.

Methods

This paper applies a blended model to a sample of 44 countries in sub-Saharan Africa to analyse the effects of financial inclusion on universal health coverage between 2000 and 2020. We assume that the effect of financial inclusion on universal health coverage differs between groups of countries with similar but unobserved characteristics.

Results

We find that the effects of financial inclusion on universal health coverage vary between two distinct categories of countries.Our results support that in the first category of countries where financial inclusion improves the level of universal health coverage, the posterior probability of belonging is 81.5% compared to 18.5% for the second category of countries where financial inclusion has a negative effect on universal

health coverage. Furthermore, we show that countries with high-quality healthcare are more likely to belong to the category where financial inclusion improves universal health coverage.

Conclusion

These results highlight the need for sub-Saharan African countries aiming to achieve universal health coverage to develop better health systems in order to reap the benefits of financial inclusion.

Keywords

Universal health coverage, Financial inclusion, Quality of healthcare mixed model, Sub-Saharan Africa.

Policy Learning on Health Financing For UHC: Could We Do Better? (Organized Session)

2:00 – 3:30 PM AD12

Bruno Meessen *World Health Organisation (WHO)*

Overview of Session

Over the last twenty years, the international aid community has implemented a variety of strategies to support LMICs in reforming their health financing system: individual peer-to-peer learning practiced by Harmonization for Health in Africa Communities of Practice, country peer-to-peer learning of the JLN network, coordination support provided by P4H country-based focal points, the mentoring strategy developed by SPARC, or the series of participatory country workshops and learning program implemented by the GFF (in partnership with the World Bank and WHO) on strategic purchasing for PHC, for example. Four experiences have been documented:

Leveraging policy learning to reduce health financing fragmentation: opportunities and challenges. We will share findings from his qualitative research on how policy learning contributes to progress towards universal health coverage (UHC) in Burkina Faso, with a particular focus on Strategic health purchasing (SHP) as a potential avenue for reducing fragmentation. The key finding of this research is that following initial setbacks due to problems with learning processes, Burkina Faso made notable advancement upon successful implementation of various learning modes.

Assisting countries on their Strategic Health Purchasing agenda – lessons from SPARC. The model of SPARC values local knowledge co-production using local research partners and policymakers, prioritizes coaching and mentoring in provision of technical support, values strategic

communication of evidence, networking and partnership. This presentation aims to draw learnings from this model. Using case study design, the presentation will start by introducing the theory of change of SPARC, with a description of the country engagement of SPARC in Benin and in Burkina Faso and reflected on to which extent the theory of change was implemented and effective or not.

Lessons from a country led learning programme on strategic purchasing for PHC. We will present a novel approach led by the GFF and the WHO focused on (a) identifying, in collaboration with national policy makers, country specific struggles with progressing towards greater strategic purchasing, and (b) identifying a concrete pathway, rooted in international level evidence, with a specific focus on peer countries.

The Health Financing Progress Matrix (HFPM) as a policy tool for national dialogue. We will present how the WHO HFPM evaluation can contribute to structuring policy learning and national dialogue on health financing. He will illustrate that empirically with lessons generated by implementation in African countries, with engagement of experts who were involved in country assessment and are present in the audience.

Factors Influencing Equitable Access to COVID-19 Vaccines: Synthesis of Scoping Review Studies and Qualitative Analysis in Selected African Countries (organized session)

Daniel Malik Achala, AfHEA, Accra, Ghana, Senait Alemayehu Beshah, AfHEA, Addis Abeba, Ethiopia, Grace Njeri Muriithi, AfHEA, Nairobi, Kenya, John E. Ataguba, AfHEA, Fadima Yaya Bocoum, Institute of Research in Health Sciences Ouagadougou, Burkina Faso, Chijioke O. Nwosu, University of the Free State, Bloemfontein, South Africa.

Description

Over the years, the development and distribution of vaccines has contributed immensely to global health outcomes. The smallpox vaccine, for instance, was the first vaccine to be used extensively amongst the human race and the first human infectious disease to be fully eradicated by vaccination, as achieved in 1979. The development and expansion of vaccination programmes specifically targeting infectious diseases in children has also improved tremendously since the initiation of the World Health Organization's (WHO) Expanded Programme of Immunization in 1974 and, of the Global Alliance for Vaccination and

Immunization in 2000. Despite these successes in vaccination programmes across the globe, there are stark inequities in the production of, and access to these vaccines across countries and even within countries, with persistent global debates on how to ensure equitable access to vaccines. Particularly, global debates are emerging on improving African's capacity for research and development of vaccines to ensure adequate availability and access. The COVID-19 pandemic triggered the re-emergence of such debates on scaling up immunisation in Africa by improving its capacity for research and development, and prioritizing domestic production of vaccines and medications. In view of this, some initiatives are currently being implemented in furtherance of the goal of equitable access to vaccines in Africa, some of which include the Saving Lives and Livelihoods initiative, Africa Medical Supplies Platform (AMSP) and African Vaccine Manufacturing Accelerator (AVMA). In 2022, the African Health Economics and Policy Association (AfHEA), the Africa Centres for Disease Prevention and Control (Africa CDC) and the United Nations Economic Commission for Africa (UNECA) commenced a project aimed generating evidence to support the evidence-based policies on equitable access to vaccines in Africa.

The project dubbed "Equitable access to the COVID-19 vaccines in Africa" (ECOVA) supported a number of country level studies on the key barriers, hesitancy issues and patterns in uptake of the COVID-19 vaccines and also examined the distributional mechanisms and challenges, recommending potential solutions to ensure equitable access to vaccines in Africa. An organized session is proposed to share findings of the studies from five African countries namely; Botswana, Ethiopia, Nigeria, Morocco and Zimbabwe. These studies reveal key insights that countries can leverage on to implement equitable vaccinations programmes especially for future pandemics or epidemics.

Equitable access to covid-19 vaccines in Botswana: a scoping review and qualitative inquiry

John Thato Tlhakanelo *ECOVA,AfHEA, Gaborone, Botswana*

Background

COVID-19 morbidity and mortality trends in Botswana, and Africa, were devastating. The pandemic highlighted pre-existing health system weaknesses, revealing deep-rooted issues in health infrastructure, access to care and resource allocation that imped systems' abilities to meet population health needs.

Objectivities

This study aimed to provide an analysis of Botswana's experience in the provision of COVID-19 vaccines -highlighting access patterns, hesitancy, uptake and exploring related barriers and mitigating factors. Vaccine distribution, delivery mechanisms and equity in vaccine provision were further explored. The goal was to summarise evidence to inform vaccine roll-out programs and policies for future new vaccines.

Methods

A scoping review was conducted, using a predetermined search strategy, between the 4th and 5th February 2024 and updated on 7th June 2024, to search Medline, CINAHL, Web of Science, PubMed, Scopus, and Google Scholar databases for eligible published articles. Nine (n = 9) studies, comprising of five (n = 5) reports from portals, websites, and government departments were included. A narrative synthesis approach was used to collect, synthesize, and map the literature. Furthermore, in-depth interviews using a semi-structured interview guide with a purposive sample of 16 key informants, including public health officials, non-state actors, policy makers, regulatory bodies and other stakeholders were conducted and analyzed using thematic analysis.

Key Findings

As of 31 December 2021, 80.6% of the targeted population received at least one dose of a vaccine, while 71.9% were fully vaccinated. Vaccine acceptance was considered generally high (73.4% amongst adults), positively associated with males, those with comorbidities, non-restrictive religious beliefs and those aged 55-64 years who thought the vaccine was safe. Vaccine access relied on existing Expanded Program on Immunization (EPI) structures, and therefore was subjected to existing EPI cold chain logistical challenges, human resources shortages and inadequate community engagement. However, collaboration with other government entities and the private sector improved vaccine access, especially for hard to reach populations. Traditional delivery mechanisms such as static health facilities, outreach and mobile stops often used for provision of routine vaccine were augmented by different stakeholders in the private sector, civil society organizations and non-governmental organizations

Conclusions

Integration of new vaccines into existing programs and traditional distribution and delivery mechanisms can potentially improve access and uptake, provided prevailing challenges are addressed. Strong strategic multisectoral partnerships can improve equitable access to vaccine.

Factors Influencing COVID-19 Vaccine Hesitancy in Ethiopia: A Scoping Review and Qualitative Exploration for Equitable Access

Senait Alemayehu Beshah *AFHEA, Addis Abeba, Ethiopia*

Background

The COVID-19 pandemic, caused by the highly contagious SARS-CoV-2 virus, has posed an unprecedented global health crisis, resulting in substantial morbidity and mortality. While effective vaccines have been developed to mitigate the disease's impact, widespread vaccine hesitancy, inequitable

distribution, and economic disparities have hindered global vaccination efforts. Africa, including Ethiopia, has been particularly affected by these challenges, underscoring the need for comprehensive strategies to increase vaccine uptake and protect vulnerable populations.

Objectives

This study aims to understand and address challenges related to COVID-19 vaccine hesitancy and vaccine distribution in Ethiopia to improve equitable access and coverage especially among vulnerable populations.

Method

Study rigorously adhered to the methodological standards outlined in the Joanne Briggs Institute reviewers' manual and employed the PRISMA-ScR checklist to ensure transparency and methodological rigor. To identify relevant literature, we developed comprehensive search strategies using controlled vocabulary and keywords for key databases (HINARI, PubMed, Cochrane, AJOL, and Science Direct) and gray literature sources, for original research conducted in Ethiopia between January 2020 and December 2023. Additionally, a qualitative study involving in-depth interviews with 21 key informants was conducted to explore COVID-19 vaccine distribution and delivery mechanisms and public private collaboration. A descriptive thematic analysis was then employed to identify and categorize the various findings within the included studies. The results are presented in a narrative format, summarizing the key themes and providing a clear and comprehensive overview of the current evidence base.

Key Findings

A review of 34 Ethiopian studies revealed significant COVID-19 vaccine hesitancy, exceeding 50% in over 40% of the studies. The lowest hesitancy was found in adults from Addis Ababa (19.1%), while the highest rates were seen among healthcare workers in Oromia (69.7%) and pregnant women in Southwest Ethiopia (68.8%). Factors like female gender, primary education level, living in rural areas, younger age, lower knowledge about the vaccine, reduced trust in authorities, and a misperception of the virus's risk all contribute to vaccine hesitancy in Ethiopia.

Conclusion

COVID-19 vaccine hesitancy in Ethiopia is influenced by a complex interplay of socio-demographic, individual, and vaccine-specific factors. Younger individuals, women, and those with lower education levels residing in rural areas and practicing Islam are disproportionately affected. Key individual determinants include knowledge gaps, perceived risk, and negative attitudes towards the vaccine. Fear of adverse events and doubts about vaccine efficacy further contribute to hesitancy.

COVID-19 vaccine acceptance and uptake in Nigeria: Approaches to reduce Hesitancy and promote advocacy for timely and equitable coverage of the vaccine.

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Background

The World Health Organization declared the COVID 19 an emergency of international concern in January 2020. The WHO reported that over 651 million cases and 6.6 million deaths were attributed to COVID-19 globally. The Nigeria Centre for Disease Control in 2022 revealed that 266,057 cases with 3,155 deaths were reported. The developments of vaccines were critical towards ending the pandemic. Nigeria did not meet the December 2021 vaccination target of 40%. There is compelling need to identify the key contextual issues and proffer recommendations to promote equitable access and improve vaccine uptake thus this study.

Objectives

This study aims to understand the COVID-19 vaccine access and uptake by exploring the factors impacting COVID-19 vaccine hesitancy among adults in Nigeria.

Methods

The study used a cross-sectional qualitative approach incorporating a scoping review and in-depth interviews. This scoping review was conducted adopting Arksey and O'Malley's framework. The qualitative in-depth interviews were conducted using key informant interviews (KIIs) and focus group discussions (FGDs).

Findings

From the review, 90% of the studies reviewed showed low acceptance and low uptake of COVID-19 vaccine in Nigeria. An average range of 9% to 24% rate of uptake were highest rates recorded from hospital-based surveys and the lowest rates recorded among adult respondents in rural locations of the country. The enablers of hesitancy and barriers against vaccine uptake were categorized into health system, community and individual factors. The interviews revealed that logistics system of the country including human, financial and infrastructural capacities need to be strengthened. The coordination systems for stakeholders need to be strengthened to ensure streamlined involvement and avoid duplication of efforts. The interviews reveal that measures to ensure equitable access to include constant context specific

information and sensitization using the community gate keepers including the religious leaders, traditional leaders and social media to spread the information.

Conclusion

The study noted low vaccination acceptance/uptake and a high COVID-19 vaccine hesitance rate in Nigeria. The factors identified in the studies for uptake and hesitancy were multifaceted and varied across different demographic groups, regions, and communities across the country. In order to redress vaccine hesitancy and opposition to COVID-19 vaccines in Nigeria, there is obvious need for relevant stakeholders to appreciate the contextual factors that underpin the reluctance to be vaccinated, and develop as well as implement evidence-based strategies that target different population groups.

Hesitation to get vaccinated against Covid-19 in Morocco: Scope study

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Introduction

The Covid-19 crisis cost many human lives and had catastrophic repercussions for nations. Sustainable public health measures were taken to ensure access to affordable, effective and quality-assured vaccines. Unfortunately, many countries have not had optimal access to vaccines for economic, logistical and even political reasons. Hence, reluctance to be vaccinated against Covid-19 has been observed in several countries. The aim of this study is to assess reluctance to vaccinate against Covid-19 based on the Moroccan experience. It is also expected to identify measures capable of reducing barriers to access to vaccines for the population as a whole.

Methods

This scoping review was conducted based on research in the main scientific search engines on studies published between January 1, 2020, and May 30, 2024, examining aspects related to the accessibility of anti-Covid-19 vaccination as well as the acceptance or hesitation regarding the COVID-19 vaccine in Morocco. A qualitative study was also conducted using a questionnaire administered to the main officials responsible for the vaccination process in Morocco.

Findings

Morocco is one of the 5 African countries that reached the WHO's goal of 40% COVID-19 vaccination coverage by the end of 2021. At the time of the study, the COVID-19 vaccination coverage in Morocco was

83.6%. The results showed that the phenomenon of hesitancy was not significant in the Moroccan population for several reasons (free of charge, mandatory for several categories and in various situations (travel, visiting administrations and public services...), communication, trust in the management of the pandemic thanks to the long experience gained by the national vaccination program). It has also been demonstrated that the parameters influencing the acceptance or hesitation towards vaccination are primarily age, gender, marital status, and health status.

Key Findings

The management of the Covid-19 crisis has been generally exemplary in Morocco. The percentage of vaccinated people is one of the highest on the African continent, and the phenomenon of vaccine hesitancy has been largely controlled thanks to several measures taken by the government before and during the Covid-19 crisis. The management of the anti-Covid-19 vaccination was entrusted almost exclusively to the government for better control of this issue. Several measures should be maintained to benefit from the success of the anti-Covid-19 vaccination experience.

Assessing Equity in COVID-19 Vaccine Distribution in Zimbabwe: A scoping review and qualitative assessment

Nyasha Masuka *AfHEA, Harare, Zimbabwe*

Background

The COVID-19 pandemic has highlighted disparities in patterns of vaccine access and hesitancy, particularly in Africa and more specifically in Zimbabwe. To address this, there is a growing emphasis on enhancing research and development (R&D) capabilities for vaccines in Africa. We aimed to identify the determinants of COVID-19 vaccine hesitancy and uptake in Zimbabwe and to understand equity in vaccine distribution. Furthermore, we explored strategies and recommendations to enhance equitable access to vaccines as well as explore public private partnerships for vaccine research, development and distribution in Zimbabwe.

Methods and Materials

The study employed a scoping literature review methodology developed by Arksey and O'Malley, expanded on by Levac et al., and Colquhoun et al., and further outlined by Peters, Godfrey et al was used. We used the Population, Context and Concept (PCC) framework to develop a search strategy. We searched for articles published in English and indexed in Medline, PubMed, and AJOL. We also searched the references and tracked the citations of key papers. Grey literature was also searched. Two reviewers conducted the review, and the results were compared. Qualitative in-depth interviews were conducted with twenty Key Informants with specialized knowledge and expertise in the expanded program on immunization and the COVID-19 vaccination program in Zimbabwe.

Key Findings and Lessons

The study identified 16 studies which included articles focused on primary research, a newspaper article, a letter to the editor, literature review papers and a mixed methods paper that collected survey data as well as a literature review. There is a strong suggestion that vaccine hesitancy is a significant challenge in Zimbabwe. Factors contributing to hesitancy include religious beliefs, negative perceptions of vaccines, and reliance on alternative treatments, especially within religious communities. Increased vaccine acceptance is associated with having chronic diseases, being male, and working in healthcare, and confidence in vaccine effectiveness and safety. The government should implement targeted communication strategies to enhance public trust, collaborate with community and religious leaders, ensure transparent reporting of vaccine safety, and improve equitable access to COVID-19 vaccines. Key Informants expressed a strong desire for domestic vaccine development, recognizing its potential public health benefits and self-sufficiency. They suggested forging partnerships with other African nations to collectively establish a regional or continental hub of excellence, sharing costs and reaping mutual benefits.

Addressing Cancer Care Inequalities and Innovations in Africa

Between-and within-socioeconomic groups inequality in the uptake of breast and cervical cancer screening among women in Kenya: A panel data analysis

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Background

Breast and cervical cancer are the two most prevalent cancers and the leading causes of cancer deaths in both sexes in Kenya. As is the trend in many Low-and-Middle Income countries (LMICs), the incidence and mortality rates of breast and cervical cancer in Kenya are on the rise. This can be alleviated by screening to promote early diagnosis. In LMICs like Kenya, however, breast and cervical cancer screening opportunities are limited compared to High-Income Countries (HICs). Previous studies have largely examined the determinants of breast and cervical cancer screening with little efforts to assess related inequalities and decomposing the inequalities across household characteristics in Kenya. This is critical as the Kenyan government scales up screening initiatives.

Objectives

The study aims to examine trends in between-group and within-group socioeconomic related inequalities in the uptake of breast and cancer screening among eligible women.

Methods

This study used Demographic Health Survey (DHS) data sets of 2014 and 2022. Clinical breast examination (CBE) in women aged 18 and older was the indicator for breast cancer screening. Cervical cancer was indicated by "having gone for a cervical examination to check for cervical cancer" by women aged 25 and older. Normalized Errygyers concentration indices were computed to demonstrated whether cancer screening was pro-rich or pro-poor. The study then used the Theil index and decomposed the index by population subgroups (place of residence and socioeconomic status-SES) to understand within-between groups inequality.

Results

Over the two periods, the rates of cervical (15.03% versus 15.43%) and breast cancer (23% versus 24%)

screening remained relatively unchanged. The Erreygers normalised concentration indices for breast (2014; 0.15, p=0.00 & 2022; 0.13, p=0.00) and cervical screening (2014; 018, p=0.000 & 2022;0.16, p=0.000) for both periods were both positive indicating women of low SES are less likely to screen for both cancers. The Theil indices show that the socioeconomic inequalities in breast and cervical cancer screening for both periods were more dominant among women living in rural areas and those of low SES while the overall inequalities in screening of both cancers widened between 2014 and 2022. For cervical cancer screening, 96.4% to 97.1% of socioeconomic inequalities were explained by within-group household variability while 2.9% to 3.6% of the inequalities were explained the socioeconomic group which the women belong to. A similar trend was observed with breast cancer screening.

Conclusion

Unequal distribution of household wealth as well as the rural-urban split enable the inequalities in breast and cervical cancer screening in Kenya. Thus, policies that bridge the rural-urban gap and those that address the within-group inequalities are vital.

Keywords

Breast cancer screening, Cervical cancer screening, Inequalities, Socioeconomic status.

An Analysis of patient costs at the Rapid Access Diagnostic LymphAdenopathy Clinic (RADLAC) at Groote Schuur Hospital, South Africa

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(4) Health Economics Unit, University of Cape Town, Cape Town, South Africa,
(5) University of Cape Town

Background

Globally, cancer is one of the leading causes of mortality and morbidity, with the greatest burden in low-to-middle-income countries where approximately 75% of deaths occur. Cancer is the non-communicable disease most likely to lead to catastrophic health expenditure. This can occur in any phase of the continuum of cancer care model. However, there exists a gap in the literature on expenditures incurred prior to receiving a diagnosis. Delays in getting a diagnosis led to adverse health outcomes along the care

continuum. Thus, the Rapid Access Diagnostic Lymph-Adenopathy Clinic (RADLAC) was established to enable rapid diagnosis of patients with lymphadenopathy. The opening of this clinic provided a chance to understand the types, magnitude, and drivers of cancer-related costs for patients seeking a diagnosis as well as their households.

Aims and Objectives

The aim of the study was to analyse patient costs associated with seeking a diagnosis at the RADLAC at Groote Schuur Hospital, a tertiary referral academic hospital in South Africa. The objectives of the study were to calculate the direct, indirect, and intangible costs related to diagnosis for patients attending the RADLAC. Coping strategies used by patients to cover costs were also investigated.

Methods

The study was a cross-sectional patient cost analysis. Data was collected from consenting newly referred and previously referred adult patients. A structured questionnaire collecting direct (medical and non-medical), and indirect costs was used to collect data via interview. Intangible costs were measured using the Brief Pain Inventory. Data was collected in RedCap and analysed using Stata15. Patient costs were calculated up to the point of diagnosis.

Key Findings

Thirty years after the end of apartheid, racial income inequalities persist. Black Africans are more likely than other racial groups to face catastrophic health expenditures and impoverishment. Low-income households are more likely to get loans from informal lenders who charge interest rates as high as 50%. Regarding interferences with daily function, most patients reported that pain predominantly affected their sleep. Most patients had informal caregivers who lost a significant proportion of daily wages each time they had to escort the patient to seek healthcare services.

Main Conclusion(s)

Direct and indirect costs of seeking a diagnosis influence health-seeking behaviours and influence health outcomes. In pursuit of Sustainable Development Goal 3, specifically, Universal Health Coverage, social and financial risk protection is a necessity.

Navigating barriers and seeking equity: a governance and policy approach to improve cancer care access informed by patient experiences in Nigeria.

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Background

Cancer burden and mortality continues to rise globally, with majority occurring in developing countries like Nigeria. In 2020, 125,000 new cancer cases were reported in Nigeria, a country with over 80% mortality rate from cancer. Constrained by limited clinical oncologists and challenged by late-stage disease presentation, the Nigerian health system faces significant hurdles in cancer control. This is further exacerbated by severe brain drain in the health sector, catastrophic and impoverishing health expenditures, and poor access to cancer care. The burden of these barriers and inequities are borne by patients, hence, the need to understand how they navigate these barriers to inform governance and policy approaches in improving access to cancer care.

Methods

Employing a qualitative constructivist grounded theory approach, the study focuses on breast and prostate cancer patients, their primary caregivers, and nursing administrative staff. Semi-structured, in-depth interviews were used for the purpose of understanding the navigation and commencement of care within the cancer control continuum, thereby identifying service gaps. Thematic content analysis was applied to the data. A system mapping of patient navigation of the cancer control continuum was compared with the provisions of the Nigeria cancer control plan.

Results

Findings showed that cancer care navigation is a complex journey for patients from diagnosis to treatment, and is characterized by delays, financial challenges, logistical difficulties, delayed diagnosis due to limited awareness and accessibility of screening programs, and extended waiting times for specialist consultations. Findings also show critical systemic issues such as inadequate funding, poor healthcare infrastructure, and lack of trained staff in oncology units. Systems mapping revealed disparities in service delivery and coordination, and a deviation of patient experiences from the Nigerian cancer control plan.

Discussion/Conclusions

Findings suggest the need for sustainable governance and policy approaches to addressing barriers and enhancing patient experiences and equity in access to cancer care. Certain approaches to consider, some of which were provided by patients, include: bringing screening, diagnostic and care services closer to communities using multidisciplinary care models that involve other healthcare professionals like

community pharmacists in different phases of the continuum to provide holistic care; developing and streamlining referral pathways for these care models; and policy-level interventions aimed at resource allocation, infrastructure development, and capacity building in oncology care. These could help address inequities in access and support governance, policy, and institutional frameworks for just and sustainable health systems for cancer care.

Navigating Rwanda's cancer health benefits package design processes: a multi-criteria assessment

Stella Matutina Umuhoza *University of Rwanda, Kigali City, Rwanda*

Rwanda's robust community-based health insurance (CBHI) scheme covers over 90% of its population. The government has been working on designing an evidence-based health benefit package (HBP) to support universal health coverage. In 2021, a Ministerial Instruction was published outlining priority-setting methods, including nine multi-decision criteria. The process began by establishing consensus on HBP objectives and Health Technology Assessment (HTA) topic selection. Forty-nine cancers were prioritized due to the growing demand to include cancer interventions in the HBP, their high costs, and the increasing disease burden. An assessment framework was developed to guide quantitative or qualitative measurements of various criteria considering time, data, and capacity constraints. Consultative discussions were facilitated with representatives from the Ministries of Health and Finance to ensure a comprehensive approach. The assessment criteria were divided into three levels: quantitative methods were undertaken to assess the cost, cost-effectiveness, burden of disease, financial risk protection, and budget impact. The assessment also used a combination of locally available costing data, international estimates of the burden of disease, and the Tufts Registry of cost-effectiveness studies. Qualitative survey techniques were used to measure feasibility whereas structured expert judgment was utilized to assess effectiveness, life-threatening, equity, and priority to vulnerable groups.

Evidence for each cancer was consolidated on an evidence sheet. Cancer HBPs' recommendations draw on cost-effectiveness and other criteria and differentiated recommendations by disease stages. Recommended cancer services for resource-constrained settings prioritize all the basic treatment modalities for all cancers including rare cancers to ensure equity of access. Core treatments were included in the recommended HBPs for most prevalent cancers that can be managed with curative intent when detected early. Furthermore, the HBP recommended a review of the co-payment structure for cancer services and the integration of palliative care into standard oncology practice to enhance patient outcomes.

This study is the first of its kind to assess many cancers at once for HBP design based on evidence from economic evaluations and contextualized criteria. Designing explicit cancer packages requires data-intensive and pragmatic approaches that consider existing data, expertise constraints, and the pressure for rapid decision-making. This is particularly important for cost-effectiveness analyses, which are

community pharmacists in different phases of the continuum to provide holistic care; developing and streamlining referral pathways for these care models; and policy-level interventions aimed at resource allocation, infrastructure development, and capacity building in oncology care. These could help address inequities in access and support governance, policy, and institutional frameworks for just and sustainable health systems for cancer care.

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limited in low- and middle-income countries. It emphasizes the necessity of structuring the appraisal processes to ensure that the quality of each type of evidence is understood and institutionalizing evidence-informed priority setting for efficient resource allocation within the CBH.

Enhancing Self-Management in Prostate Cancer: Efficacy of a Digital Coaching Program in Nigeria

Blessing Raji[1], Dennis Owusu[1], Emmanuel Onogwu[1], Chinelo Okpara[1], Faith Kuranga[1], Titilayo Oriolowo[1], Seyi Malumi[2], Adaora Odukwe[1], Kolawole Akinjiola[1], Samuel Agbaji[1], Hanna Minaye[1], Nneka Mobisson[2] and Imo Etuk[2]

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Patients with advanced cancer face intense, multifaceted symptoms and challenges and are often required to actively manage their health. While self-management support programs have proven beneficial in chronic diseases, their efficacy for cancer patients remains underexplored. Our oncology self-management program is designed to enhance self-management behaviours and improve the health-related quality of life for individuals living with prostate cancer in Nigeria

To evaluate the effectiveness of self-care coaching support in driving behavioural change, a retrospective cohort study was conducted from January 2022 to December 2022 on 81 men diagnosed with metastatic prostate cancer. This study utilized the CompleteHealth™ platform, an omnichannel digital system designed to facilitate self-management and provide patient navigation support.

Participants monitored their health data and engaged with a specialized multidisciplinary coaching team. This team delivered tailored interventions comprising behavioural health education, virtual exercise classes, nutritional guidance, and emotional support. The primary outcomes measured included behavioural changes toward self-care practices, assessed through frequency of self-reported data by participants. Additionally, changes in prostate-specific antigen (PSA) levels from baseline were analysed as a secondary outcome. This method of evaluation aims to provide a comprehensive understanding of the program's impact on both behavioural health practices and clinical outcomes among participants.

Throughout the year, participants actively engaged in our program, inputting their health data an average of three times per month over the year. This consistent level of engagement reflects the behavioural change of members towards active self-health management. In terms of exercise duration, a proxy for behaviour change, there was a substantial increase in exercise duration, with average times rising from 23.9 to 86.17 minutes per month. The health outcomes measured included significant reductions in both systolic and diastolic blood pressures, decreasing by an average of 8.19 mmHg and 4.05 mmHg respectively. These improvements in exercise habits are particularly important as they enhance cardiovascular health and

also improve the quality of life of the people living with prostate cancer. Moreover, the average PSA levels decreased by 9.00ng/ml, indicating effective management of prostate cancer progression.

These findings suggest that our integrated support contributed to better health management and cancer care. The consistent input of health data through our platform highlights the positive outcomes of sustained, proactive self-management and engagement with tailored health interventions. Future research will focus on longitudinal studies to validate these findings and explore the long-term benefits of such multidisciplinary approaches in cancer treatment regimens.

Improving Neonatal and Child Health: Management, Inequalities, and Policy Implementation in Africa

2:00 PM–3:30 PM Wednesday, 03 March 2025

Strengthening District Referral System: A new challenge to reduce maternal and perinatal mortality in Rwanda

Turate Innocent *Enabel Health Program, Rwanda, Kigali, Rwanda*

Introduction

In Rwanda, three quarters of maternal deaths might be averted if a fully provision of appropriate health services is promptly initiated. During the last two decades, the MoH focused on three pillars of MCH program, namely SBA and facility delivery, EmONC and FP, which helped the country to make a breakthrough in maternal mortality. However, there was no significant reduction of maternal mortality for the last 5 years, raising questions about the quality and access to quality of care. Strengthening the maternal referral mechanism comes as a missing piece of puzzle.

Method

We evaluated the management of inter-institutional transferred patients in terms of quality and adequate care service provided, with the intent to identify local systems-based gaps associated to poor quality of care during referral process and propose recommendations that may be addressed for an appropriate and a seamless referral of pregnant women and newborn in 7 districts.

Methods

The assessment conducted involved 41 health centres, 37 ambulances and 16 hospitals. Concurrent mixed method data collection was employed to facilitate a more comprehensive understanding of referral system gaps and to provide potential recommendations.

Results

Among 401 referral cases, 72% were accompanied by nurses 30% by midwives; 80% consented to be referred. There was a formal handover between health centres and hospitals for 82%, pretransfer treatment was provided in 64% of referred cases, 75% of the ambulance had emergency obstetrical kits. However, referring health centres were not always given feedback so that opportunities for improvement did not reach these health facilities. The average waiting time between the call of ambulance and the admission of clients in hospital was 2h26, with an extreme value from 6h37 to –19 minutes. Among key life-saving equipment that were missing, we noticed Oxygen cylinders in (in 13 out of 37 assessed ambulances), sliding stretchers (13/37), patient monitor (34/37); and 92% of nurses accompanying ambulances were not trained in EmONC.

Conclusion and Recommendations

There are still inefficiencies in referral transport clinical standards and in ambulance response, that urgently require the development of a specific maternal and neonatal referral guidelines and protocols, as per the WHO recommendation. Strengthening the referral system is a paramount; this will require the development of a specific national maternal and neonatal referral guidelines to provide the structure, processes, tools and coordination of maternal and newborn referrals within the district, as per the WHO recommendation. This will be also supported by the establishment of a call-centre, professionalization of nurses accompanying ambulances, supply chain and monitoring and evaluation.

Action Research on the preventive maintenance of medical equipment in maternity and neonatal units in Rwanda

Jean Claude Mwumvaneza[1], Véronique Zinnen[1], Eng. Ladislas Havugimana[1], Jean-Marie Sinari[1], Eng. Gad Ngilimana[2], Eng. Francine Umutesi3

(1) Enabel Health Program, Rwanda
(2) Rwanda Biomedical Centre, Maternal Child and Community Health Division
(3) Rwanda Biomedical Centre, Medical Technology Division

Introduction

Functioning equipment and preventive maintenance are essential components of quality care provision. Despite investment in life-saving equipment, an assessment done in 2020 in maternity and neonatal units in seven districts in Rwanda, showed 16% was not fully functional and there was no maintenance plan. This action research evaluates the impact of introducing preventive maintenance for maternity and neonatology equipment at the hospital level.

Methods

The intervention was conducted in 16 hospitals from 2020 to 2022. The activities included the introduction of preventive maintenance for equipment in maternity and neonatal units, the update of the equipment inventory, the training and mentorship of technicians. The main outcome was evaluated by the percentage of functional equipment before, during, and after the intervention.

Results

The percentage of hospitals with preventive maintenance implemented increased from 0% in 2020 to 63% in 2021, to 84% in 2022, and 88% in 2023. The rate of hospitals with updated equipment inventories increased from 9% to 61%, 63%, and 89%. Finally, the main outcome, the percentage of functional equipment increased from 84% in 2020 to 90% in 2021, 92% in 2022 and 96% in 2023. The budget spent on emergency repair was reduced significantly (from 118 859 in 2021 euros to 978) euros in 2024, this is due to the fact that implementing preventive maintenance was taken seriously.

Conclusion

Establishing a culture of preventive maintenance is critical to reduce the risk of equipment failure, minimize disruptions to patient care, improve patient outcomes, and help maintain the overall efficiency and effectiveness of healthcare. This shows that implementing preventive maintenance increases the number of functional equipment at health facilities, and significantly decreases the budget spent on corrective maintenance (or so-called emergency repair). However, training and continued mentorship are required to initiate and preserve good practice. Although this action research focused on medical equipment used in Maternity and Neonatology, it could be generalized to all hospital services.

Factors affecting the implementation of routine management practices for improving the quality of neonatal care: A Process Evaluation of a Hospital Management Intervention in Malawi

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Background

The neonatal mortality rate in Malawi remains high at 27 deaths per 1000 live births, despite high coverage of health facility deliveries and scale-up of clinical neonatal care interventions. Improvement in hospital management practices may improve the quality of neonatal care services. An ongoing cluster-randomized trial in Malawi is evaluating the impact of a multifaceted hospital management intervention on neonatal mortality and quality of care in 10 intervention and 20 control hospitals. The intervention includes optimization of clinical care delivery, leadership and mentorship support, improved routine data use for decision-making, peer-to-peer learning, and on-site management training, facilitated by external technical assistants. We conducted a process evaluation to explain the implementation of management practices in response to the intervention.

Methods

The process evaluation draws on the MRC guidance on process evaluation for complex interventions which emphasizes the role of implementation, mechanisms of impact, and context when seeking to understand how an intervention leads to outcomes. In March 2024, we conducted a qualitative phenomenological study involving in-depth interviews (IDIs) with 30 hospital staff and reflective practice sessions with 7 technical assistants who delivered the intervention. We purposively selected five intervention hospitals, to provide variation in type, location, and hospital management practice score. The IDIs explored factors affecting the implementation of the hospital management practices in response to the intervention. Transcripts were uploaded into Dedoose software for analysis and data were analysed through a thematic content analysis.

Results

Facilitators of intervention implementation included: support from senior leadership to help staff implement management practices; communication and collaboration between hospital departments; having a proactive champion; perception by staff that the intervention is not additional work; managers delegating management practices to more junior staff; monitoring the progress of management practices and providing feedback; and staff willingness to learn. Barriers included: the staff's expectation of additional incentives; material resource constraints; staff shortages; staff turnover; staff rotation out of the neonatal unit; and hospitals' de-prioritization of the neonatal unit in comparison to other hospital departments. Generally, participants perceived the intervention to be sustainable because the management practices promoted by the intervention were already within their mandatory scope of work.

Conclusion

The study reveals the key factors influencing the successful implementation of management practices for newborn care quality improvement. While some barriers reflected broad challenges within the health system, the identification and removal of those barriers within the hospital's control could increase the intervention's acceptability and sustainability.

What happens to school-aged children when child health policies and laws are poorly implemented and what solutions could be applied in Nigeria?

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Background

Child-related health outcomes in Nigeria are among the worst globally despite the existence of child health legislations whose optimal implementation ought to protect and promote the health of children.

Method

We undertook an in-depth review of existing child health policies for school-aged children in Nigeria to identify gaps and inconsistencies that may hinder their implementation or effectiveness and highlight areas for revision or a complete overhaul. The Child Rights Act [CRA] (2003), National School Health Policy [NSHP] (2006), National Policy on the Health and Development of Adolescents and Young People in Nigeria [NPHDAYP] (2019), and National Child Health Policy [NCHP] (2022), were the identified and reviewed policies. Information from the policy review was triangulated with evidence from interviewed 63 persons, inclusive of children from formal and informal settlements in an urban location.

Results

Using the health policy review framework, we assessed all four based on their contents, actors, processes, and context. The contents affirmed the inalienable rights of children to good health, which should be advanced using a multisectoral approach. Schools are expected to be at the centre of promoting and actualization good health for children. Despite the good intentions of the policies, we found contextual gaps between the policy aspirations and their actual implementation, such as absence of mainstreamed health services in schools, poor relationship between schools and the primary healthcare system, overlaps and conflations in policy contents, obsoleteness, and lack of voice of children in constituted child health committees. In confirmation, evidence from interviews showed that children were exposed to inimical health practices due to the lack of awareness of the policies, absence of progressive pathways, and poor/no commitment to targets and aspirations of the policies.

Conclusion

The health space for school-aged children in Nigeria is largely porous, which serially undermines their health rights. Addressing these issues demands crucial attention to the strengths and weaknesses of the relevant policies, ensuring that their contents and operational mechanisms are consensually designed in a feasible, manageable, and implementable order, as agreed by relevant stakeholders in the country, inclusive of children themselves.

Difficult choices mothers make when their newborns are admitted to a neonatal unit of a teaching hospital in Rwanda.

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Background

In Rwanda 48.8 percent of the population in Rwanda are estimated as multidimensionally poor while an additional 22.7 percent is classified as vulnerable to multidimensional poverty. Around 95% population are covered by health insurance. Within the basic benefits package for the Community Based Health Insurance are services for sick newborn infants. CHUB is a teaching hospital in the south of Rwanda that accepts referrals, including sick newborn babies, from 14 hospitals around the country. The objective of this study was to understand the challenges faced by mothers of neonates admitted to CHUB to advise policy and practice.

Methods

An interview guide was designed using open ended questions to elicit unbiased information. In-depth interviews were conducted with mothers whose newborn babies were admitted on the neonatal unit at CHUB during the months of June to August 2022. Interviews continued until no new information was forthcoming. The digital recordings were analysed using inductive reasoning methodology. Themes and sub-themes were determined through consensus among the author and co-authors.

Methods

A total of fifteen women were interviewed. Difficult choices were made on a daily basis balancing available financial resources, family needs against inputs required for survival of the newborn and the health and well-being of the mother. The unpredictable extended period living away from home and related costs exacerbated challenges mothers faced. The lack of a support system near the hospital increased the

Conclusion

Changes in National and hospital policies and infrastructure are required to address the challenges faced by families, particularly mothers, whose sick newborns are admitted to hospital. These policy changes should aim to improve economic security of families, survival of the newborn and health of the mother.

Rural-urban Socioeconomic Inequalities in Child Stunting in Tanzania: A Role of Antenatal Care Visits

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Background

Child stunting poses significant risks to both physical and cognitive development, ultimately impacting an individual's long-term socioeconomic potential. Although antenatal care (ANC) visits are recognized as a key intervention to reduce the risk of child stunting, Tanzania continues to experience persistent rural-urban inequalities in stunting prevalence despite an increase in focused ANC utilisation over the past decade.

Aims and Objectives

This research aims to explore the association between ANC visits and the socioeconomic inequalities in child stunting between rural and urban areas in Tanzania.

Methods

Data from the 2022 Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) were utilised in this study. The analysis was conducted using the standard concentration index and the recentred influence function (RIF)-Oaxaca decomposition method, which has not been previously applied in the Tanzanian context.

Key Findings

The findings indicate that rural areas experience lower ANC utilisation and higher child stunting prevalence, with wealthier households having better access to ANC, and worsening stunting among the poorer subpopulations. The results suggest that ANC visits significantly contribute to the rural-urban socioeconomic inequalities in child stunting.

Conclusion

To address these inequalities, it is essential to enhance the accessibility and availability of quality maternal

healthcare services, particularly in remote and rural areas. Investment in telemedicine and innovative approaches to disseminating information and advice to pregnant women in remote areas could help bridge the geographical divide between rural and urban subpopulations. Such interventions could play a crucial role in reducing rural-urban socioeconomic inequalities in child stunting, ultimately improving health outcomes and contributing to long-term economic productivity.

Political Economy and Leadership in Strengthening Health Systems in Developing Countries

2:00 PM–3:30 PM Wednesday, 03 March 2025

Rotating Savings and Credit Associations (ROSCAs) as Communities of Practice in Public Health and Food Security Systems: a scoping review

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Rotating Savings and Credit Associations (ROSCAs) are informal financial groups where members contribute a fixed amount of money regularly to a common fund, which is then withdrawn in turn by each participant. These associations, often used by low-income individuals and predominantly by women, provide financial services to those excluded from formal systems. ROSCAs are prevalent in low- and middle-income countries (LMICs) and among immigrant communities in developed countries. In South Africa, they are known as stokvels, with over 810,000 registered stokvels, 11.5 million members, and an estimated economic footprint of nearly ZAR 50 billion (GBP 2.5 billion). In Kenya, ROSCAs began as small 'chamas' where women pooled resources to purchase food items rotationally, evolving into formalized societies managing assets totalling Ksh 300 billion (GBP 2 billion). Despite their significant potential to function as communities of practice (CoPs) within public health and food security systems, research on this application is sparse.

ROSCAs facilitate knowledge sharing, collective problem-solving, and capacity building, aligning with CoP principles. They have been leveraged to enhance public health and food security outcomes, particularly in resource-limited settings. By synthesizing evidence from diverse geographical contexts and health and food security initiatives, this review examines how ROSCAs have been leveraged to enhance public health and food security outcomes, particularly in resource-limited settings.

The findings suggested that ROSCAs can be instrumental in disseminating health information, promoting

preventive practices, and fostering community engagement in health initiatives. Their operations are grounded in trust, reciprocal relationships, and social capital, making them well-suited to address public health and food security challenges. For example, in Johannesburg, some stokvels have organized HIV/AIDS prevention and management sessions, leading to notable improvements in community health outcomes. In rural areas with limited access to formal healthcare, stokvels pool resources to overcome financial and geographical barriers.

Additionally, ROSCAs promote a culture of mutual support, which is vital during health crises. The integration of ROSCAs into public health and food security strategies could offer valuable insights for policymakers and practitioners. These traditional financial systems can support health education, improve healthcare access, and promote collective responsibility, thereby addressing health disparities and fostering resilient communities. Leveraging ROSCAs' potential can enhance health outcomes and drive sustainable community development.

The politics of budget reform to advance health system strengthening

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Background

Public financing, and the underlying public financial management (PFM) system, is essential for making progress on UHC. A critical component of PFM reform is consideration of the political economy in which budget reforms occur. As Programme Based Budgeting (PBB) has been increasingly promoted as a PFM reform with potential benefits to better align resources with sector priorities and provide more flexibility accountability in spending, it is necessary to understand the political economy dynamics that impact these reforms and related outcomes.

Aims

The purpose of this work is to understand political economy factors and related strategies to incorporate into effective PBB reform implementation plans to align to health system reform requirements needed to advance UHC objectives.

Methods

The study is based on a series of case studies that examine the political economy of PBB reforms in the

health sector in Ghana, South Africa, Burkina Faso, Kenya and Cameroon. Case studies draw from an iterative document review and an expert consultation, with representatives of government (Ministries of Health (MoH), Finance (MoF) and related agencies), donors, civil society and technical advisors. A critical synthesis of the findings is also presented and discussed.

Findings

Our study goes beyond the technical specificities of PBB reforms to provide evidence about the processes by which structural budget decisions are made and to highlight the politics of PBB reforms in the health sector, focused on the impact of these politics on reform process and health outcomes. The stakeholder mapping and analysis conducted in each country highlights the main actors, their position in relation to the PBB, their interests and agenda, and the dynamic of power and influence. Reflections emerge on the importance of alignment of interests between dyads of actors: executive and bureaucracy, MoF and MoH, central and decentralized levels. The potential interest of external actors in capturing PBB reforms to align domestic budget to own priorities also emerges. Finally, the role of high-level political support in relation to alignment to strategic reforms is identified as a factor facilitating the success of PBB.

Conclusions

PBB is an inherently political process that deals with how resources are allocated and distributed across health systems. The evidence presented demonstrates the key political economy considerations that impact effective PBB reform processes and outputs and thus affect health system strengthening. Insights from this applied political economy analysis support the advancement of the PBB agenda, and more broadly health reforms and UHC.

Exploring political economy factors that influence planning and budgeting for financing primary care in resource limited settings: Lessons from Ghana and Rwanda.

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Aims and Objectives

Health resource planning and budgeting processes play a crucial role in strengthening primary health care (PHC) systems and service delivery by ensuring the efficient and effective use of resources. However, health planning processes are often ill-defined and not always executed as designed. As part of the Gates Foundation-funded PHC Performance Management (PHC-PM) Activity, Management Sciences for Health (MSH) and Three Stones International aimed to document these processes as outlined and compared them to their real-world application. This assessment sought to highlight political and contextual factors affecting planning and budgeting in each country, understand the roles of key actors and identify challenges and corresponding gaps in resource allocations and service delivery.

Methods

The partners identified key stakeholders at each level (facility, district, regional/provincial, central alongside retired central-level officials in Ghana. Key informant interviews were conducted to capture overall planning and budgeting policies vs. practices for key inputs (workforce, infrastructure, service package and supplies & equipment). Interviews were reviewed for key themes and to identify political economy dimensions relevant to successes and failures of planning and budgeting processes in both countries.

Findings

The planning process varied in both countries and adherence in practice differed depending on input area. Political economy dimensions affecting planning and budgeting included political & governance factors, historical factors, enabling and inhibiting reforms, government accountability and oversight, geographical/contextual factors, societal and cultural factors and stakeholder involvement.

Findings within each dimension differed between countries. In Rwanda, governance played a large role; priorities centered around decentralized decision-making within the planning process but also implementation of central Imihigo plans. This highlighted a participatory planning process with few delays; however, districts held minimal autonomy to influence plans and include inputs from community engagements, ultimately creating plans influenced by central priorities as opposed to local needs.

In Ghana, less political pressure allowed districts more freedom to plan for their contexts; however, the planning process faced significant delays in distribution and completion of planning templates. Districts, regions and facilities also reported limited capacity for data analytics. Historical factors (e.g. extreme conflict in Rwanda and economic crises in Ghana) heavily influenced planning processes in both countries, leading to significant donor presence.

Ultimately, identifying political economy factors can explain deviations from outlined practices and addresses key overarching challenges to support districts, national governments, and partners to create more efficient PHC systems and improve the allocation of resources.

Who Leads Nigeria's Subnational Health System? Analysing the Characteristics of Health Commissioners from 2015–2023

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Introduction

In federal states like Nigeria, sub-national governments significantly influence health system effectiveness. The attributes of Commissioners of Health (HCH), the primary leaders in Nigeria's sub-national health sectors, are critical determinants of health outcomes. Navigating a complex landscape, HCHs must blend technical, political, and administrative skills. This study analyses the characteristics of HCH across Nigeria's 36 states from 2015 to 2023, focusing on educational backgrounds, professional experiences, and gender, to understand their impact on health policy implementation.

Methodology

This study employed a comprehensive web-based search to examine healthcare leaders' characteristics in Nigeria's sub-national health sectors from May 2015 to May 2023. Using targeted keywords on Google, we identified appointed commissioners across Nigeria's 36 states. Information was collected on their educational backgrounds, professional experiences, and gender, using credible sources such as government websites, authoritative reports, and reputable publications. We cross-verified data across multiple sources for accuracy and consistency and analysed it using Microsoft Excel.

Results

A total of 101 commissioners led the health sector across 2,878 (83.3%) state-months during the study period, with no HCH in office for 578 (16.7%) state-months. The average tenure was 28.4 months (± 17.7). Notably, 83.2% of commissioners were male, with only 16.8% female representation. Due to incomplete educational and professional information for 31 commissioners, these individuals were excluded from further analysis. Of the commissioners with complete profiles, 91.2% held medical degrees, but less than half possessed relevant advanced degrees (41.2%) or extensive administrative experience (44.1%). Additionally, only 54.4% had prior public health or public service experience.

Discussion and Conclusion

The high turnover rate, prolonged absence of HCH, and underrepresentation of women highlight significant challenges in Nigeria's sub-national health sector. Leadership instability and a lack of diverse expertise

may hinder effective health governance. To strengthen sub-national health systems, efforts must focus on improving leadership continuity, enhancing gender equity, and prioritizing HCH with relevant qualifications and experience. Further research is required to explore the relationship between HCH characteristics and changes in health sector performance during their stay in office.

A political Economy Analysis (PEA) of demand and Supply and Supply of PHC Services in Developing Countries

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Background

Notwithstanding the importance of Primary Health Care (PHC) to population health, poor PHC outcomes continue to exist, with the literature suggesting that poor PHC outcomes are a function of demand and supply constraints as well the politics of actors within the PHC ecosystem. Thus, the current paper examines demand and supply constraints to PHC service utilisation, especially among women and girls, and how such constraints are shaped by the power of PHC actors.

Method

The study via scooping review, retrieved a total of 3048 records (published and grey literature) from databases (PubMed, EBSCOhost, Web of Science, Google Scholar, Effective-state.org, World Health Organization IRIS website). After different levels of screening, 114 records were retained. The retained records were read through, after which relevant information (reference details; study objective; target population; study setting; study design and key findings) were extracted. The Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for Scoping Review (PRISMA-SCR) guidelines was used to report findings from the review.

Results

The review identified demand side constraints to PHC utilisation, including economic factors (financial constraints to healthcare access, geographic accessibility challenges), institutional factors (healthcare provider-patients relationships, quality of care concerns), socio-cultural factors (preference for traditional medicine and practitioners, low health literacy among women, social stigmatisation and healthcare disparities, negative socio-cultural beliefs and practices and socio-demographic factors) and policy policy engagement issues. On the supply side, challenges included institutional factors (ineffective management of healthcare systems, challenges with evidence-based decision-making, inadequate infrastructure and drug supplies and inadequate staffing and skilled personnel), economic factors

Conclusions

Based on the findings, a framework for understanding pathways to improving PHC demand and supply challenges was developed. The framework is important not only to guide empirical studies on PHC demand and supply, but more importantly, the design of PHC related programmes and systems. This could be crucial for addressing existing PHC related challenges.

Health Insurance Expansion and Willingness to Pay in Informal and Community Settings in Africa

2:00 PM–3:30 PM Wednesday, 03 March 2025

Ensuring the Inclusion and Participation of Persons Living with HIV in sub-national Social Health Protection Schemes: GESI Perspectives from Nigeria's two most populous States.

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Background

More than two-third of resources for the HIV response in Nigeria come from international donors. This is against a background of high out-of-pocket payments for healthcare with over 90% of Nigerians affected. These out-of-pocket payments pose financial barriers for People Living with HIV (PLHIV), a significant proportion of whom are socioeconomically disadvantaged and have challenges affording health services. While the inclusion and participation of PLHIV in Social Health Protection Schemes provides a valuable opportunity to reducing catastrophic costs for healthcare, gender -related barriers may hinder access and utilization.

The USAID-Local Health System Sustainability (LHSS) Project examined Gender Equality and Social Inclusion (GESI) related factors limiting access to and utilization of health services under social health protection schemes by PLHIV.

Methodology

This GESI analysis included comprehensive desk review and primary data collection to capture constraints and opportunities for the inclusion of PLHIV in social health protection schemes. Primary data was

qualitatively collected through 32 key informant interviews (KIIs) and 5 focus group discussions (FGDs) with stakeholders from 32 male and 54 female respondents across the two states.

Findings

Key informant interviews indicate that the operational guidelines of the Sub-national Social Health Protection Schemes were largely gender blind, overlooking potential gender issues that could affect enrolment and utilization, particularly by different groups of persons living with HIV. Content analysis of the guidelines also revealed that gender-related barriers for access to and utilization of the state health insurance scheme were not recognized. There was low level of awareness for social health protection schemes among persons living with HIV, especially married adolescents and young women and members of key population. Certain gender norms around ideal masculinity requires men to be strong thus hindering them from accessing care in health facilities.

On social inclusion, the study found that participation in social health protection schemes in the two states was largely skewed towards formal sector workers, especially in Kano State. This increases the vulnerability of HIV positive individuals, many of whom are either unemployed or work in the informal sector and may not afford the premiums which hinders their access to and utilization of health services.

Conclusion

Understanding and addressing policy and HIV community-specific factors influencing the participation of PLHIV in social health protection schemes, particularly those related to GESI would result in more inclusive and sustainable health outcomes in target states.

Keywords

Social Health Protection, Access, Gender, Utilization.

Strategies Implemented to Expand Health Insurance Coverage to Informal Sector Groups in Nigeria: A case study of a sub-national health insurance scheme

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Background

Low- and middle-income countries (LMICs) face challenges of poor enrolment of the informal sector group in health insurance. Nigeria's informal sector accounts for over 70% of the country's total labour force, yet access to health insurance coverage is extremely limited due to the challenges associated with providing coverage to those in the informal sector exacerbating health inequities.

Aim

This study examines the strategies implemented/adopted to increase enrolment to health insurance for informal sector groups and the effectiveness of the strategies in Anambra state, Nigeria. The study highlights the practicalities of implementing these strategies, including the facilitators and barriers that influenced the process.

Methods

The study was conducted in Anambra State and employed a mixed-methods approach, incorporating quantitative and qualitative data. The quantitative data were collected from existing databases, which provided information on the number of registered informal sector groups that had enrolled in the state health insurance. The qualitative data were collected through semi-structured interviews (n=19) with health insurance managers and informal sector workers. Univariate analysis was performed for quantitative data, while qualitative data were analyzed using a manual content approach.

Results

The results revealed that over five years, informal sector coverage is 37% of the total Anambra State Health Insurance Scheme (ASHIS) enrollees. The major strategies that have been implemented/adopted to expand health insurance coverage to informal sector groups include the adoption model (31.7%), testimonial marketing (43.6%) and outreach programs (12.0%) through community structure including use of town announcers, churches, traditional rulers/influencers, civil society organization engagement and government tax for health insurance policy (tax-for-healthcare model) where certain percentage of taxes paid by commercial vehicle are remitted to the state health insurance scheme (6.0%). The effectiveness of these strategies was largely influenced by certain facilitators such as government support/commitments and policy frameworks, partnerships with informal sector associations and the availability of willing philanthropists to pay premiums for the less privileged. Conversely, the barriers include limited awareness and understanding of health insurance affordability cost constraints, and mistrust in government programs.

Conclusion

By adopting effective strategies, Anambra state has expanded and increased health insurance enrolment among the informal sector, hence reducing financial barriers to healthcare and possibly improving health outcomes. There is a need for similar countries in LMICs seeking to increase health insurance enrolment

in the informal sector to adopt such context-specific, inclusive, and sustainable solutions to address the health insurance gap in the informal sector.

Examining the willingness to pay for haemodialysis among patients with chronic kidney disease in Abuja, Nigeria

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Background

Evidence of willingness to pay for kidney replacement therapy is scarce in low-middle-income countries, including Nigeria's Formal Sector Social Health Insurance Programme. The study, therefore, assessed the willingness to pay for haemodialysis among chronic kidney disease patients in Abuja, Nigeria.

Methods

The study adopted a cross-sectional survey design. We used the contingent valuation method to estimate the maximum stated willingness to pay (WTP) for haemodialysis among end-stage renal disease (ESRD) patients. We obtained informed written consent from respondents before data collection. The socio-demographic characteristics and willingness to pay data were summarized using descriptive statistics. We evaluated the mean differences in respondents' WTP using Mann-Whitney and Kruskal-Wallis tests. All variables that had $p < 0.25$ in the bivariate analysis were included in the Generalized Linear Model (gamma with link function) to determine the predictors of the WTP for one's and another's haemodialysis. The level of significance in the final model was $\rho < 0.05$.

Results

About 88.3% and 64.8% of ESRD patients were willing to pay for personal and altruistic haemodialysis, correspondingly. The mean annual WTP for haemodialysis for one's and altruistic haemodialysis was USD25,999.06 and USD 1539.89, respectively. Private hospital patients were likelier to pay for their haemodialysis ($\beta = 0.39$, 95%CI: 0.21 to 0.57, $p < 0.001$). Patients attending public-private partnership hospitals were less likely to pay for altruistic haemodialysis than those attending public hospitals ($\beta = -1.65$, 95%CI: -2.51 to -0.79, $p < 0.001$).

Conclusions

The willingness to pay for haemodialysis for themselves and others was high. The type of facility ESKD patients attended influenced their willingness to pay for haemodialysis. The findings highlight the need for policies to enhance affordable and equitable access to haemodialysis in Nigeria through pre-payment mechanisms and altruistic financing strategies.

Expanding Health Insurance Coverage in Lagos: Lessons from Informal Sector Enrollment

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Background

The Lagos State Health Scheme (LSHS) was established in 2015 as a cornerstone of the state's strategy to achieve Universal Health Coverage (UHC). The scheme's funding is diversified, drawing from income-based contributions from the formal sector, premiums from the informal sector, a dedicated 1% allocation from the state's Consolidated Revenue Fund, support from the Basic Health Care Provision Fund (BHCPF), and contributions from organizations and individuals. Despite its potential to mobilize additional health revenues and stimulate economic growth, the LSHS faces significant challenges in covering Lagos State's substantial informal sector, which constitutes approximately 70% of the workforce

Aim

To enhance informal sector participation in the LSHS through a targeted demand generation strategy.

Methodology

The initiative commenced by mapping and segmenting the diverse informal sector, understanding their perceptions of insurance, and developing and deploying a contextualized demand generation (DG) strategy including LSHS branding. The strategy employed various channels, including radio jingles, market engagements, association meetings, and promotions. The strategy included an informal sector enrolment plan with 300 community-based enrolment officers (CBEOs) and 25 community mobilization officers, trained and incentivized through performance-linked contracts. User-friendly approaches to premium collection were deployed.

Key Findings

At close out, the project supported the airing of 1,233 air-time for jingles with an estimated reach of about 12 million people. Through aggressive DG and community-based enrolment, informal sector participation in the LSHS (Ilera Eko), surged, accounting for 41,687 informal sector enrolments total enrollees as of October 2022. HSCL and the state are reviewing CBEOs contracts to engage higher-performing individuals and seek external support to sustainably deploy more CBEOs.

Conclusion

Achieving UHC necessitates innovative strategies to engage the informal sector. Lagos State's experience highlights the effectiveness of community-based enrolment in expanding health insurance coverage. However, scaling up these efforts requires sustained financial and institutional support. While the initiative demonstrated the potential of community-based approaches, the need for sustained investment in human resources and infrastructure is evident to ensure long-term sustainability.

Membership Enrolment Trends (2019-2022) in Tanzania's Improved Community Health Insurance Fund (iCHF)

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Introduction

Sustainable Development Goal number three (SDG-3) encompasses the aspiration of good health and well-being for all. Target 8 of the SDG-3 aims to achieve Universal Health Coverage (UHC). More than half (56%) of sub-Saharan African countries, including Tanzania, rely heavily on out-of-pocket (OOP) payments to finance health. OOP is estimated to exceed 30% of these countries' total health expenditure (THE). Tanzania introduced iCHF to address health financing challenges. No study has been done to describe membership trends in Tanzania iCHF. This study was conducted to describe membership trends in Tanzania iCHF.

Aim

To describe the trends of iCHF membership enrolment from 2019 to 2022

Methods

This retrospective study targeted 4,020,750 beneficiaries registered in the Tanzania's iCHF health information management system. Claims data was retrieved from iCHF's electronic database covering the period from 2019 to 2022. Membership trends were described using descriptive statistics frequencies and relative frequencies. Demographic characteristics of enrolled members such as sex, age, marital status, region of residence was also described.

Results

Descriptive results indicate that a total of 3,788,818 new members were registered in iCHF between 2019 and 2022. Most iCHF members were female, single, and with a median age of 16, IQR (9-31). About 22% of the members, were household heads. There was an increasing trend of membership enrolment from 2019 to 2021, and a decline happened in 2022. Overall, about a quarter, 938,026 (24.7%) of the members were from 3 regions which are Dodoma with the highest proportion of members 334,770 (8.8%), followed by Shinyanga with 310,790 (8.2%) and Morogoro with 292,466 (7.7%). Overall, there were 815,891 household heads in the four years studied. Over half (56.3%) of the household heads were female. The trend on the sex of the household head over the four years shows there was a steady decline in the number of male household heads from 53.1% in 2019 to 36.9% in 2022.

Conclusion

The trends in iCHF membership trends indicated a significant decline in the number of iCHF members in the recent. The trend also indicates there is a higher decline of males as compared to females. The decline in enrolments could be contributed by the transition phase where Tanzania is making efforts to introduce Universal Health Insurance (UHI). Tanzania needs to have a clear plan on how it is going to navigate the transition phase without significantly affecting existing systems.

Income-related inequality in mental health during the COVID-19 pandemic: Insights from South Africa

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Background

Shocks, whether local or global, are associated with shifts in pre-existing inequalities. There is, however, no consensus on whether the shocks widen or narrow inequality.

Aims and Objectives

The current study aims to determine the impact of a significant global shock, the COVID-19 pandemic, on mental health (depressive symptoms) as it relates to inequality in South Africa.

Methods

We employed a recentered influence function (RIF) decomposition method for rank-dependent indices using data from the fifth round of the South African National Income Dynamics Study (NIDS) and the fifth round of the NIDS-Coronavirus Rapid Mobile Survey (NIDS-CRAM) data.

Results

Our findings reveal that the COVID-19 pandemic was associated with the convergence of income-related inequality in mental health in South Africa. Our results confirm earlier findings showing that the mental health burden of the pandemic has disproportionately affected affluent South Africans, which has flattened the income gradient in mental health. We also find that employment status, and population group affect inequality in depressive symptoms.

Conclusion

There is no consensus on the preferred measure of inequality due to differences in value judgements underlying each measure. This study contributes to the literature on income-related inequality in mental health by giving a broader view on inequality through estimation, and the RIF decompositions, of both relative and absolute rank-dependent inequality indices. Our main result remained relatively the same, suggesting that our findings are not dependent on the value judgements underpinning specific inequality indices. The breadth of our analysis present policy makers with options of inequality indices to address.

Socio-Economic Determinants of Healthcare Access in Sub-Saharan Africa: Insight from the LSMS Survey

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Healthcare access is one of the greatest challenges in Africa. More than 600 million people (about 45%) in Africa lack access to basic healthcare services, with approximately 97 million people incurring catastrophic healthcare spending. Recent literature identified socioeconomic factors such as residence, distance to health facilities, education, and wealth/income as major socioeconomic determinants of healthcare access. This study uses the LSMS high-frequency survey of representative households in five African countries (Burkina Faso, Ethiopia, Malawi, Nigeria, Tanzania, and Uganda) to identify other important determinants such as age, sex, and type of respondent's employment. Healthcare access was measured by a respondent being asked if "healthcare last month was adequate, more than adequate, and less than adequate." The healthcare access model was estimated using logit regression to examine if age, sex, and type of employment were important variables affecting healthcare access among respondents.

Descriptive statistics show that 26% of respondents have "less than adequate" health care, and 55% have "adequate" healthcare. In comparison, only 4% had "more than adequate health care. Results from logistic regressions show that types of employment such as "respondent mainly employed in the household enterprise" and "respondent mainly employed on the family farm" were major determinants of whether a respondent has less than adequate or adequate healthcare. The study concludes that the employment category could affect healthcare access in the selected countries in Africa.

Keywords

Healthcare access, LSMS survey, Africa, socioeconomic determinants, employment.

More money for primary health care (PHC) for better health to resolutely advance towards universal health coverage (UHC)

Thiane Gueye and Thiane Thiane *OUI, Dakar, Senegal*

Background

In 1978, the Alma-Ata Declaration was adopted in response to the inequalities that exist in the health situation of populations and proposed a strategy to reduce these gaps by advocating for a fundamental change in health systems and the provision of care.
In 2018, the Astana Declaration adopted by Senegal reaffirms the importance of PHC by emphasizing, among other things, the strengthening of integrated person-centered health services and better addressing non-communicable diseases (NCDs).

Method

The methodology for developing health accounts was used to have the results exploited. The health accounts are a retrospective, descriptive and analytical macroeconomic study from 2017 to 2021.

Findings

In 2021, current expenditure on PHC rose by CFAF 365.4 billion compared with 2017, to CFAF 477.9 billion. However, more than half of this expenditure (55.9%) is borne by households, mainly through direct payments. The share of Technical and Financial Partners (TFPs) in this expenditure is 23.9%, while that of the public administration is 15.2%. NGOs and businesses account for only 5% of PHC expenditure.

On average, more than 70% of PHC expenditure borne by the State and its decentralised bodies is directed towards steering and coordination. Most of the remaining 30% is allocated to immunisation.
Over the period, an average of 43.5% of PHC expenditure was devoted to the purchase of pharmaceutical products. Other operating expenses (remuneration, purchase of imaging and laboratory consumables, etc.) account for 56.5%.

Between 2017 and 2021, on average, 72.1% of TFP expenditure on PHC was devoted to communicable diseases (TB-3.5%, HIV and other STIs-7.8%, malaria-9.9%), which are covered by specific programmes, the SRMNIA-N (40.9%) and immunisation (10.0%).

Conclusions

Primary healthcare helps improve equity in access to efficient health services provided as close as possible to the populations, within the community. They undoubtedly constitute the gateway of any system in the advancement towards UHC.

Keywords

Primary healthcare, mobilization, Universal Health Coverage, household, payment.

Factors influencing informal savings groups decision-making related to food preferences and procurement strategies: a discrete choice experiment

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Background

In a country facing the dual burden of undernutrition and overweight, informal savings groups, also known as stokvels, can be leveraged to promote affordable and healthy nutrition. These groups have long been utilized to alleviate poverty, promote food security, and empower women. This study aims to evaluate the factors influencing stokvel members' decision-making related to food preferences and procurement strategies using a discrete choice experiment (DCE).

Methods

The research was conducted in the economically disadvantaged urban areas of Dunoon and Khayelitsha in Cape Town, South Africa. The DCE was designed to understand the factors influencing the demand for healthy food among stokvel members, incorporating attributes such as travel distance for grocery shopping, criteria for purchasing staple groceries, and shopping frequency. The sample comprised 183 stokvel members (insert Female %). Scenarios were constructed by altering the levels associated with these attributes using Sawtooth software. The data were subsequently analysed using a mixed effects logit regression model.

Results

Our study findings revealed that shopping frequency, shop-delivery preferences, and proximity to shopping venues accounted for more than 90% of the factors influencing food choice decision-making among stokvel members. These factors significantly dictate purchasing patterns, overshadowing the perceived value for money. Notably, the study found that food cost alone has minimal influence on food selection compared to time and last-mile distribution costs. These insights from stokvel members provides a lens to

better understanding what drives food choice in economically disadvantaged urbans areas in Cape Town These insights shave the potential to contribute significantly to economic development and nutritional strategies. Policymakers can leverage these findings for public health advancement and food security enhancement by aligning health and nutrition interventions with consumer shopping patterns.

Conclusion

Our study underscores the importance of logistical considerations, notably shopping frequency, delivery options, and store proximity, in stokvel members' food purchasing decisions, which overshadow price concerns. These findings challenge traditional consumer behaviour models and highlight the critical role of stokvels in both economic sustenance and public health domains. This offers a strategic avenue for policy interventions to bolster food security in South Africa.

Untying difficult knots in health systems reform implementation; the experience and lessons from a multi-program, integrated, politically-savvy, approach for equitable health outcomes.

Frances Ilika

USAID Health Policy Plus (HP+) Project of Palladium International Development Company – Abuja, Abuja, Nigeria

Background

The Nigeria, National Health Act of 2014, established the Basic Healthcare Provision Fund (BHCPF) that will ensure a basic package of essential health care services especially to poor and vulnerable populations, through an inter-governmental fiscal transfer. This major policy reform will be driven by major government health agencies at the National and Sub-national levels in all 36 states. In 2019, 5 years following enactment, this policy was yet to be fully implemented with none of the 36 states in the country having accessed this fund.

Methods

The USAID Funded Health Policy Plus HP+, and Integrated Health Project IHP and the FCDO funded Lafiya project between 2018 to 2023 supported governments at the national and sub-national level in 12 Nigerian states to advance the implementation of this major reform. This support was multi-level, from the national, state, local government, facility, and community level and multisectoral including strengthening government, civil society groups, community leadership structures, and engaging Ministries of Finance to ensure that the funds were released and reached primary health care facilities. Multi-level institutional capacity strengthening was provided through legal and institutional frameworks and social accountability

mechanisms. Political economy knowledge was applied to improve relational capacity between institutions and actors and efficiency was enhanced by improving synergy of efforts and shared solutions.

Results

As a result of this support, the first 4 states met the criteria for implementing this important policy and received finances down to the primary health care level for the first time, catalysing an implementation of this program. The systems and approaches were subsequently scaled across in12 states and subsequently across all 36 states, from 2020 to 2024. This resulted in increased budgetary allocations and releases, 1023 PHCs received a total of N233,983,500 direct facility funding, which totalled N394,947,644 as of September 30th, 2023, improving access to quality health care and equity at PHC levels. Over 2.4 million people were enrolled into health insurance and the BHCPF. In addition, this support catalysed ANC 1 visits for 2.78 million women in poor communities, 900,000 ANC 4 visits (45% increase) and 1.3 million facility-based deliveries, with a 67% increase in deliveries with a skilled birth attendant. 6,807 maternal deaths, 33,332 child deaths and 1,337,207 unintended pregnancies were averted.

Conclusion

Applying comprehensive, evidence-based, politically savvy, integrated approaches to unravelling health system reforms has the capacity to not only advance policy, but can catalyse improved outcomes and ensure the sustainability of interventions in complex settings.

Socio-Economic Inequalities in Malaria Prevalence among Under-Five Children in Ghana between 2016 and 2019: A Decomposition Analysis

Marian Yaa Abrafi Edusei *University of Cape Town, South Africa, Kumasi, Ghana*

Background

In Ghana, malaria causes 20,000 child deaths each year, a quarter of which are in children under five. Although, previous studies report the association of socioeconomic inequalities related to malaria prevalence, there is limited evidence on factors explaining socioeconomic status (SES)-related inequality in malaria prevalence among Ghanaian children under five. Understanding these inequalities is crucial for Ghana to advance towards its sustainable developmental goals (SDG) 10 and SDG 3, whilst promoting socioeconomic development and eradicating malaria.

Aims and Objectives

Aim

To ascertain socioeconomic inequalities in malaria prevalence among children under-five years in Ghana between 2016 and 2019 towards a comprehensive malaria control.

Objectives

- To examine socioeconomic inequalities in under-five malaria prevalence in Ghana between 2016 and 2019.
- To analyse the role of socioeconomic factors on the inequalities in malaria prevalence in children under-five in Ghana between 2016 and 2019.

Methods

The study adopts a literature review structured into theoretical, methodological, and empirical sections. It discusses the economic burden of malaria and defines theoretical frameworks for SES-related inequalities, using the commission of social determinants of health (CSDH) framework as the conceptual foundation. The outcome variable was malaria prevalence in under-five children, explanatory variables included socio-economic status (household wealth), age of child, mother's education, place of stay, region and a few others. The 2016 and 2019 Ghana malaria indicator survey datasets were analysed using Stata 15. Socioeconomic inequalities in malaria prevalence among under-five children were assessed using concentration indices and curves and decomposed to identify contributing socioeconomic factors.

Results

The 2019 concentration index was significantly negative (CI= -0.224; SE=0.059), indicating a higher prevalence of malaria in children from lower socioeconomic backgrounds. While the 2016 index was not statistically significant, it was still negative, suggesting a pro-poor bias in malaria prevalence (CI= -0.052; SE= 0.053). The decomposition analysis found that wealth index, region, and ethnicity were significant contributors to the observed inequalities, accounting for 59.28%, 23.51%, and 4.15% of them, respectively, in 2019.

Conclusion

There are pro-poor inequalities in malaria prevalence among under-five children in Ghana, with a higher burden on those from lower SES backgrounds. Wealth and region explained such inequalities. Malaria intervention programs should be tailored to target these vulnerable populations and regions that are disproportionately affected by the disease to effectively combat malaria and advance toward meeting the SDGs related to health and socioeconomic improvement.

Expanding the health fiscal space to improve health outcomes in low-and middle-income countries: what is the role of tax expenditure optimization through PFM strengthening?

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(2). Independent consultant, Yaounde, Cameroon

The health outcome improvement needs to find windows to mobilize additional resources for the health sector without jeopardising governments' long-term solvency and crowding out spending in other sectors needed to achieve other development goals. Low-and-middle income countries provide fiscal exoneration to several corporates with the aim to attract foreign direct investment, to reduce unemployment and to increase consumption and investment. In this respect, tax expenditures should lead to strong and conducive macroeconomic conditions with then improve health outcomes. However, tax expenditures, could be also a shortfall in tax revenue mobilization and could contribute to a decline in health outcomes. To clarify this issue, the paper uses panel data models based on OLS estimator to estimate the causal effect of tax expenditures on maternal and under-five mortality on a sample of 64 low-and middle-income countries over 2000-2022. The evidences point out a negative effect of tax expenditures on mortality indicators, suggesting that an increase in tax expenditures resulted in a decline in maternal and under-five mortality. This effect is strong and significant in Latin American and Caribbean countries as well as in middle-income countries which has the highest tax expenditures as a share of GDP. The estimations also show the negative effect of tax expenditures on mortality indicators is lower in the countries with high-quality PFM proxied through CPIA indexes focusing on the quality of budgetary and financial management, the quality of public administration, the transparency, accountability and corruption control in the budget cycle, the equity of public resources and the efficiency of revenue mobilization. The findings from this empirical study show that the optimization of tax expenditures would expand the fiscal space for health, an option which would critical since they have an adverse effect on maternal and under-five mortality. They also call on countries to strengthen the PFM quality.

Linking Public Financial Management to Quality Improvement Processes: Improving Nigeria's Primary Health Care Quality

Elaine Baruwa[1], Bolanle Bukola Olusola-Faleye[2] and Benjamin Madaki[2]

(1). Member, Rockville, MD,
(2). Member, Abuja, Federal Capital Territory, Nigeria

Background

Public financial management (PFM) theory suggests that improvements in the allocation, execution, and monitoring of public funds can contribute to improved health outcomes. Nigeria's Basic Health Care Provision Fund (BHCPF) is a public program for expanding access to health services that provides direct facility financing to primary health care centers to improve their delivery. Facilities must produce a business plan and report expenditures against it to receive funding. Furthermore, a quality assessment exercise has been digitalized to facilitate its quarterly implementation. This analysis aims to demonstrate a positive association between effective public financial management and quality improvement processes in the BHCPF program.

Approach

Routine PHC facility inspection and quality assessment were carried out in 205 facilities in Plateau State quarterly in 2023. The digitally produced scorecard identified quality gaps that were discussed with the facility staff who then identified specific quality improvement interventions for inclusion in their next quarter's business plan. Alignment of facility priority investments to quality improvement plans, tracking of funds released to facilities, and facility financial expenditure reporting became a cyclical, quarterly practice. The scorecard uses a 'traffic light' color coding system to indicate the level of performance for each of 10 priority areas so that increased scores are easily comprehensible when printed and posted on facility notice boards. A convenience sample of high and low scoring facilities was chosen for key informant interviews, business plan reviews and expenditure tracking to identify challenges with budgeting for or implementing quality improvement processes.

Results

In Plateau State, there was a substantial improvement in the overall quality assessment score in Q3 2023, rising from 74% in Q2 to 78% in Q3. Facilities in 7 out of 17 LGAs had optimal quality scores (>80%) in Q3 compared to 3 LGAs in Q2 of 2023. Specifically, laboratory services and community engagement scores increased across the board. Given these improvements there is an on-going review of business plans across select facilities to cross check alignment of business plans with quality assessment findings, and alignment of business plan expenditures with quality assessment improvements over the final three quarters of 2023. Inadequate training, financing, and lack of expenditure tracking processes were found to inhibit implementing improvement plans.

Conclusion/Discussion

Nigeria's BHCPF program is implementing a quality improvement process that aligns quality assessments

(1). Member, Rockville, MD,
(2). Member, Abuja, Federal Capital Territory, Nigeria

Background

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results with direct facility financing via business plans to enable the implementation of quality improvement interventions. By tracking expenditures as well program implementers can determine the pathway by which direct facility funding is leading to quality improvement and identify approaches to optimize the use of direct facility financing and resource gaps that increased financing could address. However, in practice, facility leadership requires additional financial and technical support for the QI cycle to demonstrate how direct facility financing and insurance capitation payments can lead to improved quality.

Education and ageing in China

Wenxuan Zhong, Adelaide, China and Raul Barreto

Did historical access to education, or lack thereof, make Chinese seniors' perception of themselves unique as compared to their counterparts across the world? We consider the impacts of idiosyncratic institutional development, particularly in terms of access to formal education, on objective and subjective aging in China. Using as a 2018 survey of 6118 elderly Chinese, we use Instrument variable strategy to endogenously identify and generate three composite latent factors representing objective cognitive ability, subjective self-evaluation of health and wellbeing, and incidence of age-related ailments. We define two linear simultaneous equations representing subjective and objective successful aging to find that Chinese seniors maintain an observable distinction between the two. We further observe the consequences of China's historical lack of access to formal education amongst this age group and its impact on their aging. Our results demonstrate the importance of multidimensional evaluation of aging as well as identifies the potential impact of promoting lifelong learning as a Chinese policy response. We suggest that government recognize the value of cognitive rehabilitation to compensate for the insufficient educational opportunities when young.

Evaluation of the capitation policy at PHC in Rwanda: A mixed-method approach

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(1). Rwanda Social Security Board (RSSB),
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(4). USAID Ireme / MSH, Rwanda

Background

Rwanda's national community-based health insurance (CBHI), known as "Mutuelle de Sante," was introduced in 2005 to improve healthcare access and financial protection. Coverage has grown from 7% in 2003 to 85.6% in 2021. However, CBHI has faced sustainability challenges, recording cumulative deficits of RWF 76.8 billion between 2016 and 2020. To address this, a CBHI sustainability plan recommended several changes, including transitioning from fee-for-service to capitation at the primary care level to improve care quality and efficiency.

Objectives

This study evaluates the impact of switching from fee-for-service to capitation on primary healthcare in Rwanda. It will analyse changes in service utilization, availability of laboratory tests and essential drugs, and prescription practices among CBHI members. The study will also assess experiences and perceptions of care quality, the policy's effect on healthcare facility efficiency and RSSB processes, and its impact on revenues and expenditures, providing insights into financial sustainability.

Methods

This evaluation will use a mixed-method approach, including an interrupted time series design to analyse trends in service utilization, supply availability, prescription practices, and health facility revenues and expenditures. A difference-in-difference analysis will compare resource utilization changes and CBHI performance indicators. Interviews with health providers, patients, health facility management, and RSSB managers will assess the impact of capitation on care quality, patient experiences, challenges and operational adjustments to the new payment method.

Results

The study is expected to provide significant insights into the impact of transitioning from fee-for-service to capitation on primary healthcare delivery in Rwanda. Anticipated results include changes in service utilization patterns among CBHI members, improvements in the availability and use of essential drugs and laboratory tests, enhanced quality and efficiency of care delivery, and better financial sustainability for health facilities and the CBHI scheme.

Conclusions

Findings from this study will provide comprehensive evidence on the effectiveness of the capitation model in the Rwandan context. This evidence will be crucial for informing policy decisions aimed at sustaining and improving the CBHI scheme and the overall primary healthcare system in Rwanda, ultimately contributing to the achievement of universal health coverage in Rwanda.

Effects of colonial legacy and regional affiliation on the disparity in health policy bargaining power at World Health Organisation: economic evidence through a cross-sectional approach

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(2) University of Ngaoundere, Applied Economics Laboratory, Cameroon

Background

Bargaining power plays an important role in health economics studies. It determines certain economic outcomes in health debates. This importance is perceptible in many situations at the WHO as: the controversy surrounding the medicines prices and access to, the definition of counterfeit medicines, or the pandemics declaration, which highlight the disparities between members in terms of decision-making, economic and financial capacities. In this context, Africa faces these leadership challenges. With its health strategies dependent on external policies and financial resources, coupled with its marginal position in global health funding, it is important to understand the factors associated with its weak bargaining power. This would make it possible to respond to Sustainable Development Goal 16, which calls for greater participation by developing countries in global governance institutions, and to Goal 3, which calls for better health by strengthening inclusive governance.

Aims

over a ten-year average, analysing of colonial legacy and regional affiliation effect on the Africa's bargaining power at WHO.

Method

data synthesis' from World Development Indicator, World Health Assembly and economiccon_data by La Porta et al. (2008) is used. Variables used are measured respectively by legal origin as colonial legacy indicator, region for regional affiliation and Bargaining Power Index as bargaining power measurement. The model used to estimate the relationship between variables is the censored Tobit, whose context effects were taken into account by mixed-effects multilevel Tobit.

Results

- affiliation to African region decreases the probability of a country reducing its bargaining power gap.

- Relative to countries with a British legal origin, countries with a French or socialist legal origin have a low probability of improving their bargaining power.

Conclusion

At regional level, African countries should encourage economic and health policies able to reduce fragmentations that characterise this region and encourage different economic forces pooling: a real common market development, characterised by real health goods and services free movement, health expertise and even capital, is a way of increasing the economic potential needed to improve its status with the rest of the world, which defines the likelihood of global health governance responding to local needs.

While waiting to define an institutional and legal framework adapted to their needs, which is the ideal, French legal African countries should draw inspiration from Anglo-Saxon institutional models, which seem to offer better results in terms of economic and political power through effective institutions, political and economic freedom.

Critical unemployment or shortage of the health workforce in west Africa? Unravelling the health labour market puzzle in Guinea, 2024.

Delphin Kolie

Department of Family Medicine and Population Health, University of Antwerp, Belgium, Guinea

Background

Since 2018, Guinea has initiated reforms of its health system to address health workforce shortages and maldistribution. We undertook a study in the N'zérékoré region of Guinea to assess the availability, distribution, gender composition and employment of workforce in 2024.

Method

Following a WHO methodology, we conducted a health labour market analysis focusing on HRH data at regional and district level. Mixed methods were employed for data collection and analysis. Detailed data on HRH trends were collected from private and public health facilities and training schools. Data were also extracted from policy documents and published articles from 2018 to 2024.

Results

The region of N'zérékoré has 5,360 skilled health workers across eight health occupations in 2024; mostly nurse-aides (39.6%), state registered nurses (31.7%), midwives (15.9%) while medical doctors represented 3.0%. This corresponded to a ratio of 2.6 skilled health workers per 1,000 inhabitants, which is nine times higher compared to 2019 statistics. However, about 60% of the health workforce stayed in urban and semi-urban areas where 28% of the region's population lives as compared to 70% in 2019. The health district of N'zérékoré had the highest health workforce concentration with a density of 4 per 1,000 population, compared with the lowest density of 0.9 in Beyla health district. The aggregate unemployment rate among health workers was 82% with the highest among allied health professional (86%), nurses and midwives (84%), nurse-aides (83%) and biomedicals (82%). Over the past eight years, 30% of the 8,348-health workforce produced by health training schools in the region have been locally absorbed by the public/private health system: in 96% of the case as a temporarily contracted or volunteer health worker, but not as a salaried civil servant position. While female staff represented 63% of the health workforce, their male counterparts occupied more than two-third of the highly paid health occupations (medical doctors, pharmacists) and positions (health system managers). Moreover, men constituted 87% of the medical and public health specialists of the regional health system.

Conclusion

Guinea has made significant progress towards the global health workforce strategy attainment by halving the SDG requirement of 4.5 skilled health workforce per 1,000 population, increasing the workforce production capacity and geographical distribution in rural areas. However, the levels of unemployment and gender inequity have grown, with implications for professional development. Addressing these challenges will require strengthening health workforce recruitment, financing, and decent employment strategies in the health sector.

3:45 PM–5:15 PM Wednesday, 03 March 2025

Designing Accessible Health Benefits: Contextualizing Priority-Setting to Country Health Financing and Service Delivery Systems (Organised Session)

Altea Sitruk[1], Bruno Meessen[1], Andrew Mirelman, Kingsley Addai Frimpong[1], Josephine Gatua[2]

(1) WHO
(2) Africa CDC, Division of Health Economics and Financing

Description

In their effort to make entitlements explicit under the Universal Health Coverage (UHC) goal, a growing number of African countries are opting for developing a health benefit package (HBP) with an evidence-informed priority-setting process. Their experience is a major source of learning. When designed as a narrow priority-setting effort uncoupled from contextual and implementation considerations, including the overall health financing architecture and service delivery capacity, the HBP does not achieve its full potential in supporting sustainable change for the population. In this session, we will review contextual and implementation considerations which are critical for successful HBP design.

Experts from Ethiopia, Ghana and Rwanda will share their country journey towards institutionalization of HBP design processes, and their ongoing work to reconcile priority setting analyses with broader efforts for realizing entitlements through paying providers and quality service delivery. We will hear about the challenges they encountered and identify issues which may require more attention from the community of experts.

Methods

A framework identifying the linkages between the policy and planning instruments that are part of the health benefit design process will be presented.

Through the choice of speakers and engagement with the audience, facilitators of the session will ensure an open conversation between two sub-communities of health economic expertise, which need to collaborate more closely: economists working on Health Technology Assessment (HTA) and economists working on health financing arrangements. As an outcome, participants will learn more about the processes different aspects of prioritizing and designing benefits for guaranteed entitlements, identifying system constraints, and defining services in detail to support planning, costing, and financing for implementation.
The objectives of this session will be to:

- Present current thinking on institutionalizing robust health benefit design processes and considering health system implementation considerations that should form part of the benefit design framework, enabling a rich discussion on further strengthening institutionalization and implementation processes.

- Share country experiences from low- and middle-income countries and highlight practical, hands-on solutions to support such processes.

Results

Expected outcomes from this session include:

- Increased understanding of comprehensive country-level priority-setting processes for health benefit packages and their institutionalization and implementation considerations

- Increased awareness of tools and resources available to support country processes at different levels

- Shared lessons from country applications on institutionalization and implementation challenges and considerations

The session will be chaired by Kingsley Addai Frimpong, WHO Ethiopia.

Institutionalizing health technology assessment in Ethiopia: experience and way forward

Muluken Argaw *Ministry of Health, Ethiopia*

Over the last two decades, Ethiopia has made impressive progress in delivering essential health services to its population. To guide future developments, the country launched a participatory priority setting process which led to the determination of a new Essential Health Service Package in 2019. Whilst this has determined many subsequent aspects of the national health policy (e.g., national guidelines), allocating financial resources to the delivery of the 1,018 priority interventions proved difficult in a context of high decentralization, insecurity & conflict, and deterioration of the macroeconomic conditions.Over the last two decades, Ethiopia has made impressive progress in delivering essential health services to its population. To guide future developments, the country launched a participatory priority setting process which led to the determination of a new Essential Health Service Package in 2019. Whilst this has determined many subsequent aspects of the national health policy (e.g., national guidelines), allocating financial resources to the delivery of the 1,018 priority interventions proved difficult in a context of high decentralization, insecurity & conflict, and deterioration of the macroeconomic conditions.

The speaker will present the priority setting process implemented in Ethiopia and identify its many strengths and benefits at short and long terms, but also the contextual factors which may have hindered the full delivery of benefits to the population. He will draw key lessons for other countries, with a focus on points of attention to secure the best fit between the health benefit package and the health financing and service delivery contexts. He will report on the more recent steps taken by Ethiopian stakeholders to secure that best fit. He will also present the more recent roadmap which has been developed to guide Ethiopia in establishing a comprehensive and sustainable HTA system. To conclude, he will critically reflect on possible lessons for global actors committed to priority setting and health financing reforms in African countries.

Aligning health technology assessment to health financing arrangements in Ghana

Ruby Aileen Mensah *National Health Insurance Authority, Ghana*

Over the last two decades, Ghana has made great strides towards UHC, with significant development of its health financing arrangements and priority setting processes. Specific to Ghana is (1) the central place of two main pooled funds, each with its respective provider payment system (the Ministry of Health budget with its line-item financing and the National Health Insurance with its retrospective case-based payment - the first one with an implicit benefit package and the second one with an explicit one) and (2) three main categories of service delivery providers: the public network under the Ghana Health Service, the faith-based facilities represented by the Christian Health Association of Ghana, and a more fragmented private-for-profit sector. De facto, this setup establishes a complex landscape of actors involved in priority setting, with not full overlap of beneficiary population.

In this presentation, an expert from Ghana will present the organization of HTA in Ghana and how different priority setting responsibilities are distributed across entities. She/he will present some relevant progress which has been made in HTA institutionalization, and provide illustrations of impact and integration into guidelines and benefit packages, lessons learned, good practices but also 'pain points'.

Assessing feasibility of health benefit package implementation from a health systems/health workforce perspective in Rwanda

Umuhoza Stella Matutina *National University of Rwanda School of Public Health*

In the past few years, Rwanda has been developing an evidence-informed deliberative process for making decisions to the health benefit package of the national community-based health insurance (CBHI)

scheme. A health benefit package committee was established with multiple stakeholders from the Rwandan health sector and further support structures and methodology were established. A pilot recommendation process was undertaken for cancer services, which led to a recommended set of services officially approved by the Ministry of Health.

The objective of developing a systematic priority-setting process for the Rwanda CBHI, was to have a fair process for making decisions that identifies interventions that provide the most health for the population within the available CBHI budget. The process also serves to improve transparency and accountability among stakeholders including: members, health services providers, fund managers, and policy makers.

While Rwanda is making significant progress in implementing a robust health priority-setting process, there remains further work to do on understanding how the evidence used in the process links with the financing and service delivery on the ground. The link with the CBHI scheme represents a good start and data from the social security agency were used in the assessment and appraisal processes. However, further work can be done to improve understandings of human resource readiness, facility preparedness, and capacity needs assessment. The establishment of a well-capacitated secretariat, or administrative structure, is also a critical learning. There is limited guidance on the steps for developing an implementation plan of health benefit packages in low- and middle-income countries, and a more integrated framework encompassing the entire health benefit package process, with key steps to guide both the design and the implementation of the health benefit package is needed.

A WHO framework for robust institutionalized health benefit design processes

Altea Sitruk *WHO*

An increasing number of countries are recognizing the importance of evidence-informed priority-setting processes for health benefit design, and many are taking steps towards the institutionalization of such processes. However, these processes often do not achieve their promised potential of advancing UHC, as they fall short of incorporating important implementation considerations including the health financing architecture and service delivery capacity. As such, a framework for health benefit design that incorporates understanding of the financing environment, priority-setting space, and realistic considerations of implementation will be presented.

Current thinking on the linkages between priority-setting, health financing and implementation considerations in benefit design will be presented with the objective of identifying gaps that may respond to current country challenges and laying out the basis for a rich discussion.

The integrated framework attempts to systematically identify key gaps and considerations to advance linkages between priority-setting and health policy and planning instruments. This is expected to enable

the audience to visualize the issues for discussion and to increase awareness of resources available to support country processes.

Investing in Health Systems Post COVID

A process evaluation of the implementation of COVID-19 vaccine deployment in Kenya

Stacey Orangi, MPH, BPharm[1], Daniel Mbuthia[1], Elwyn Elizabeth Chondo[2], Carol Ngunu[3], John Ojal[4] and Edwine Barasa[5]

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(4) KEMRI-Wellcome Trust Research Program, Kilifi, Kenya,
(5) Health Economics Research Unit,KEMRI Wellcome Trust Research Programme, Nairobi, Kenya

Background

COVID-19 vaccines were introduced in Kenya in March 2021. To ensure availability of vaccines to the target population, compliance to national guidelines is pivotal especially in relation to delivery activities such as: regulation, procurement, planning and coordination, budgeting, supply chain, training, safety surveillance, data management, service delivery and demand generation. In response, this study aimed to examine the implementation experiences of the COVID-19 deployment process and its influence on access, to inform future pandemic response or future vaccines rolled out to the adult population.

Method

We conducted a cross-sectional qualitative study in two purposively selected counties in Kenya (urban and rural). We collected data through in-depth interviews with national level health officials, developmental partners, county and sub-county health managers, and front-line workers (n=30). Data was analysed using a framework approach in line with the study's conceptual framework.

Results

COVID-19 vaccine delivery activities resulted in increased access to COVID-19 vaccines. In practice, most deployment activities (regulation, vaccine supply chain, service delivery, supervision) leveraged on existing systems and were integrated with other routine processes, resulting in increased efficiency. A mixed approach to service-delivery (facility-based, outreaches and campaigns) increased vaccine reachability.

The electronic data management system for COVID-19 vaccines has been instrumental in ensuring real time registration, vaccine administration tracking, stock management, and production of reports, resulting in timely availability of vaccines and limiting expired vaccines. Despite these strengths, some challenges persist. First, stock outs at a national level of different types of vaccines presented a barrier to uptake due to vaccine preferences or eligibility criteria for certain population groups. Second, financing for some deployment activities was insufficient and was mainly done through supplies and equipment sourced from national government or through donor support, with limited financial autonomy at county and facility level. Additionally, despite demand generation efforts mainly involving community health volunteers, leaders and outreaches, vaccine hesitancy remained a pertinent challenge.

Conclusion

Our findings highlight the importance of pandemic preparedness including addressing public finance management bottlenecks, resource mobilization, adaptable health systems that can be leveraged on for vaccine deployment during pandemics. We also highlight the importance of multi-sectoral approaches including capacity building for local vaccine manufacture and leveraging on electronic data systems to alleviate inequities and promote just and sustainable vaccine access. These may serve as a transferable learning for low-and middle-income settings facing similar challenges. Further, we emphasize the need for process evaluations to track program implementation and address challenges.

Strengthening Civil Society Engagement for Effective COVID-19 Response in Nigeria

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(2) Health Systems Consult Limited, Abuja, Nigeria

Background

In March 2020, the WHO declared COVID-19 a pandemic, emphasizing the need for resilient health systems and robust responses to diseases of public health concern. To battle the pandemic, the Nigerian Government established structures and rolled out several initiatives to control and mitigate the challenges. However, in the implementation of these response actions and initiatives, the role of Civil Society Organizations (CSOs) was not fully leveraged, and this impacted the effectiveness of the government's community engagement efforts. Nigeria's response, while comprehensive, underutilized CSOs, impacting community engagement.

Aims and Objectives

The project aimed to address this gap by improving the coordination and mobilization of a multi-sector Civil Society Response to COVID-19 to mitigate community transmission and minimize the health, social and economic impact of COVID-19 at the subnational and community level.

Methodology

The project focused on four pillars: coordination, capability, communication, and accountability. Coordination improved linkages between state and federal CSOs, amplifying community voices. Communication enhanced transparency and stakeholder information sharing. Capability was strengthened through gap assessments, training and monitoring, while accountability evaluated response effectiveness and resource mobilization. Through virtual engagements, co-creation workshops were organized to map multisectoral CSOs and co-define key indicators across the four pillars.

Key Findings

The forty-three (43) empowered CSOs contributed to awareness creation activities, training, projects, and advocacies. Simplified multi-sectoral guidance documents were developed, including guidelines for reopening of schools and worship centres, advisories for vulnerable groups, safe management of dead bodies, and self-isolation. Contextual information on government and community response to the pandemic that can be leveraged by the government in improving current response actions for COVID-19 as well as plan for future pandemics was generated. This resulted in seven states comprising Plateau, Anambra, Ebonyi, Niger, Ekiti, FCT and Kaduna States - achieving the milestone of having a CSO incorporated as a member of the state COVID-19 task force team following several engagements of CSOs with state actors.

Conclusion

CSOs have played a vital role in improving the COVID-19 response. This was achieved through capacity building, effective risk communication, peer learning, policy dialogues, and accountability activities. CSOs led discussions with stakeholders advocating for necessary response enhancements. To ensure sustainability, we boosted CSOs' capacity and established a policy engagement framework, ensuring ongoing engagement in our quest for an effective COVID-19 response.

Epidemics as opportunities for social transformation: a policy framework on collateral effects of responses to epidemics in West-Africa

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(6) Institut de Recherche en Sciences de la Santé (IRSS), Ouagadougou, Burkina Faso

Background

In 2020-2021, the global excess mortality– was estimated at 14,91 million. However, only 5.45 million deaths were directly attributed to COVID-19 indicating 9.5 million "collateral" deaths during the SARS-COV2 pandemic. Eighty-six percent of this excess mortality occurred in Low-and Middle-Income Countries including West-African countries. Collateral deaths, and other collateral effects resulting from societies response to epidemics, must be explicitly accounted for in the formulation and implementation of epidemic response plans, in West Africa.

Aim

This paper presents the processes and key attributes in the production of a generic policy framework in accounting for collateral effects of epidemic responses on health systems in West Africa.

Method

The West-African Network for Emerging Leaders in Health Policy and Systems (WANEL) served as a space of co-creation and co-learning between health policy and systems researchers and practitioners. After the beginning of the pandemic, the network developed and implemented the RECOVER project. Within the RECOVER project, and through a series of stakeholder's engagement comprised of policy makers, researchers, academicians and healthcare practitioners, findings of a rapid assessment exercise across 14 West-African countries in 2021, and five in-countries deep dive case studies, provided content for construction of the framework.

Aim

The co-creation of the framework concluded that effects of epidemics can be framed as:

Level 1: morbidity and mortality naturally brought up by the pathogen responsible for the epidemic

Level 2 Effects: mediated by the societal response to the epidemic that include targeted and collateral effects of the responses. In terms of principles and values, the policy framework states that epidemic responses should be:

- people-centered
- respect the "First do no harm

Level 3: used as transformative opportunities to promote gender equity and social justice

Level 4: grounded on context-sensitive evidence, systems thinking, multi-sectoral collaboration and social trust. Key three meta-strategies suggested in the policy framework include:

- prevent the occurrence of collateral effects of epidemic responses by using various strategies including evidence and systems thinking during epidemic response plans formulation and evaluation
- monitor timely the collateral effects of epidemics and react timely to correct them
- develop and implement prospective policy approaches for continuous learning on the political economy drivers around the epidemic response, and for active adaptation.

Conclusion

The policy framework provides context sensitive strategies, that can be adapted by countries and organizations for accounting for collateral effects of response to epidemics in West Africa, and beyond.

Keywords

Policy framework, West Africa, Collateral effects, Epidemics, Vulnerable groups, Epidemic response, People centered.

Enhancing Public Health Emergency preparedness and responses in Africa through Data and Knowledge Sharing: A Scoping Review

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(4) London School of Hygiene & Tropical Medicine, London, United Kingdom

Background

Public health emergencies require robust and coordinated responses to mitigate their impact on communities and prevent the spreading of infectious diseases. In public health emergencies, data sharing aids in the early identification of disease outbreaks, monitoring disease progression, and adjusting strategies as needed.

Aims and Objectives

This scoping review aimed to identify the national, regional, and global capacity to support data and knowledge sharing within and between African countries and the international community.

Methodology

We conducted a scoping review of literature between 2010 and 2024 to identify relevant studies on data-sharing components of pandemic preparedness and response in Africa. Electronic data bases like Embase, PubMed, Scopus, Web of Science, and Google Scholar were utilized to perform the search. The search strategy included keywords like data sharing, evidence-based decision-making, priority setting, and pandemic. We selected articles based on inclusion and exclusion criteria and developed a data extraction template, themes and sub-themes were identified and reported. The report was prepared in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) guidelines.

Key Findings

The Ebola and COVID-19 pandemics highlighted the need for open data sharing in Africa. The Africa CDC encourages regional collaboration in disease surveillance, data sharing, and outbreak responses. Global frameworks and platforms exist to improve international and regional data sharing during pandemics. These initiatives facilitate the exchange of epidemiological data, genetic sequences, research findings, and operational information, promoting a coordinated and evidence-based approach to pandemic control. Although the pandemic led to a surge in data exchange, it did not align with findable, accessible, interoperable, and reusable principles. The key challenges in data sharing in Africa include data availability, no standardized approach for data collection and reporting, poor technological infrastructure, data fragmentation, lack of trust, and data privacy. To improve data sharing, infrastructure improvement, uniform data standards and protocols, collaboration, and promoting ethical data exchange are crucial.

Main Conclusions

Global collaboration and data sharing on public health emergencies are crucial for combating infectious diseases. Open data sharing between scientists and health workers can enhance preparedness and faster response to disease outbreaks, thereby enhancing pandemic preparedness.

The role of existing structures and past experience in a successful COVID-19 vaccination strategy: The experience of Rwanda.

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Background

Rwanda was the only country in Sub-Saharan Africa that attained the WHO target of 40% population fully vaccinated by December 2021 and almost 70% population fully vaccinated by June 2022. The objective of the study was to identify the key factors that contributed to this success to provide lessons to the global community for preparation for future pandemics.

Methods

We conducted a political analysis using the Tony Blair Institute framework to identify the key factors to the vaccine campaign success. The components of pre-delivery, delivery and post-delivery strategies were examined. The four essential pillars for success as described in the framework were; whole government co-ordination; a tailored approach to deliver; digital data and technology infrastructure and pro-active communication with the public.

Results

The results showed the Rwanda fulfilled each of the essential pillars for success. A multisectoral approach was deployed from the outset both at central and decentralised levels. The approval, procurement, storage and transportation of vaccines to target population was data driven. Rwanda profited from high access to internet and a fully functioning online data-base that could be adapted and utilised using local expertise. Finally, existing community structures were leveraged to sensitise, reach and follow-up the population living in both urban and rural areas.

Conclusion

Other low- and middle-income countries can use the lessons identified in this study to build a foundation for future health crises.

Addressing Health Inequities and Financial Barriers in African Healthcare Systems

3:45 PM–5:15 PM Wednesday, 03 March 2025

Catastrophic expenditure due to out-of-pocket health payments and its determinants among women receiving cervical cancer treatment at a tertiary hospital (Groote Schuur Hospital) in Cape Town, South Africa

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Background

Cervical cancer is the second most incident female cancer and the leading cause of cancer deaths among females in South Africa. As the country intensifies efforts toward Universal Health Coverage (UHC), it is crucial to assess financial protection related to specific diseases, such as cervical cancer. Despite substantial government healthcare subsidies, our hypothesis posits that cervical cancer patients still incur significant out-of-pocket (OOP) expenses, leading to Catastrophic Health Expenditure (CHE), particularly given the chronic nature of the disease.

Objectives

The study aims to :

- Quantify out-of-pocket spending incurred during cervical cancer treatment.
- Examine how this spending varies by stage of disease
- Examine the incidence of CHE and stratify this by stage of disease.
- Investigate the determinants of CHE and (5) Examine various cost-coping mechanisms adopted by patients.

Methods

Analysis used a cross-sectional survey data from Groote Schuur Hospital in Cape Town, South Africa,

involving women undergoing treatment across all cervical cancer stages (Stages I-IV). The data include sociodemographic and clinical characteristics, cervical cancer-related OOP healthcare payments in the past 30 days, living conditions, monthly household expenditures, and cost-coping mechanisms. For analysis, OOP payment areas are identified, quantified, and then stratified by disease stage. A novel method, using disease-specific thresholds from national household surveys, was employed to calculate CHE, avoiding underestimation by traditional methods which apply unadjusted thresholds. The assessment was stratified by disease stage. Multivariate logistic regression then used to determine the sociodemographic and clinical factors associated with CHE. Cost-coping mechanisms are analysed as proportions and stratified by disease stage and socioeconomic status (SES).

Preliminary Results

Transport costs are the largest OOP expense, constituting about 40% of total costs. CHE is prevalent, especially among women in lower SES groups, with nearly 60% in the lowest quintile experiencing CHE. The incidence of CHE escalates with the disease stage, from 25% in Stage I to over 75% in Stage IV. Factors such as low SES, lack of health insurance, living outside Cape Town, residing in a female-headed household, and comorbidities significantly increase the likelihood of CHE. Cost-coping mechanisms include informal loans, asset sales, and reduced essential expenditures, particularly in advanced disease stages.

Conclusions

Since transport costs account for a significant portion of OOP expenses, the government should consider providing transport subsidies for women receiving treatment. Additionally, decentralizing cervical cancer treatment services could reduce the need for distant hospital visits, thereby alleviating financial burdens on patients.

Keywords

Catastrophic Healthcare Expenditure, Cervical cancer, Health financing, Expenditure (CHE), Universal Health Coverage (UHC).

Informal Payments for Healthcare at Public Health Facilities in Kenya: Influencing Factors and Effects on Equitable Access to Care

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(2) Department of Global Health and Development, London School of Hygiene and Tropical Medicine, London, United Kingdom

Background

Informal payments are payments made by a patient to a health provider in addition to the officially determined service fees. In 2021, 15% of Kenyans had paid informally to access health services at public facilities. Informal payments limit access to care and expose individuals to financial hardship.

Objectives

This study examined the supply, demand, and contextual factors influencing informal payments at public health facilities in Kenya and their effects on equitable access to care.

Methods

We conducted a qualitative study at 8 public health facilities (4 hospitals and 4 health centres) in two counties (urban and rural). Study participants were identified through purposive sampling. We conducted 8 focus group discussions (4/county) with a total of 79 patients seeking different health services, and in-depth interviews (n=35) with health workers, non-clinical staff, and county and sub-county health managers. Data were analysed using a thematic approach.

Findings

Regarding the supply-side, informal payments were more common for: services that were charged user fees compared to free services, outpatient, specialist, pregnancy termination, and non-routine/seasonal services such as voluntary medical male circumcision, especially at primary health facilities. Low, delayed, and lack of salaries for some cadres, delayed and unfair promotions, understaffing, and individual morals were the main human resource factors reported. We found informal charging to be more likely at health facilities with high patient workloads, long waiting lists, inadequate supervision, and those that lacked drugs/supplies/services. On the demand side, patients paid informally to access services/drugs/supplies, to receive higher quality care mainly through reduced waiting times, and to reduce financial hardship from health costs for example by paying reduced inpatient bills. Within the broader context, widespread corruption within the public sector, lack of/inadequate sanctions, and harsh economic times influenced informal charging. The inability to pay informally exposed patients to injustices in access such as delayed/denial/foregoing of care and discrimination based on ability to pay. Informal payments exposed vulnerable groups especially the poor and informal sector members to financial hardship.

Conclusion

Factors associated with informal payments were largely linked to health system inadequacies and inefficiencies in health financing and governance functions. Policy considerations that can reduce health inequities associated with informal charging include increasing public spending to ensure the availability of services, commodities, and human resources while ensuring fair remuneration and strengthened .oversight. Enhancing public awareness of service entitlements, costs, and grievance redress mechanisms,

Healthcare financing for refugees: a literature review of approaches towards integration with national health systems

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Background

As the number of refugees increases and displacement becomes protracted, providing equitable, accessible and quality healthcare in (financially) sustainable ways is increasingly challenging. The Global Compact for Refugees calls for greater inclusion of refugees in national health systems. However, the evidence base is thin on the most suitable approaches to achieve integration.

Aims

This study reviewed normative and empirical literatures on health financing for refugees, reflecting on different arrangements, their level of integration with national health systems and their impact on the health of refugees and hosts.

Methods

More than 50 documents, including peer-reviewed papers and grey literature were included. Data was analysed following the WHO's health financing framework, reviewing the core function arrangements (raising revenues, pooling, purchasing, benefit packages) and reflecting on the impact of those arrangements on final UHC goals (utilisation, financial protection, quality).

Findings

Health financing for refugees is diverse and context-specific, with variations between and within countries depending on refugees' nationality, location and status. Health financing arrangements vary also in relation to integration, ranging from parallel financing - where funding sources are external, pooling is limited to refugees (or a subset of them), purchasing is through NGO contracting, and services are free at the point of use - to integrated financing, where arrangements are the same as the host population's, although usually this is applicable to a minority of refugees (e.g. those covered by national insurance) and in reality a patchwork of mixed approaches exists. Innovations have focused mostly on raising revenues (through the Global Concessional Financing Facility, impact bonds, etc.), and less on other financing functions.

Although limited, evidence shows that health financing arrangements impact equity and access, but also

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health outcomes for refugees and hosts. Additionally, they have different cost and cost-effectiveness implications, with parallel health financing often considered inefficient, though evidence is weak.

Conclusions

The review presents empirical evidence on health financing for refugees and its integration. A key message is that integration is to be understood along a spectrum, with (observed and ideal) levels of integration varying across financing functions and for subsets of refugees. Importantly, integration necessarily reflects the arrangements of the national health system. Where the health system is weak and financing is pluralistic and inequitable, this is mirrored in the integrated health financing arrangements for refugees. While integrating health financing is seen as advantageous in terms of sustainability, effectiveness and continuity of care, gaps remain in the evidence-base.

Healthcare disparities in household out-of-pocket spending among urban slum dwellers in Southeast Nigeria

Okechukwu Timothy Ozor[1], Chukwudi Nwokolo[2], Aloysius Odii[3], Noemia Teixeira de Siqueira Filha[4], Joseph Paul Hicks[5], Shushan Li[4], Uchenna Rita Ezenwaka[1], Bryony Dawkins[5] and Obinna Emmanuel Onwujekwe[1]

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(5) School of Medicine, University of Leeds, United Kingdom

Background

Urban slum dwellers face economic barriers when accessing healthcare due to inequal financial health systems, primarily funded out-of-pocket.

Aim and Objective

This paper examines the economic burden and inequalities in out-of-pocket expenditures (OOPEs) to access healthcare in urban slums in Nigeria.

Methods

The cross-sectional study was undertaken in eight purposively selected urban slums in Enugu and

Anambra states, Southeast Nigeria. Participants (n=1,025) were randomly selected to respond to a pre-tested questionnaire collecting data on socio-economic characteristics, access to healthcare, and OOPE. Gamma regression was applied to estimate the mean difference in OOPE by socioeconomic groups and characteristics of healthcare utilisation. Inequality in OOPE was estimated by using financing incidence analysis and computing the Gini, Concentration, and Kakwani indices.

Key Findings

Residents of Enugu and individuals with formal occupations incurred lower costs than the residents in Anambra (-2,854; $6) and those employed in informal occupations (-1,296; $3). Households on the average wealth quintile incurred higher costs than those on the poorest quintile (5,692, $13). The Gini index (0.585) indicated an equal distribution of the ability to pay (ATP) across wealth quintiles. The concentration index (0.695) indicated OOPE concentrated amongst the richest households. The Kakwani index (0.110) indicated a more progressive financing system, with the richest contributing proportionately more than their share of ATP. Poorest households used informal healthcare services more often than the wealthier households in both States (23% vs 16%).

Conclusion

Although payment for healthcare in urban slums is progressive, the poorest households still suffer the most in accessing quality healthcare in Nigeria. Our findings highlight the role ATP may play in healthcare denial among the urban poor who are priced out of the formal health system. Health insurance schemes and policies integrating formal and informal healthcare can reduce the financial burden of healthcare access for the urban poor.

Examining the Socioeconomic Inequalities in Ideal Cardiovascular Health in Kenya: A Decomposition Analysis

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University of Sheffield, Sheffield Centre for Health and Related Research (SCHARR), Sheffield, United Kingdom

Background

In recent decades, Kenya has seen a significant increase in cardiovascular diseases (CVDs), necessitating urgent action to address the rising risk factors. Past research has identified inequalities favouring the wealthy in both hypertension prevalence and access to antihypertensive treatment in Kenya. However,

there is limited evidence on socioeconomic disparities in ideal cardiovascular health (iCVH), which evaluates the population's CVH using eight metrics. This study examines socioeconomic inequality in overall iCVH in Kenya, explores gender differences, and identifies the drivers behind these disparities.

Methods

Utilizing data from the 2015 WHO STEPwise survey on non-communicable disease risk factors, the study classified individuals with iCVH if they met 5-7 of the following metrics: tobacco exposure, fruit and vegetable intake (FV), physical activity (PA), body mass index (BMI), fasting blood glucose (FBG), blood pressure (BP), and cholesterol levels, as per the American Heart Association 2010 standards. The concentration index (C) measured socioeconomic inequalities in iCVH. A Wagstaff-type decomposition analysis identified the factors contributing to these inequalities, and sensitivity analyses assessed gender differences.

Results

The study included 3,803 adults aged 18-69. A positive overall concentration index ($C = 0.084$; $p = 0.006$) indicated iCVH was more prevalent among wealthier individuals. Significant pro-rich inequalities were found in ideal BMI ($C = 0.314$; $p < 0.001$), BP ($C = 0.156$; $p < 0.001$), and cholesterol ($C = 0.148$; $p = 0.005$). Conversely, pro-poor inequalities were noted in ideal tobacco exposure ($C = -0.098$; $p = 0.012$) and FV intake ($C = -0.090$; $p = 0.048$). No significant disparities were observed in ideal FBG ($C = -0.028$; $p = 0.534$) and PA ($C = 0.052$; $p = 0.291$). Gender-specific analysis showed significant pro-rich inequalities in iCVH among females ($C = 0.109$; $p = 0.006$) but not males ($C = 0.071$; $p = 0.128$). The decomposition analysis explained 73.1% of the overall iCVH inequality, with wealth (31.4%) and urban residence (30.6%) as primary contributors, followed by region (16.4%), education level (8.6%), alcohol intake (5.5%), ethnicity (5.3%), age (1.6%), and occupation (0.6%).

Conclusion

The study reveals significant pro-rich inequalities in iCVH in Kenya, with more pronounced disparities among women. These inequalities are mainly driven by wealth, urban residence, and education levels. The findings underscore the need for equity and gender-focused health interventions, particularly targeting poorer, less-educated populations in urban areas

Healthcare Purchasing, Capitation, and Quality Improvement Strategies

3:45 PM–5:15 PM Wednesday, 03 March 2025

Improving efficiency in provincial procurement through strengthening digital systems to manage public sector tenders.

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Background

The lack of digital real-time tracking for contract stages makes it difficult to determine a contract's status in the tender acquisition process, which takes an average of 509 days from Demand Memo to Letter of Award. Only 22% of contracts reach the service level agreement stage, leading to poor execution of the procurement plan. To address this, the Tender Management Application was developed to digitize the process and provide real-time tracking.

Description of intervention

The Tender Management Application enhances the efficiency of the tender acquisition process for the Eastern Cape Department of Health (ECDoH). It automates key tasks using Microsoft Power Apps and SharePoint, streamlining the workflow and integrating with existing NdoH systems. The application requires digital copies of contract documents to be uploaded and centrally stored on SharePoint, where they are logically filed and automatically renamed to improve standardization.

The Tender Management Application is poised to revolutionize supply chain management within the ECDoH. By providing access to real-time data and actionable insights, it will enable the department to optimize its resources, reduce operational costs, and enhance the execution of yearly procurement plans.

Results

An impact survey will be conducted later in the year however from the initial pilot of the application in 2023 at the ECDoH Supply Chain head office in Bhisho. Supply chain managers from various units such as demand, acquisition, procurement and inventory, contracts and record management including risk & compliance. All provided positive feedback after receiving practical training on using the applications functions. They stated the system provides oversight to everyone involved in the tender process.

Lessons Learnt

Implementing such an application requires sufficient stakeholder engagement to ensure they take ownership of the application.

Key Messages

This is a cutting-edge solution designed to enhance transparency, efficiency, and real-time monitoring in the procurement process of the ECDoH. It aligns with the department's strategic goals and ensures optimal resource management.

Advocacy Message

We urge the Eastern Cape Department of Health to endorse and invest in the Tender Management Application. This innovative tool will revolutionize supply chain management by providing real-time data, streamlining procurement processes, and fostering transparency.

Keywords

Transparency, Tender Management, Monitoring

Prescription Drug expenditures and utilization - examining policy, enablers and access factors -a case of the US State Medicaid

Kwesi E Eghan *Management Sciences for Health, Arlington, VA*

Background

Prescription drug expenditures and utilization are the fastest growing and most widely varying Medicaid programs. The Affordable Care Act (ACA) passed in 2010 and its subsequent state expansions resulted in substantial health insurance coverage. Recognizing the determinants of state-level pharmaceutical expenditures influences priority and budget setting, effective pharmaceutical expenditure control strategies, and effectiveness of resource allocations.

Aim

To identify the predictors of state-level Medicaid drug expenditures, examine the effects of the interactions between drug expenditure predictors and estimate a Medicaid pharmaceutical use and expenditure model

Methodology

Utilizes a cross-sectional, retrospective study on secondary health insurance claims and state-level

demographic, policy and health service need data. The dependent variable, total Drug Expenditure is measured as prescription medicines reimbursed per eligible resident per year (Medicaid drug Per Capita Exp). Anderson's behavioural model of health services use was adopted as the conceptual framework to identify and analyse the 53 independent variables employing a state level panel data set covering the period 2009-2015 (n=350) before and after the ACA to examine the importance of demographic, need for health care, economic and policy variables for explaining variations in per capita Medicaid pharmaceutical expenditures all US states (n=350). We perform an econometric analysis to estimate parameters for the regression model. Without a prior knowledge of best fit model estimates for drug expenditures within Medicaid both fixed effect (FE) and random effect (RE) panel regression models were estimated

Results

Estimated coefficients reveal significant influences on drug expenditures from state non-drug Medicaid spending, proportion of males in the population, and provider education programs on generics. The random effects (RE) regression model explains 52.6 % of variation in the dependent variable, a very good fit for panel data. Coefficients for several variables included in the model, (e.g., Per capita prescriptions, proportion of males, and provider generic education were not statistically different from zero. Including an interaction term between ACA Expansion and the percent of state Medicaid expenses reimbursed by the Federal government yielded a negative -significant effect on state level drug expenditures.

Conclusion

The study adds to the conceptual understanding of the determinants of pharmaceutical expenditures within health systems and within third party health payer programs in support of Universal Health coverage.

Critical Analysis of Healthcare Purchasing Practices in Niger State, North Central Nigeria: Progress, Challenges & Opportunities for enhanced Strategic Purchasing

Charles C Ezenduka *University of Nigeria Enugu Campus, Enugu, Enugu, Nigeria*

Background

Effective implementation of strategic health purchasing (SHP) remains critical to achieving Universal Health Coverage (UHC), through enhanced system performance. Countries committed to UHC have made progress towards SHP to optimize attainment of health system goals. The study examined the purchasing practices in the Niger state healthcare system to assess and identify progress, challenges and opportunities for SHP.

Methods

The study critically analysed the Niger state's health financing schemes to assess their purchasing practices using a descriptive qualitative case study approach. Data was collected from a comprehensive review of relevant documents as well as in-depth interviews with key stakeholders in the state's health system. Information on external factors and governance, purchasing practices, and other capacities in the state's financing schemes were collected. Analysis was guided by the SPARC recommended framework for examining purchasing practices for progress towards SHP.

Findings

The SMOH is the dominant provider/purchaser of healthcare in the state, with other agencies possessing purchasing functions. A governance and accountability structure is led by the Commissioner for Health through the SMOH across departments and agencies with clear lines of responsibilities. Government commitment towards UHC has led to development of policy and regulatory frameworks for SHP, revitalization of PHC facilities for improved service delivery, and establishment of the state's health contributory scheme NICARE, all of which support SHP objectives. However, budget allocation for healthcare remains very inadequate due to poor revenue sources, which constrain SHP objectives. As an integrated system, the SMOH lack purchaser-provider split as providers are not selected based on quality-of-service delivery and performance. Provider performance monitoring is weak with limited incentive to drive performance. Provider payments through salary and line-item budget do not promote quality and efficiency of service delivery. There are no clear channels between the SMOH and the citizens to provide timely feedback on service delivery. Capacity for strategic purchasing is very limited but willingness to receive technical support is high.

Conclusion

Healthcare purchasing in Niger state remains largely passive given the operation of public integrated system which portends impediments to SHP. However, significant progress has been made towards SHP in the state. Health infrastructure upgrade, establishment of contributory health scheme among significant policy and regulatory frameworks represent major progress towards SHP. Strong government's commitment towards UHC, strengthening of the contributory health scheme and availability of technical support, among other recommended measures will boost implementation of SHP in the state for progress towards UHC.

Understanding the experience and perceptions of providers and purchasers for payment methods in Tanzania.

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(4) London School of Hygiene & Tropical Medicine

Background

Many Low- and Middle-Income Countries are reforming health financing systems to achieve Universal Health Coverage (UHC). Given that there are limited resources for health, a recent move has been toward strategic purchasing of health services. This requires strategic decisions on purchasing services, provider selection, establishing contractual agreements and efficient provider payment methods (PPMs). PPMs create different incentives that influence healthcare providers (HCPs) to enhance efficiency, quality, and utilization of needed health services. Tanzania plans to start implementing universal health insurance (UHI), but this may require robust evidence in designing the scheme including PPMs. Despite these efforts, the experiences and perceptions of HCPs and purchasers are overlooked in designing PPMs, leading to implementation challenges. We aim to fill this gap in Tanzania.

Methods

A qualitative research design was used. We conducted 40 in-depth interviews with HCPs and purchasers, and 2 focus group discussions with community representatives from two regions (Manyara and Singida) in Tanzania. HCPs included healthcare workers from 20 facilities and four health managers at the district level in selected regions. Transcribed interviews were analyzed thematically to identify key findings.

Results

Two common payment methods, capitation and fee-for-service (FFS), were highly discussed around several characteristics of PPMs, including revenue contribution, predictability of the payment amount, adequacy of the payment rates, timeliness, accountability mechanisms, and autonomy to allocated resources. Capitation for the Health Basket Fund (HBF) and FFS for the NHIF were perceived as significant revenue contributors, while capitation for the Improved Community Health Fund (iCHF) and Social Health Insurance Benefits (SHIB) was seen as not contributing enough. FFS for NHIF is seen as more predictable, while capitation funds across various schemes were not, due to unclear adjustors, payment delays and unclear enrolment numbers. Both payment rates were perceived as inadequate to cover the service cost, partly because of low rates or deductions. Common challenges in both methods include system issues. Both methods lacked autonomy in spending allocated funds. Finally, FFS was preferred for motivation, while capitation was valued for its reliability in some cases.

Conclusion

The experiences of HCPs and purchasers highlight key insights for consideration when designing a PPM for UHI in Tanzania. They recommended enhancing the transparency of payment adjustments, ensuring timely disbursements, and increasing autonomy in fund allocation. Also, aligning payment rates with service costs and simplifying administrative processes could improve the effectiveness of both methods.

Keywords

Capitation, Fee for service, Primary healthcare, Provider payment methods.

When The Capitation Design Model Is adjusted To Sustainably Fit Primary Healthcare Facilities in Rwanda

Alexis Rulisa, Regis Hitimana, Ina Kalisa, Jean Marie Vianney Hakizayezu and Eric Rubyagiza,

Rwanda Social Security Board (RSSB), Kigali, Rwanda

Background

Rwanda introduced the Community Based Health Insurance (CBHI) since 1999, covering closer to 90% of the population in 2024. Its management is under Rwanda Social Security Board (RSSB) since 2015. The CBHI sustainability plan developed in 2021 recommended, among key strategic purchasing reforms, to change the Provider Payment Mechanism (PPM) in primary healthcare facilities from Fee-For-Service (FFS) to capitation meant for efficiency and sustainability. The study aims at customizing the capitation design model to fit the context of Rwanda.

Methodology

Quantitative historical data of payment from CBHI to health centers (HCs) and health posts (HPs) in the fiscal year 2023-202 was used to design the PPM, inspired by the literature review on implementation by other countries and the general formula to determine the capitation amount to be paid to HCs was adapted to the local context of Rwanda.

Specific adjustments were made to cater for the fact that HCs are in different utilization zones, thus different capitation rates (per zone). Plus, members are allowed to visit out of network HCs whereby those closer to the Hospital tend to receive many patients for transfer purposes, thus a lower payment per member. Regression analysis was used on historical payment data to estimate model parameters. The modelling process takes the following steps:

Conclusion

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- Assign a utilization group to each HC,
- Assign to each HC a distance to hospital and
- run the regression model using members, HC utilization estimates and inflow members as other model inputs.

Findings

While the model has two parameters, the 1st parameter was estimated to be FRW 912, FRW 1,246 and FRW 1,557 depending on whether the HC is in low, medium and high utilization group respectively. The second parameter, catering for inflows, was estimated to be FRW 907 and FRW 1,239 for HCs whose distance to hospital is below or above 1km respectively. Projections show that nearly 90% of the HCs are within 30% deviation of historical payments. The fixed fee per encounter at HP level ranges from FRW 910 to FRW 1,630 depending on provided services. Capitation amount will be paid before the beginning of the month for HCs while HPs will receive their payments at the end of the month.

Conclusion

The adjustment of the general capitation formula to the context of Rwanda is key to ensure fairness among health facilities, to improve on efficiency in health services delivery and predictability of resources.

How equitable and efficient is financing for reproductive, maternal, neonatal and child health, and nutrition? A case study of Senegal, 2014-21

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Introduction

Reducing the high rates of neonatal and maternal mortality in low- and middle-income countries involves improving health systems and allocating financial resources to reproductive, maternal, neonatal and child health and nutrition (RMNCH-N). In a context of scarce financial resources, funding sources such as the government and donors are therefore challenged to use their financing for RMNCH-N more equitably and effectively than ever before. This study aims to analyse the equity and efficiency of RMNCH-N financing in Senegal.

Methods

We used secondary data from Senegal's National Health Accounts and Yearbook of Health and Social Statistics, including government expenditure, out-of-pockets expenditure (OOP), and donor aid for RMNCH-N, over the 2014-2021 period. We examined RMNCH-N financing trends at national and sub-national levels, equity, and efficiency across Senegal's 14 regions. We analysed the equity of financing using concentration curves and concentration indices. We analysed efficiency by calculating efficiency scores for each region using data envelopment analysis (DEA).

Results

Annual RMNCH-N expenditure in Senegal increased substantially over 2014-21, from 90,873 million FCFA (USD 148 million) in 2014 to 129,260 million FCFA (USD 210 million) in 2021. Households and external donors are the two largest sources of funding over 2014-21. Aid is the only source of funding that allocates its resources in proportion to health needs. There has been an improvement in the efficiency of government and donor funding, excluding OOP, over 2015-20, with efficiency scores of 100% for the Dakar and Thiès regions, the two largest regions demographically and economically.

Discussion

Despite improvements in maternal and child health outcomes seen in Senegal during recent years, resources are not always put to best use. The results show that the government is not taking account of regional health needs in its allocation. In some regions, funds allocated to RMNCH-N in Senegal are being underused or wasted. This points to the need to improve resource mobilization and allocation, while furthering research into the determinants of RMNCH-N funding efficiency in Senegal.

Economic Evaluation and Financing for Health in French-Speaking Countries in Africa

3:45 PM–5:15 PM Wednesday, 03 March 2025

Business model of private dental practices in Côte d'Ivoire

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Background

The economic model refers to the way a company generates or will generate profitability. It is a factor to consider in private dental practices, which are healthcare businesses facing the issue of profitability in an increasingly competitive environment. The present work aimed to study the economic or management model of private dental practices in Côte d'Ivoire for efficient decision-making assistance.

Methods

The cross-sectional descriptive study concerned private dental practices in Abidjan. Data collection was conducted with the owners or managers of dental practices using a self-administered questionnaire. The main variables of interest concerned the economic environment, managerial characteristics, and financial flows of dental practices.

Findings

A total of 50 owners of private dental practices or their managers took part in the study. Less than ¼ of the dental practices (24.0%) were run by women. The preferred areas for setting up dental practices were accessible areas (70.0%), where the population was thought to be solvent (38.0%) and large (30.0%). The dental practice was mainly financed by equity capital combined with a loan from a family member (42.0%). Expenditure represented 90.0% of the dental practice's income and profits 10.0%.

Conclusion

The study showed that the economic environment of private dental practices remains underperforming. The management model used is not always clear. Capacity-building for dentists is needed to improve the profitability of dental practices and thus their sustainability.

Keywords

management, private dental practice, business model, profitability, Côte d'Ivoire

Estimated annual cost of implementing the ProCCM in the Madinani health district, Côte d'Ivoire.

Karna Georges Kone *Muso health, Montréal, QC, Canada*

Background

Côte d'Ivoire, in addition to putting in place a policy of targeted free health care for children and pregnant women, has developed several strategic documents that focus on primary health care and community health in particular. In support of the government's efforts, the NGO Muso has implemented its care model (ProCCM) in the Madinani health district. The ProCCM model has made it possible to ensure the availability and responsiveness of services, by incorporating completely free care and professionally trained CHWs with dedicated supervisors. The ProCCM model of care was implemented in the Madinani district in 2023. All care services are taken into account, including prescriptions and evacuations, for the entire population of the district. This study aims to estimate the overall annual cost of implementing the ProCCM, for the first year.

Methodology

The perspective adopted for estimating costs is that of the programme approach, with the addition of the government's contribution. A bottom-up costing approach was used. Indirect payments by households (hidden costs), as well as the costs of other programmes, have not been taken into account in this study.

Findings

The overall annual cost of implementing the ProCCM in the Madinani district is USD 4.219 million, with 86% coming from the Muso project and 14% from the Government of Côte d'Ivoire. The annual cost according to the Programme approach is USD 3.484 million, or USD 36.8 per capita. The per capita cost varies between US$22.4 (Koura CS) and US$93.1 (Gbongaha CS). The largest cost items are medicines (40%), operation support costs (20%), equipment (18%) and salaries (12%). Fixed costs account for 35% of total annual costs, or US$13.1 per capita. The variable cost represents 65% of the total annual cost, or US$23.7 per capita. The drug cost per capita is $16.4 US. The cost of the drug per patient is $14.4. The average unit cost for an evacuation referral is $578, more than 15 times the per capita cost of the ProCCM (US$36.8). The cost at community level represents 11.5% of the total cost of the ProCCM, or $4.2 per capita.

Conclusion

The cost per person served is lower than the per capita health expenditure in the RCI. The cost per person served at community level is close to that obtained in Mali (US$3.44 per capita and US$2,409 per CHW). This cost would appear to be sustainable for national scale-up.

There is an opportunity to reduce the cost per person served by optimising the level of variable cost (65% of total cost) and the cost of medicines, with control of the supply chain.

DRC EAF Cost Effectiveness Study.

Louis Tshituka[1], Nneoma Ekwem[2], Mariam Zameer[3]

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According to estimates for 2022, approximately 14.3 million children worldwide are considered to be zero-dose children. As one of the countries with the highest number of ZD children in the world, the DRC faces a significant public health challenge, as these children are at risk of vaccine-preventable diseases (Daniel Katuashi Ishoso et al., 2023).

Among the interventions that have been implemented in the state to reduce the prevalence of zero-dose children in the country are the Mashako Plan and initiatives that have targeted vulnerable provinces. The Mashako Plan began in 2018 and aimed to reach a target number of zero-dose children by leveraging the immunisation programme in DRC.

Low immunisation coverage and recurrent outbreaks in some regions have highlighted the need to improve outbreak responses and the existing vaccine distribution system. One of the response plans is Gavi's Equity Acceleration Fund for the reduction of zero-dose and under-vaccinated children (in French, Fonds Accélérateur de (FAE)), which builds on the Mashako 2.0 Plan. The fund aims to reduce the number of children receiving a zero dose by 35% by 2025. The funds complement existing GAVI support to the DRC.

Given its potential benefits and the paucity of published data on distributional impact, a cost and cost-effectiveness analysis is underway to assess the cost-effectiveness of this programme from a distributional perspective on inequalities in health outcomes and access, particularly the reduction in zero-dose and under-vaccinated children.

To do this, the evaluation will adopt a mixed-methods approach involving primary and secondary data collection at baseline and endline. The baseline period is between October 2023 and March 2024. The

final period is 9 months after the implementation of the interventions. To understand the costs, we adopt the perspective of the healthcare payer - the donor for high-impact interventions. This evaluation is divided into two (2) parts: i) cost analysis and ii) cost-effectiveness analysis.

Economic feasibility study for the establishment of rapid and universal access to healthcare in a health zone in Côte d'Ivoire

Karna Georges Kone *Muso health, Montréal, QC, Canada*

Background

Despite a rapidly growing economy and a dynamic administration, Côte d'Ivoire has the resources to remove barriers to healthcare access. The country has implemented a targeted free healthcare policy for children and pregnant women, followed by a universal health insurance policy. To support the Ivorian government in this vision, the NGO MUSO has implemented a pilot project for rapid and universal access to primary healthcare in the Diapé health area. This study aimed to estimate the cost and sustainability of universal access to healthcare at the level of ESPCs in Côte d'Ivoire. Moreover, financing mechanisms for the cost of universal access were analysed.

Methodology

Data collection was carried out in two phases: i) first phase: collection of financial data on the level of use of the health centre in 2018; ii) second phase: collection of the same data for 2019 and 2020. In addition to these data, a literature review was carried out on the organisation of primary healthcare provision, on the various studies of the costs of previous care and on health financing policy. The financing requirement was estimated solely on the basis of the direct costs of patient care.

Findings

The epidemiological profile shows that the following diseases are the most important: malaria, diarrhoea, moderate malnutrition and diabetes. The service utilisation ratio in 2018 was 0.39 contacts/year for children. With the current level of use of services at the Diapé CSR, we estimate the cost of the first year of free care at 11.5 million CFA francs for direct care for medicines; 3.7 million CFA francs for consumables; 21.3 million CFA francs for additional staff; and 1.5 million CFA francs for the operation of the COGES. The introduction of free services could multiply by 3 the current level of use of services, which would represent a need for additional funding.

The financing mechanisms identified for making universal access operational are: CANAM's Medical

Assistance Scheme (RAM); the FBR; direct financing of ESPCs by the micro-plan; or a combination of these three financing mechanisms.

Conclusion

The operationalisation of universal access to primary healthcare is struggling to be achieved due to a lack of convincing data. This study has provided us with the information we need to make the right political decisions. The introduction of the UHC is a sustainable and effective solution, as it will increase the use of services and reduce catastrophic expenditure, which is a source of household impoverishment.

Implementation of the programme budget at Senegal's Ministry of Health and Social Action (MHSA)

Cheikh Tidiane Bathily *Regional Health Directorate of Saint-Louis, Saint Louis, Senegal*

Background and Objective

The WAEMU adopted six new directives in June 2009 that form the new harmonized framework for public finance management. This reform is driven by a concern for transparency in the regulatory framework and data comparability within the framework of the Convergence Pact[1].
In order to move from a 'means' budget to a 'programme' budget, Senegal has internalised these directives with the gradual adoption of new legal texts.

However, the MHSA has been slow to fully implement the programme budget, which will come into force in 2020 with the appointment of programme managers.
A situational analysis was carried out to identify the obstacles to optimal implementation of the PB.
The general objective was to analyse the level of implementation of the programme budget. Specifically, this involved:

- Analyse the level of application of the texts concerning the implementation of the programme budget;
- To assess the level of commitment of the parties involved in implementing the programme budget.

Methodology

The situational analysis was conducted in several stages. First, there was an inclusive methodological scoping workshop involving all stakeholders.

Next, semi-directive interviews were used to gather data from key players involved in implementing the programme budget.

Findings

It is necessary:

- Develop the ministerial management charter
- Define rules and operational procedures for managing the budget process through the establishment of criteria for the allocation of budgetary resources, the implementation of a main structure for material management, the definition of delegation modalities of ordonnateur competencies to program managers, the establishment of internal committees for engagement plans, and the creation of a text making the accumulation of functions impossible.
- Implement the management control system with the necessary tools;
- Redefine the scope of internal control;
- Strengthen the capacities of stakeholders at all levels of the management chain.

Conclusion

The completion of appointments in the management chain is helping to better situate the responsibilities of the parties involved.
The increased accountability of stakeholders requires their upgrading for the proper implementation of the Program Budget.

The joint definition, negotiation, and acceptance of results by all stakeholders are essential for achieving performance.

Protocol for developing Quality Adjusted Life Years value set for children and adolescents in Nigeria

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Background

QALY which is the unit for the cost-utility analysis of health intervention requires specific value sets to ascertain the health status of the population within a particular country.

Aim

In Nigeria, there are no known country-specific QALY value sets for children and adolescents. This limits evidence-based decision-making in the allocation of healthcare resources to this population. Therefore, we developed a framework that will be used in the determination of QALY value sets for health status assessment for the health status of children and adolescents in Nigeria.

Methods

A cross-sectional study will be conducted in Nigeria. Multi-stage sampling will be used to select participants between the ages of 8-17 years old, from the six geopolitical zones in Nigeria (North East, North Central, North West, South East, South West, and South-South), considering income level and population size. EQ-5D-Y-3L, EuroQol Visual Analog Scale (EQ-VAS), Composite Time-Trade Off (cTTO), and Discrete Choice Experiment (DCE) would be used to determine participants' health state, preference weight, and utility values. These will be interviewer-administered to eligible respondents from urban and rural areas in Lagos, Enugu, Delta, Kano, Nasarawa, and Adamawa states.

Expected Results

A total of "n" participants is expected to take part in the study at a response rate of ≥90%. The guides will be pretested and piloted and adjustments effected where necessary. Developed guides will be used as the methodological framework in the determination of the value set for children and adolescents.

Conclusion

A protocol that will guide the development of a Nigeria value set for children has been produced for health economic use and allocation of resources.

Utilizing the Eclampsia Checklist to Enhance Management of Severe Pre-eclampsia and Eclampsia: A Strategy to Mitigate Maternal Mortality at Liberia's Foremost Hospital.

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Background

Severe pre-eclampsia and eclampsia remain significant drivers of maternal mortality in the West African region. Despite advances in medical knowledge and technology, effective management of these conditions remains a challenge, leading to preventable deaths. The "eclampsia checklist" is a structured tool designed to standardize the assessment and ensure adherence to the protocol of managing patients presenting with severe pre-eclampsia and eclampsia. It encompasses key components such as initial assessment, prompt initiation of magnesium sulfate therapy, blood pressure control, seizure management, and timely delivery of the fetus. By ensuring adherence to evidence-based guidelines and best practices, the checklist facilitates a systematic and comprehensive approach to patient care, thereby reducing the risk of adverse outcomes.

Aims and Objective

This abstract explores the implementation of the eclampsia checklist as an innovative approach to

improving the management of women with severe pre-eclampsia and eclampsia, to reduce maternal mortality at JFKMC.

Methodology

A quality improvement initiative was designed for the JFK Maternity Hospital to address the identified major drivers of maternal death through the USAID-funded Health Systems Strengthening Accelerator project. One of the goals of the initiative was to address maternal complications and drivers of maternal mortality such as eclampsia and post-partum haemorrhage. To achieve these and consequently, improve maternal health outcomes, the QI team developed change ideas which included the introduction and adoption of eclampsia checklist, training of HCWs on its use, and monitoring its use and adherence via clinical audit.

Results

After 8 months of implementation/intervention, the result of data analysis showed that: (i) the appropriate use of the eclampsia checklist (which contributes to the final maternal outcome) increased as adherence to protocol in the care management increased, indicating a positive correlation; and (ii) the use of the tool contributed to reduction in maternal deaths by 27% at 8 months after implementing the intervention.

Conclusion

The adoption of the eclampsia checklist represents a promising strategy for enhancing the management of severe pre-eclampsia and eclampsia, as demonstrated by its contribution to the reduction of maternal mortality at JFKMC. However, successfully implementing this initiative requires commitment from the leadership of the health facility, adequate training of healthcare personnel, and sustained quality improvement initiative. Further research is required to evaluate the long-term impact and scalability of this approach in diverse clinical settings.

Evaluation of a Public Health Incident Management System: Case of the 2021-2023 Cholera Epidemic in Cameroon

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Since October 2021, a cholera epidemic has emerged, necessitating the activation of an Incident Management System (IMS) on January 3, 2022. This IMS has gone through nine operational periods (P.O.) at

the time of the study, and the epidemic is still ongoing. The aim of this study was to conduct a thorough evaluation of the IMS established for the cholera response during the period from 2021 to 2023. This evaluation sought to identify the strengths and weaknesses of the IMS in order to propose improvements for more effective management of future incidents.

The study employed a mixed-action research approach, combining quantitative and qualitative methods in a descriptive framework. From August 7 to September 22, 2023, a semi-structured quantitative questionnaire and an interview guide were administered to IMS members at both the central (ministry) and regional (Centre) levels. Qualitative data were analysed through content analysis, while quantitative data were processed using univariate analyses with CsPro 7.1, Atlas-ti 1, SPSS 2.0, and Excel.

Among the 70 participants in our study, 62.86% were from the central level, with an average age of 39.11 years. Although 67% of participants had received training on the IMS, only 51.4% held a FEMA certificate. The most commonly used method for notifying suspected cases was receiving calls/SMS combined with the transmission of notification forms (44.3%). In terms of responsiveness, 50% of participants reported that suspected cases were notified immediately. Regarding data quality, 78.6% of participants were dissatisfied with data completeness, 90.0% with timeliness, 67.1% with reliability, and 44% with data consistency. Qualitative interviews with 15 respondents highlighted various challenges, such as adverse climatic conditions, limited understanding of the importance of cholera eradication within communities, as well as internal issues like insufficient data reporting, collaboration problems among stakeholders, and excessive centralization of the IMS.

The study results underscore the critical need to strengthen the capacities of various IMS Cholera actors, improve the quality of collected data, enhance community awareness efforts, and develop planning based on lessons learned to optimize responses to future epidemic crises.

Keywords

IMS, Incident, Cholera, Epidemic, Evaluation, Public Health, Cameroon.

Geographical and socio-economic determinants of childhood nutritional status in Nigeria

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Background

Childhood undernutrition has remained a challenge in many low- and middle-income countries. Nigeria

has the second highest burden of stunted children globally. An estimated 2 million children in Nigeria suffer from severe acute malnutrition, but only 20% of them are currently reached with treatment.

Objectives

This study examined the geographical and socioeconomic determinants of childhood nutritional status in Nigeria.

Methods

We analyzed data from the 2018 Nigeria Demographic and Health Survey. The outcome variables were childhood stunting and being underweight. The predictors included geographical and socio-economic characteristics of mothers, children, and households. The association between outcome and predictor variables was examined using complex sample logistic regression; adjusted odds ratios (AOR) were reported. Statistical significance was set at $p < 0.05$.

Results

The prevalence of childhood stunting and underweight was 36.7% and 21.5% correspondingly. Mothers with no education (AOR:1.37, 1.21-1.56, $p < 0.001$), underweight mothers (AOR: 1.07, 0.89-1.28, $p < 0.001$), child's age 1-2 (AOR: 3.47, 2.94-4.08, $p < 0.001$), age 3-4 (AOR: 2.82, 2.40-3.32, $p < 0.001$), being a male child (1.31, 1.18-1.45), being poor (AOR: 1.67, 1.46-1.92, $p < 0.001$) and middle quintile (AOR: 1.51, 1.27-1.78, $p < 0.001$), living in rural area (AOR: 1.53, 1.34-1.75, $p < 0.001$), and residing in the North-East (AOR: 2.24, 1.77-2.84, $p < 0.001$) and North-West (AOR: 3.29, 2.63-4.10, $p < 0.001$) regions increased the likelihood of stunting. Residing in the South-East region decreased the odds of stunting (AOR: 0.91, 0.71-1.15, $p = 0.003$). Similarly, mothers with no education (AOR: 1.50, 1.29-1.74, $p < 0.001$), underweight mothers (AOR: 1.70, 1.43-2.02, $p < 0.001$), child's age 3-4 (AOR: 1.17, 1.00-1.38, $p < 0.001$), being a male child (AOR: 1.15, 1.03-1.28, $p = 0.010$), being poor (AOR: 1.69, 1.43-2.00, $p < 0.001$) and middle quintile (AOR: 1.43, 1.15-1.78, $p = 0.001$), living in rural area (AOR: 1.40, 1.21-1.62, $p < 0.001$), and residing in the North West (AOR: 2.28, 1.75-2.96, $p = 0.001$), South-East (AOR: 1.02, 0.76-1.37, $p = 0.008$), and South-West (AOR: 1.49, 1.11-2.00, $p = 0.008$) regions increased the likelihood of underweight in children. Women who are overweight (AOR: 0.69, 0.58-0.82, $p < 0.001$), and residing in the North-Central region decreased the odds of stunting (AOR: 0.96, 0.73-1.28, $p = 0.002$).

Conclusion

The prevalence of undernutrition is high in Nigeria. The study highlights geographical, gender, educational and economic variations in childhood undernutrition that can inform policies and programs intended to improve childhood nutritional status in Nigeria.

Medical approach and social approach to disability: beyond divisions

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The concept of handicap appeared in the 16th century in England. Literally, "Hand in cap," or "Hand in the hat," it refers to a barter game where one of the protagonists puts their hand in their hat to express their disagreement. Over time and circumstances, the term has evolved significantly.

In the 19th century, it was adopted in the medical field to refer to the consequence of the disease. In this perspective, the World Health Organization (WHO) produced a report in 1980 titled "International Classification of Impairments, Disabilities, and Handicaps (ICIDH)," inspired by the work of Philippe Wood. The document is focused on the triptych: impairment – disability – handicap. In 2000, another typology emerged under the influence of the Quebec school. It is the "International Classification of Functioning, Disability and Health (ICF)." From now on, orientation is no longer based exclusively on the medical. Often, the perception of disability creates an antagonism between the medical and the social, as the former "accuses" the latter of emphasizing "pathology" at the expense of "potential."

Moreover, this medicalizing perspective prompted associations of people with disabilities to call upon the United Nations (UN). This led the international institution to declare the period from 1983 to 1992 as the "Decade of Disabled Persons," dedicated to the promotion of their rights. Furthermore, the Convention on the Rights of Persons with Disabilities (CRPD), adopted in 2006, will make inclusive education a new global educational orientation.

Thus, this qualitative study aims to transcend the disciplinary divides between the medical and social fields in order to create a synergy in addressing disability. At the Fann University Hospital Centre in the Dakar region, a content analysis was conducted on the most relevant categories derived from semi-structured interviews conducted with strategic groups, consisting of people with disabilities, social workers, psychologists, and physiotherapists. In the end, it results in a dynamic of complementarity and mutualization between the two poles in the transversal management of disability.

Keywords

Disability – WHO – medical model – social model – Transcend

Innovative Healthcare Delivery in Conflict Settings: Pseudo Hubs for TB Treatment in Kaduna, Nigeria

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Background

Delivering healthcare in conflict zones is a complex challenge, with issues such as security concerns, disrupted infrastructure, and limited access to healthcare facilities. This is particularly critical in the context of tuberculosis (TB) treatment, where consistent care and medication adherence are crucial. Kaduna, a state in Nigeria experiencing security challenges, requires innovative strategies to ensure that TB patients receive uninterrupted care. One such strategy is the implementation of "Pseudo Hubs. This abstract seeks to explore the implementation of pseudo hubs as an innovative strategy to enhance TB treatment coverage in these difficult circumstances.

Objectives

- To establish pseudo hubs as alternative TB treatment centres in security-challenged areas of Kaduna.
- To assess the impact of pseudo hubs on TB case detection and treatment outcomes.
- To foster community engagement and trust in conflict-affected regions through reliable healthcare delivery.

Methods

- **Identification of Pseudo Hub Locations:**

Areas with high TB prevalence and significant security challenges were identified through data analysis and community consultations.

- **Community Engagement:**

Collaborated with local leaders, Community-Based Organizations (CBOs), and Public-Private Mix (PPM) partners to gain community trust and participation.

- **Capacity Building:**

Trained healthcare workers and volunteers on TB management, security protocols, and data collection.

- **Service Delivery:**

Implemented TB diagnostic and treatment services, ensuring accessibility and continuity of care through mobile clinics and local health workers.

- **Monitoring and Evaluation:**

Established robust data collection and monitoring systems to track TB case detection, treatment adherence, and outcomes.

Results

- **Increased TB Case Detection:**

Preliminary data indicates a 30% increase in TB case detection rates in areas served by pseudo hubs.

- **Improved Treatment Outcomes:**

Treatment adherence improved by 25% due to the accessibility and reliability of pseudo hub services.

- **Community Trust:**

Enhanced trust and cooperation with local communities, evidenced by increased patient referrals and community participation in TB awareness activities.

Conclusion

Pseudo hubs represent a viable and innovative solution for delivering TB treatment in conflict settings. By leveraging local resources, engaging communities, and adapting to security challenges, pseudo hubs have significantly improved TB care in Kaduna. This model can be replicated in other conflict-affected regions to ensure uninterrupted healthcare delivery.

Principles and practices of health systems strengthening in fragile settings: conceptual reflections and operational perspectives through PhotoVoice

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Background

Despite its importance, health system strengthening (HSS) remains an elusive concept – even more so in fragile and conflict-affected settings (FCAS) where HSS efforts are complicated by weak governance and fragmented response. As such, there is a need for extending the current conceptual understanding of HSS to FCAS specifically and discussing operational implications on HSS programming and evaluation, from the perspective of practitioners.

Aims

This presentation reflects on the principles and practices of HSS in FCAS, combining conceptual thinking, photos and stories from those involved in "doing" HSS on the ground. The ultimate aim is to influence NGOs and donors' practices on HSS programming in FCAS to ensure strong and equitable health systems for all.

Methods

This study adopted a highly consultative and participatory design, with two main elements: (i) an iterative expert consultation and document review which were conducted to capture the current conceptual understanding of HSS and the key elements that challenge current views with reference to fragile contexts. Experts included academics, but also professionals working in international organisations, governments and NGOs (including humanitarian ones); and (ii) a PhotoVoice exercise with images and stories shared by actors working on HSS in FCAS, such as NGO and district programme managers.

Findings

Findings combine images and narratives from field actors in fragile settings with a focus on African countries (Somalia, DR Congo, Nigeria among others) with conceptual reflections. They highlight the importance of HSS to ensure a robust response that addresses health needs but goes beyond the emergency response by strengthening the health system in the long term, with potential impacts on peace and state-building. Findings also stress the challenges for doing HSS in FCAS, where efforts are complicated by factors such as weak governance, presence of non-state actors for service provision, as well as siloed and fragmented external responses (including emergency actors and vertical programming), all of which contributes to an inefficient and non-equitable health system.

Conclusion

The study offers high level conceptual reflections on HSS in FCAS, but importantly also captures important views from practitioners on the ground on doing HSS in practice, which are often overlooked. This has important implications to reflect on how can HSS programmes be designed, implemented and evaluated, and HSS supported in FCAS.

Strengthening Primary Health Care for Universal Health Coverage: A Health Economic and Policy Perspective.

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In 2025, the AfHEA Conference in Kigali, Rwanda, therefore provides a room to discuss new methods on creating robust and powerful African health systems. The conference's theme "Strengthening Primary Health Care (PHC) for Universal Health Coverage (UHC)", places a significant emphasis on PHC which serves to ensure that high quality healthcare is accessible to every person regardless of their socio-economic background.

Background

Primary Health Care is the basis of any health system as it is where the fundamental and multidisciplinary health services are provided to anyone, no matter his/her circumstances or cultural background. On the other hand, several African member-states face meaningful PHC providing challenges to them in executing plans for universal healthcare delivery.

Objective

These abstract points out the role that PHC serves as the foundation in achieving UHC from intellectual materials from health economics and health policy research.

Methods

Building on existing studies, policies, and case studies, the presentation will review different PCH boosting techniques and UHC realities. Main directions cover financial mechanisms, service delivery and viable infrastructures, workforce creation, democratic models and community engagement.

Results

The session will provide with research-proven facts around PHC and cases of successful interventions towards PHC expansion and health services for all. It will demonstrate the use of innovative policies, programs, as well as investments that were twice proven to bring more impact on the health outcomes, reducing the disparities, and enhancing the health system resilience.

Implications

The presentation will explore how health economics and policy researches strengthen PHC and is aimed at inducing contribution on behalf of policymakers, practitioners, researchers, and stakeholders. It would highlight the indispensability of data-driven demands, cross-sector partnerships, and perpetual investments in family planning to attain health systems that are synergized and glutenous in Africa.

Conclusion

Bulk up the Primary Health Care is a necessary step to see The Universal Health Coverage and to have a stronger health system in Africa. The presentation will offer discreet practical QC measures and specific active approaches based on health economics and policy studies evidence to help states move forward with the Universal Health Coverage program.

Financing Primary Health Care and Promoting Community-Based Health Insurance in Madagascar (Organized Session)

Laurent Musango *World Health Organisation (WHO)*

Description

Madagascar's underdeveloped public health system, particularly in rural areas where 80% of the low-income population resides, makes healthcare financially inaccessible, hindering efforts to reduce morbidity and mortality, especially among children and pregnant women. Health financing is critical compromising service accessibility and quality. Since 2015, Madagascar has pursued Universal Health Coverage (UHC), but the National Health Solidarity Fund (2018-2020) faced legal and quality challenges. The 2022 pilot of community-based health insurance shows promise for improving financial protection.

Aims and Objectives of the Session

This session explores the outcomes of comprehensive discussions between public health ministry stakeholders and technical partners on PHC reform, identifying essential care packages tailored to the population's needs. It further investigates the impact of health financing on Madagascar's progress towards UHC, emphasizing areas where financial adjustments could improve health outcomes through more equitable resource allocation. Additionally, the study searches for evidence on the challenges and lessons learned from implementing a Community-Based Health Insurance (CBHI) scheme in the Sainte Marie Health District.

Methods Used

Between March and July 2024, a review of PHC policies and strategies, along with stakeholder consultations, was conducted to redefine essential care packages. Thematic presentations by international organizations informed the development of equitable packages. Data analysis utilized the WHO Global Health Expenditure database (2021), the WHO Integrated African Health Observatory, and Madagascar Health Observatory data. A comparative analysis from Senegal and Rwanda provided insights for potential adaptation in Madagascar. The feasibility and implementation in Sainte Marie district were analysed using a comparative descriptive method.

Key Findings and Main Conclusions

Health financing depends on unpredictable donor funding, which accounts for 63% of total health expenditure. Out-of-pocket payments are hight (34% of health expenditure) and there is an insufficient budget allocation (7% in 2023, below the Abuja Declaration's 15% target)

The evaluation of PHC in Madagascar reveals significant weaknesses, with low scores in strategic and operational levels, and a UHC index of 35, far below the 85% target for 2030. High maternal mortality rates (335/100 000 live births) and low vaccination coverage (49% of fully vaccinated children) persist. Health financing challenges, including minimal CHBI coverage (under 1%), impede UHC progress. The studies recommend increasing domestic resource mobilisation, strategic purchasing, capitation payment and promoting national health insurance for enhanced financial protection.

Approaches for Revitalizing Primary Health Care in Madagascar: Implementation Process, Challenges, and Perspectives

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Background

The public health system in Madagascar is underdeveloped, with limited health coverage, especially in rural areas where about 80% of the low-income population lives, making healthcare financially inaccessible. This situation affects the goals of reducing morbidity and mortality, particularly among children under 5 years old and pregnant women. Madagascar has participated in international workshops to evaluate the performance of primary health care (PHC) in Africa. These evaluations aimed to measure progress in the implementation of PHC and harmonize the understanding of UHC indicators.

Aims and Objectives

This study aims to present the results of comprehensive and inclusive discussions conducted between

public health ministry actors and technical partners for PHC reform, identifying essential care packages that meet the population's needs at different levels of the health system.

Methods Used

Between March and July 2024, a review of policies and strategies related to PHC was conducted, along with stakeholder consultations to redefine essential care packages. Thematic presentations by international organizations on PHC and financing mechanisms guided the choices to build equitable care packages that protect populations from catastrophic health expenditures. Evaluations of implementation, based on key components and strategic and operational levers, were used to measure the health system's performance.

Key Results

The evaluation of PHC in Madagascar shows weaknesses in implementing operational framework elements, with low indices for strategic levers (50/100), operational levers (53/100), and health system capacity (54.50/100). The UHC index is at 35, well below the target of 85% by 2030. Maternal, neonatal, and under-five mortality rates remain high, and only 49% of children aged 12 to 23 months are fully vaccinated. The health system is underfunded, with only 7% of the state budget allocated to health. Proposals for essential care packages and financing mechanisms are necessary to achieve UHC and SDG goals by 2030.

Impact of Health Care Financing on Health Outcomes in Madagascar

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Background

Health financing has a profound impact on health outcomes in Madagascar, influencing both the

accessibility and quality of healthcare services. The Malagasy health system is heavily dependent on donor funding. This reliance creates vulnerability in the health system, as external funds are often unpredictable and may not align with national priorities. In addition, out-of-pocket payments, place a significant financial burden on individuals, potentially leading to catastrophic health expenditures. Government funding remains insufficient, despite an increase in the health sector's budget from 6% in 2019 to 8% in 2023. This allocation is still far below the 15% target set by the Abuja Declaration.

Aims and Objectives of the Research

The research aims to examine the impact of health financing on health outcomes in Madagascar, focusing on how the current financial structure either supports or hinders progress toward Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs). It seeks to identify key areas where adjustments in financing mechanisms could lead to improved health outcomes, particularly through more equitable and sustainable resource allocation.

Methods Used

Data analysis was conducted using the WHO Global Health Expenditure database for 2021, WHO Integrated African Health Observatory, WHO trends in maternal mortality data, and data from the Madagascar Health Observatory. Additionally, a comparative analysis of health financing models from countries like Senegal and Rwanda has provided further insights into the potential adaptation of these models in Madagascar's context.

Key Findings and Main Conclusions

The research highlights the critical role of health financing in shaping health outcomes in Madagascar. The heavy reliance on donor funding, coupled with high out-of-pocket payments, negatively impacts access to healthcare, particularly for the most vulnerable populations. The limited coverage of the current community health-based insurance (CHBI) schemes, which reach less than 1% of the population, further exacerbates this issue, making it difficult to advance toward UHC. Examples from Senegal and Rwanda show that even well-established schemes may struggle to reach their targets, highlighting the limitations of relying solely on CHBI to achieve UHC.

The study suggests that Madagascar could improve health outcomes by increasing domestic resource mobilization for primary health care (PHC) and reducing its dependence on external funding. Introducing strategic purchasing and capitation payment models could enhance the efficiency of health expenditures, ensuring that resources are directed toward interventions that have the greatest impact on health outcomes.

Implementation of Community Health Insurance in a Pilot District in Madagascar: Challenges and Lesson Learnt

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Background

The Member states of the World Health Organization (WHO) have agreed on strong national commitments and goals for Universal Health Coverage (UHC). Since 2015, Madagascar has been committed to implementing this global objective by developing the National UHC Strategy 2015-2022. From 2018 to 2020, the establishment of the National Health Solidarity Fund faced legal voids and challenges in providing quality services. Starting in 2022, a shift towards implementing community-based health insurance in a pilot district has been one of the promising strategies to develop financial health protection mechanisms in the country.

Aims and objectives of the research

This study aims to share evidence on the challenges and lessons learned from implementing community-based health insurance scheme in the Sainte Marie Health District.

Methods Used

A comparative descriptive method was used to analyse the stages: the feasibility study of implementation, the actual implementation in the Sainte Marie district using strengths, weaknesses, threats, and opportunities approach. The choice of this district is motivated by over 15 years of health system strengthening support from the Principality of Monaco, collaboration between the community, local political-administrative authorities, civil society, technical and financial partners working in this district. The study period covered 2021 to July 2024.

Key Findings

The feasibility study showed insufficient quality service delivery, inadequate human resources, unavailability

of functional materials and equipment, and medical supply shortages. Salary motivation was among the needs expressed by 95% of health workers. After two years of implementation, 26% of vulnerable people and voluntary members were covered in 2023, and 12% in total by July 2024. The strategy of community sensitization to join common interest groups was considered in 2024, after a feasibility study showed that member contributions should increase from $1.18/year/individual in a household to $1.71 per family per month. The separation of functions, namely the buyers, the providers and the regulator are well defined. The offered package is limited to minimum activity package. Health personnel are motivated by an income-generating activity through the rental of a cold room for fish preservation. The project still faces insufficient quality of attractive care, qualified human resources, and financial means of the population to join, among other challenges.

In conclusion, a legal framework to define the minimum package of attractive health care and a mandatory financial health protection system to accelerate the achievement of the SDG for 2030 in terms of UHC.

Governance Arrangements for Public Financing of Private Sector Engagement in Mixed Health Systems of Low and Lower-Middle-Income Countries: What Works and for Whom? (organized session).

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Background

The private sector's significant role in delivering health services in low and lower-middle-income countries (LLMICs) offers an opportunity to address gaps in access to care and to bolster state capacities. However, misalignment in incentives between public payers and private actors can potentially threaten health system goals. Governance behaviours, implemented through public financing levers, are vital for effective engagement. In this session, we aim to understand and compare the experiences of Uganda and India in engaging the private sector for publicly financed health services, assessing the effectiveness of this engagement on health system goals and delineating the factors that underly performance, focusing on the governance arrangements.

Approach

We present three studies, from Uganda [engaging Private-Not-For-Profit (PNFPs) health facilities under the Ministry of Health's Public Private Partnership for Health Policy] and India (empanelling private hospitals in the publicly financed national insurance scheme and contracting private insurance companies to support healthcare purchasing). The studies adopt mixed methods case study approaches and were intended to provide early insights to policymakers on the effectiveness of these initiatives.

Results

The studies provide a broad canvas of experiences across country contexts. The health financing subsidies that the Government of Uganda has put in place to support PNFPs have improved the alignment of the private sector's activities to national priorities and have increased utilization of health care services at the PNFP facilities. These facilities also account for a higher proportion of outpatient and inpatient service delivery. In India, private providers show mixed responses to public incentives. Market and incentive structures showed that while social responsibility and economic factors motivate providers, unviable provider reimbursement rates reduce scheme attractiveness for private providers.

Weak institutional capacities to efficiently manage scheme operations also hindered payment timelines and provider satisfaction with the scheme. In states where private insurance companies were contracted to support the public purchaser, appropriate contract terms and their enforcement were seen to be effective in preventing wrongful claim rejections and improving scheme utilization. However, the earning potential of the scheme created perverse incentives among private insurers to offer untenably low premium rates to win contracts, later impacting scheme operations and affecting relationships between the public payer and private providers.

Discussions

These studies indicate successes and challenges to public-private engagement in mixed health systems, delineating the governance arrangements and supply-side dynamics that drive the effectiveness of these arrangements and offering lessons to guide other LLMICs in their health financing reforms.

Impact of Health Care Financing on Health Outcomes in Madagascar

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Introduction

Uganda is one of the first Sub-Saharan African countries to pass a Public Private Partnerships Policy

translated to the health sector with draft implementation guidelines for Private Not For Profit (PNFP) health facilities. The Ugandan government has put into place the policy framework and the institutional arrangement needed to engage the private sector. GOU has put into place the necessary institutions, for example the Ministry of Finance, Planning and Economic Development (MoFPED) Public Private Partnerships Unit (PPP) and Ministry of Health (MoH) PPPH Node and Public Private Partnership for Health (PPPH) Focal Persons at the district level, to engage the private sector.

Objective

The overarching objective was to assess public financing arrangements and their impact on service delivery output for PNFPs, in comparison to private for-profit health facilities that do not receive these subsidies.

Methodology

A desk-based review of qualitative research design was employed, supplemented by quantitative inputs. Data were collected from published and grey literature. Key informant interviews were conducted with key Ministry of Health officials to validate the study's findings.

Key Findings

The Primary Health Care (PHC) grant channelled to PNFPs by the government has increased substantially over the last decade and a private sector assessment noted that the PHC Conditional Grant covered approximately 9% of a PNFP health facility's costs. In addition to the PHC grant, the MoH budget formalized a wage subvention for PNFP facilities to pay seconded medical officers; and the government introduced a medicines credit line allowing PNFP hospitals and health centres to purchase medicines and supplies using credit. In FY 2022/23, the credit line for PNFPs was UGX 13,638,120,137 for 545 PNFP facilities. The health financing subsidies that GOU has put in place to support PNFPs has improved the alignment of private sector's activities to national priorities and has resulted into increased utilization of health care services at the PNFP facilities. In FY 2022/23, the PNFPs facilities accounted for 14% of outpatient services and 27% of inpatient services. In contrast, private for-profit health facilities which do not receive these financial subsidies from the government contributed 7% of outpatient and 6% of inpatient services.

Discussion

In Uganda, public financing to private not-for-profit health facilities has been used as tool to: (a) increase utilization of services in the private sector and (b) to improve governance of the private sector through aligning the private sector's behaviours, capacities, and instruments to national health priorities.

Determinants of private provider engagement and empanelment in India's publicly financed Pradhan Mantri Jan Arogya Yojana (PMJAY) health insurance scheme

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Introduction

In 2018, the Government of India launched the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), a national health insurance scheme aimed at covering 100 million families. This scheme was designed to alleviate the financial burden on the poor from catastrophic hospital episodes, ensure quality health services, and increase the availability and choice of healthcare facilities. One of the successes of the scheme has been the empanelling of the large, unregulated private sector to provide access to services for vulnerable households within the financial and regulatory bounds of the scheme. This study explores the determinants influencing private hospitals' decisions regarding empanelment under PMJAY and identifies the challenges faced by those currently participating.

Objective

To understand the decision-making processes of private hospitals concerning empanelment under PMJAY and to study their experiences in engaging with the public payer. By examining these factors, the study aims to provide insights that could enhance private sector engagement and improve the scheme's implementation.

Methodology

A qualitative research design was adopted. Key informant interviews were conducted with 48 stakeholders, including from the National Health Authority, State Health Agencies, Third Party Administrators, private hospitals and hospital association representatives. Thematic analysis of the data was conducted to extract motivations and constraints of the private sector vis-à-vis their decision to engage or not with the PMJAY scheme, including perspectives on sustaining this engagement.

Key Findings

Hospital operational processes revealed significant issues, such as complex empanelment procedures and claim management challenges, including claim rejections after pre-authorization and long turn-around-time for claims settlement process leading to payment delays. Market and incentive structures showed that while social responsibility and economic factors motivate providers, low package rates and reserved procedures for public hospitals reduce scheme attractiveness. Provider payment mechanisms highlighted the unviability of package rates due to rising input costs and inflation, with no appropriate rate revisions. Institutional engagement varied, with some states demonstrating

effective communication mechanisms and others facing significant challenges. Technology and data management issues included slow Transaction Management System (TMS) responses and complexities in bio-authentication processes.

Discussion

An enabling institutional architecture is required by promoting collaboration through an inclusive platform to discuss policy decisions regarding the scheme and outstanding grievances. Addressing the identified operational, economic, and technical challenges is essential for improving private sector engagement and ensuring the successful implementation of PMJAY.

Engaging private insurance companies to support healthcare purchasing functions for the public payer: lessons from India's Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana scheme

Kheya Melo Furtado *Goa Institute of Management, Poriem, Goa, India*

Introduction

India launched the national tax-financed health insurance scheme Pradhan Mantri Jan Arogya Yojana in late 2018, targeting 500 million beneficiaries from the lowest socio-economic strata. States could either directly purchase care through a public trust (trust model) or contract private insurance companies (ICs) as intermediaries to purchase services where state capacities were insufficient (insurance model).

Objectives

This study aimed to

- Compare the performance of states adopting the trust or insurance model on scheme utilization and claim management; and
- Delineate public-private governance arrangements contributing to performance.

Methods

A mixed-methods approach was used, selecting six states (three with either model). Performance was analysed using three years of claims data from the Transaction Management System. Governance arrangements were analysed through document reviews of scheme guidelines, contract terms and key informant interviews with 34 respondents from public and private implementing agencies. Descriptive

statistics are reported for quantitative analysis and content analysis was carried out for thematic reporting of qualitative data.

Results

Hospitalization rates were similar between the models (insurance 2.8%, trust 2.5%). States with the insurance model processed a higher volume of claims despite a smaller workforce (475 vs. 274 claims per 10,000 enrolled beneficiaries, $p<0.05$). Claims were processed faster in insurance states (median 14 days vs. 48 days, $p=0.000$), though providers in trust states were satisfied with reimbursement times. Contrary to expectations, ICs had lower claim rejection rates than trust states (2.3% vs. 4.8%, $p=0.000$). Implementation of contract terms between the public payer and the IC contributed to this finding by maintaining a cap on administrative fees retained by ICs, and by revoking wrongfully rejected claims. In two states, claim pay-out ratios exceeded 100%, indicating inadequate premiums charged to the public payer vis-à-vis scheme utilization rates. This caused operational disruptions and strained relationships between hospitals, ICs and the public payer.

Discussion

Contracting private insurers in states with limited public purchasing capacities demonstrated efficiency benefits, with timely claim reimbursements and a smaller workforce. Effective contract terms and public payer oversight prevented unnecessary claim rejections. However, the scheme's earning potential incentivized private insurers to offer unsustainably low premium rates to win contracts, affecting operational stability. This underscores the need for stringent technical criteria in selecting private insurers as intermediaries. Further study is required to ensure quality claim auditing and fraud prevention by the private insurers.

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Strengthening Primary Healthcare Systems for Universal Health Coverage in Africa

Leveraging the EMBRACE Model to Address Human Resource for Health Gaps in the Nigerian Primary Healthcare Facilities: A Case Study of Skilled Birth Attendants

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(6) Sydani Initiative for International Development, Sydani Group, Abuja, Federal Capital Territory, Nigeria

Background

Human Resource for Health (HRH) remains a major challenge within the primary healthcare system in Nigeria. Evidence from empirical findings revealed that different HRH models address specific elements of the HRH value chain, these models are not entirely comprehensive. Therefore, to tackle the Skilled Birth Attendants (SBAs) HRH challenges in the Nigerian primary healthcare system requires either integrating multiple models or deploying models in a phased approach.

Aims and Objectives

This study, therefore, attempted to address the SBA – HRH gap at the PHC level in Nigeria, using a re-engineered HRH solutions model.

Methods

A three-level strategic approach was adopted to design the HRH solutions model in this study. The first level approach was a scoping review to identify existing HRH models across low and middle-income countries (LMICs) The second level approach was the adoption of the WHO HRH Action Framework (HAF)

to analyse selected HRH models in the study which led to the development of a contextualized HRH solutions model called the EMBRACE Model. Nine (9) models for improving HRH planning and implementation in public health were reviewed, and these include; the Task Shifting and Task Sharing Model (TSTS), Community Midwifery Model (CMM), Performance-Based Financing Model (PBF), Needs-Based Planning Model, Facilities-Based HRH Planning Model, Utilization-Based HRH Planning Model, Workforce Indicator Staffing Needs Model, USAID – Financing Innovations for Nutrition (FINFI) Model, and Micro-Learning Model. While the third level approach involved, experts' consultations and opinions through key informant interview sessions, to refine the model development.

Key Findings

The EMBRACE model can be adopted to address more than one HRH gap allowing for a holistic approach to solving the SBA-HRH challenge at the PHCs level. It's more useful and applicable in low-resource settings.

Conclusion

The EMBRACE model provides a blueprint to address the lingering midwives gap in the PHC facilities in Nigeria. By presenting this model, this study improves the understanding of HRH dynamics and offers pragmatic recommendations for stakeholders to fortify PHC services in Nigeria.

Implementing the Primary Care Networks in Kenya: What you know? What we don't

Kandie Geredine *Financing Alliance for Health, Kenya*

Background

Primary Care Networks (PCNs) have emerged as a promising strategy to address fragmentation in healthcare systems by enhancing coordination and service integration. Kenya's adoption of PCNs is aimed at improving its primary healthcare system and advancing towards Universal Health Coverage (UHC). While PCNs aim to improve healthcare delivery through better coordination and resource optimization, there are significant gaps in service readiness, including inadequate infrastructure, understaffing, weak health information systems, health financing and inefficient emergency services.

Objectives

This study assesses the gaps and opportunities for the successful implementation of the in service PCNs in Kenya.

Methodology

This is a qualitative study using the review of grays and publishing literatures around this topic to understand the issues and opportunities. Moreover, we also interviewed key informants for five counties who were purposively selected. The analysis concentrated on service readiness, availability, financial management from counties at varying stages of PCN implementation.

Results

This study revealed that out of 315 PCNSs in the 47 counties that were to be established in all counties since August 2023, only 172 PCNs (54%) were established, and 5 counties haven't initiated any PCNs as of July 2024. Moreover, among the 172 PCNs many of these PCN weren't gazetted and are not fully operationalized. Despite being not operationalized, most of them rely on external fund provided by Development Partners. Hence, challenges related to availability and readiness of healthcare services provision were observed coupled to financing issues. Also, critical deficiencies across several areas of healthcare service delivery were identified. Hence, the lack of basic amenities coupled to irrational referral systems, lack of inappropriate maternity and newborn care, radiology services due to issues in pharmacy due to stock out adding to staff burnout stalled the effective operationalization of the PCNs in all counties. These deficiencies compromise patient outcomes, increase infection rates and all issues of health care quality which is very important for the UHC.

Conclusion

This study suggests several recommendations including prioritization of investments in critical areas such as infrastructures, supply chain management, human resources, digitalizing the health information systems at both facility and community level. Furthermore, the study suggests that increase domestic financing and strengthening Public Financial Management in PCN will be paramount for their successful operationalization and advancing Universal Health Coverage (UHC).

Effect of First Healthcare Contact with healthcare providers on Out-of-Pocket Expenditure in Nigeria: Insights from the National Living Standards Survey 2021

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(2) Initiative for International Development, Sydani Group, Abuja, FCT, Nigeria

Background

The first point of contact in the healthcare system often determines the care pathway, influencing the type and cost of services utilized. In Nigeria, although primary health centres are designated as the primary point of care, most initial or sole contacts occur through informal pathways. In an environment with high out-of-pocket expenditure (OOPE), which can lead to catastrophic health costs, it is crucial to understand how the first point of contact affects OOPE. This study investigates the relationship between the first point of contact with the healthcare system and total OOPE.

Methods

Using data from a cohort of 116,262 households from the 2021 Nigeria National Living Standards Survey, we employed multiple linear regression models to assess the relationship between total OOPE (dependent variable) and the first point of contact with the healthcare system (independent variable). The point of contact was trichotomized into high-level formal providers, low-level formal providers, and informal providers. High-level formal providers have highly specialized training, lower-level formal providers are licensed with lower qualifications, and informal providers lack requisite training and licenses. The type of illness was identified as a potential confounder and adjusted for in our model.

$$OOPEi = \beta 0 + \beta 1\ HighFormali + \beta 2\ LowFormali + \beta 3\ Informali + \beta 4\ ChronicIllnessi + \ i$$

Results

The majority of households (97,756; 84.1%) consulted informal providers as their first point of contact, 14.1% consulted lower-level providers and 1.9% consulted high-level formal providers. Multiple linear regression analysis showed that households consulting high-level formal providers had significantly higher OOPE compared to those consulting low-level formal providers and informal providers (P-value < 0.05). Specifically, high-level formal providers were associated with the highest OOPE, followed by low-level formal providers, and then informal providers, who had the lowest OOPE. These results remained significant after adjusting for the type of illness, indicating that the financial impact of the first point of contact varied by provider type.

Conclusions

The first point of contact with healthcare providers significantly influences OOPE in Nigeria. High-level formal providers incur the highest costs, followed by lower-level formal providers, with informal providers incurring the lowest costs. The type of illness further modifies this relationship, underscoring the need for targeted interventions to mitigate financial barriers. These findings highlight the importance of strengthening gatekeeping in Nigeria's healthcare system to ensure care is provided by qualified but more cost-effective healthcare professionals.

Financing Primary Health Care Service Delivery through Direct Facility Financing and Community-Led Governance in Malawi

Lalit Sharma[1], Joe Zonda[2], Precious Chitsulo[2], Moses Zuze[3], Stephanie Heung[1], Bejoy Nambiar[4], Westain Nyirenda[5], Briony Pasipanodya[6], Mihereteab Teshome[1], Eoghan Brady[7], Joe Collins Opio[8], Dominic Nkhoma[2], Emily Chirwa[3], Gerald Manthalu[3] and Andrews Gunda[1]

(1) Clinton Health Access Initiative, Lilongwe, Malawi,
(2) Kamuzu University of Health Sciences, Malawi,
(3) Ministry of Health, Malawi,
(4) World Health Organisation, Ethiopia,
(5) Rumphi District Council, Malawi,
(6) Clinton Health Access Initiative, Kenya,
(7) CHAI, Boston, MA,
(8) UNICEF, Malawi

Background/Objectives

Health facilities (HFs) are the frontlines of Primary Health Care (PHC) for Malawi's predominantly rural population. However, HFs have limited autonomy, lack dedicated plans or budgets, and passively receive in-kind support from the District Council (DC) and partners. Resultingly, HF managers cannot flexibly and quickly respond to local priorities, reducing health worker motivation and constraining PHC quality and responsiveness.

To address these challenges, the Ministry of Health (MoH) identified Direct Facility Financing (DFF) as a key reform in its Health Sector Strategic Plan III (2023-2030). MoH piloted an intervention of Health Centre Improvement Grants (HCIGs) across 15 HFs in Rumphi district to evaluate the feasibility and effectiveness of DFF in Malawi. Health Centre Management Committees (HCMCs), a key community structure composed of 20% HF staff and 80% community representatives including women and youth groups were reconstituted and capacitated by Rumphi DC to provide oversight on Public Financial Management (PFM) functions. The HCMCs consultatively assessed and prioritized needs to implement grants ranging from USD1,000-USD2,000 transferred to their bank accounts, supported by DC supervision.

Background/Objectives

A mixed-methods approach was used for evaluation of the treatment arm in Rumphi against the control arm of 53 HFs across 12 districts of Malawi with no DFF. The Public Expenditure and Financial Accountability Framework (PEFA) was adapted to assess the impact of DFF on budget formulation, execution and evaluation by HCMCs on service delivery goals of efficiency, equity, quality, and accountability for both control and treatment arms. OECD Evaluation Criteria was used to assess the programme relevance, efficiency, effectiveness, and sustainability for treatment arm. Data collection involved key informant

interviews and focus group discussions.

Key Findings

With DC's support, all HCMCs successfully received and implemented the HCIGs. Evaluation suggests that DFF intervention improved PEFA scores from generally "Very Weak" to "Very Good" and "Good" for community hospitals; and from "Very Weak" to "Weak" and "Good" for health centres. Process evaluation suggests increased flexibility and autonomy to address local needs led to better availability of inputs such as minor medical equipment, maternity services etc. This enhanced the perceived access, quality, effectiveness and efficiency of services delivered amongst beneficiaries.

Conclusion

The pilot demonstrated that providing autonomy, capacity, and funding to HFs and communities in the treatment arm improved perceived health worker motivation and PHC quality and responsiveness. MoH has since then drafted national DFF guidelines to inform all donor and government investments towards DFF in Malawi.

Improving the Quality of Care in Primary Healthcare Facilities through Facility-Led Quality Improvement Initiatives in Northwest Nigeria

Akeem Adesina[1], Rotimi Oduloju[1], Immaculata Pat-Natson[1], Christopher Agada[2], Nkata Chuku[3] and Alozie Ananaba[3]

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(2) Health Systems Consult Limited, Abuja, Nigeria,
(3) Sanitas Health and Development Foundation [SANHDEF], Abuja, Nigeria

Background

The utilization of healthcare services is significantly impacted by the quality of services provided in health facilities. Improved quality of care in primary healthcare facilities is key to the achievement of universal health coverage. Supportive supervision has been found effective by several studies in increasing motivation and job performance among health workers, however, regular supervisory visits by the health leadership at the National, State, and Local Government levels are inadequate due to the constraints of resource. In addressing this, quality improvement process driven by the health facility team with health workers prioritizing changes within their control is critical. This paper examines the roles Sanitas Health and Development Foundation (SANHDEF) played in institutionalizing continuous quality improvement in health facilities in Kebbi, Sokoto and Zamfara States of Nigeria.

Descriptions

The initiative involved training of forty-five (45) health workers from 45 primary healthcare facilities spread across Kebbi, Sokoto, and Zamfara States. Five (5) health facilities were selected in each of the three (3) Local Government Areas (LGA) where the activity was piloted in each state. Using the WHO Quality of Care (QoC) framework based on the Donabedian model, the health workers were taken through 3-day capacity building activities which focused on facility-led quality improvement process. The activities involved interactive sessions and scenario-based learning. Practical exercises, group discussions, and presentations were integral to the training.

Results

Analysis of the training outcome shows a knowledge gain across the 3 locations of the training: 69% in Kebbi, 59% in Sokoto, and 55% in Zamfara States. The participants made strong commitments towards stepping down the training to their colleagues and ensuring sustainable continuous quality improvement activities in the health facilities.

Conclusion

A facility-led quality improvement approach has the potential to improve the quality of healthcare delivery in primary healthcare facilities by using data for decision making. The facility teams take responsibility for leading efforts to improve the quality of services. This initiative is sustainable, and it is therefore recommended that the intervention should be scaled up to other primary healthcare facilities in the states.

Keywords

Quality of Care, Facility-Led Quality Improvement, Primary Healthcare Facilities, Health Workers.

Workforce, Interventions, and Policy Impact in African Healthcare Systems

10:00 AM–11:30 AM Thursday, 03 March 2025

The association between the Health Promotion Levy and employment in South Africa: an interrupted time series analysis

Chengetai Dare1,

SAMR/Wits Centre for Health Economics and Decision Science - PRICELESS SA, School of Public Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa

Background

The production and consumption of sugar-sweetened beverages (SSBs) have been increasing over the past years, globally. However, there is overwhelming evidence linking SSBs to the rising prevalence in obesity and its comorbidities. In South Africa, the prevalence of overweight and obesity is high and is among the highest in Sub-Saharan Africa. In response to rising prevalence in obesity and its comorbidities, on 1 April 2018 the South African government introduced an SSB tax, known as the Health Promotion Levy (HPL). However, the levy has been opposed by the sugar industry, claiming that it leads to jobs losses. Against this backdrop, this study seeks to investigate the association between the HPL and employment in the sugar industry.

Methods

We employed single-group interrupted time series analyses using the Quarterly Labour Force Survey data from Statistics South Africa.

Results

Our results show that the HPL has not been associated with job losses (or generation) in the sugar-related industries in South Africa. These findings are consistent with the findings on the effects of SSB taxes on employment in other jurisdictions.

Conclusions

Considering that the HPL does not impede employment, and the overwhelming evidence on the effectiveness of SSB taxes, together with the relatively low tax burden, it is imperative that the government raises the HPL from the current 8% of the retail price to the WHO-recommended 20% threshold. The government should also consider expanding the HPL to fruit juices. Such strategies are important in encouraging people to reduce the intake of SSBs, while enabling the government to raise additional revenue for the fiscus.

The Cost of Health Worker Migration from Africa, a Systematic Review

Nzube Ifediba *University of Birmingham, Birmingham, United Kingdom*

Background

The migration of health workers from Africa is a public health concern with significant economic burden. The economic burden of migration is felt on the health system, the population, and the economy, and can be measured in monetary and non-monetary units.

Objectives

To systematically identify, critically appraise, and synthesise empirical studies on the monetary costs of health worker migration from Africa.

Methods

A systematic search strategy was used to review literature published between 1946 and 12 July 2023 across three databases. Studies were selected using a two-stage categorization process. Data from selected studies were extracted and analysed using narrative synthesis. The quality of each study was assessed using an appraisal tool.

Results

Seven studies met the inclusion criteria. The most calculated costs were direct costs in the form of cost of education and loss of return on investments. Indirect costs such as productivity losses and mortality rates were also measured in monetary units. Overall, direct cost in the form of cost of subsidized education ranged from $21,040 (USD 2011) - $58,698 (in USD 2011) per migrated health worker. Loss of return on investments ranged from $314,472 (USD 2006) to $46,001,250 (USD 2007) per migrated health worker. Total indirect costs ranged from $15,720, 000 to $15, 414,000 (USD 2017) per year.

Conclusion

The cost of health worker migration from Africa is significant. More studies on indirect costs are needed to capture these costs fully. Furthermore, more research with better methodological approaches is required to improve certainty on these costs.

Effect of health extension workers led home-based multicomponent intervention on blood pressure reduction among hypertensive patients in rural districts of northwest Ethiopia: A Cluster-Randomized Controlled Trial

Destaw Fetene Teshome *University of Gondar, Gondar, Amhara, Ethiopia*

Background

Despite hypertension is a common public health problem in Ethiopia and effective treatments are available, it is poorly managed and controlled. Community health workers have shown promising results in hypertension management in areas where healthcare providers are scarce and access to health care is limited. This study aimed to evaluate the effects of health extension workers led home-based multicomponent intervention on blood pressure change in hypertensive patients in rural districts of northwest Ethiopia.

Methods

Two-arm cluster randomized controlled trial was conducted. Hypertensive patients' age ≥25 years were included. Twenty kebeles with 456 participants were randomly assigned to the intervention group (10 kebeles with 228 participants) and the control group (10 kebeles with 228 participants). Participants in the intervention kebeles received health extension workers led home-based multicomponent interventions every other month for 40-60 minutes for nine months. The primary outcomes were the differences in mean SBP and DBP changes from baseline between patients' intervention and control groups. Intention-to treat analysis was used for the primary analyses. Linear mixed effect model was used to evaluate the intervention's effect on change in mean SBP and DBP. Effect sizes of mean difference and relative benefit increase were used.

Results

At nine months, the mean SBP decreased by 15.8 mmHg (95% CI: 13.5, 18.1) in the intervention and 10.8 mmHg (95% CI: 8.7, 12.9) in the control groups; with a 5.0 mmHg (95% CI: 1.9, 8.1) greater reduction in the intervention group. The mean DBP decreased by 12.1 mmHg (95% CI: 10.6, 13.5) in the intervention and 8.4 mmHg (95% CI: 7.0, 9.8) in the control group. The proportion of optimal blood pressure control was higher in the intervention group (45.8%) than the control group (28.2%) with percentage difference of 17.6% (95% CI: 8.5, 26.7).

Conclusions

Health extension workers led home-based multicomponent intervention has resulted significant reduction of blood pressure and achieved a higher proportion of optimal blood pressure control. This strategy is effective, but further research is needed to determine its cost effectiveness for scaling up and integrating in primary care settings.

Trial registration: PACTR202102729454417

Keywords

Hypertension, Blood Pressure Change, Health Extension workers, Ethiopia.

A Situational Analysis of Human Resource for Health at the Primary Healthcare Facilities in Nigeria: Examining Stakeholders' Perspectives

Saheed Dipo Isiaka[1], Oluwadamilare Olatunji[2], Olugbemisola Samuel[3], Toluwani Oluwatola[2], Terver Orbunde[2], Hilda Ebinim[2], Sidney Sampson[4], Emediong Otu[2], Hilary Okagbue[5], Sunday Atobatele[6] and Miriamtherese Omanukwe[2]

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Background

Studies have shown that high rates of maternal and child mortality in most low- and middle-income countries (LMICs) are associated with the quality, size, and distribution of human resources for health (HRH) within primary healthcare facilities. In Nigeria, maternal and child mortality rates stood at 1,047 per 100,000 live births and 63 per 1000 live births respectively as of 2021. Despite, several efforts that have been made to address the skilled birth attendants' gap in Nigeria, there still exists an SBA –HRH challenge in most PHCs.

Aims and Objectives

Therefore, this study assessed the HRH landscape across its relevant domains to understand the underlying drivers of the lingering Skilled Birth attendants' gap in Nigeria.

Methods

A qualitative research method was adopted for this study and was conducted across five (5) states (Lagos, Kano, Kaduna, Enugu, and Bauchi) in Nigeria based on their position from a composite HRH indicators maturity level. Key informant interviews were conducted among 59 stakeholders who were purposively selected across relevant agencies responsible for the production, recruitment, retention, and leadership of SBAs at the PHC facilities in Nigeria. The recorded audio interviews were transcribed and coded (inductively

and deductively) using Dedoose software (v9.0). Four themes and seven sub-themes were generated from the participants' responses.

Key Findings

Our findings revealed that the HRH situation falls significantly below the WHO recommended standard for the health workforce in the PHC setting. The study participants exuded that the existence of a sub-optimal HRH management and coordination system, insufficient and poor distribution of SBAs across PHC facilities, and poor health training institute's capacity to produce SBAs, amongst others, are challenges bedevilling PHCs in Nigeria.

Conclusion and Recommendation

This study highlights the Nigerian HRH quagmire across the study settings and gleans stakeholders' insights on strategies to holistically assess the HRH situations in PHC facilities. The study concluded that the government must conduct a massive recruitment of midwives. Additionally, the government should provide scholarships for midwife programs, and increase the monthly rural allowances of midwives. The government should develop, deploy, and integrate the midwife performance system into the DHIS to track and monitor midwives' quality of care.

Clinical competence of public and private primary care providers: Evidence from a cross-sectional vignette study in Tunisia

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(3) London School of Economics (LSE), London, United Kingdom

Background

Health outcomes in Tunisia have improved significantly in recent decades, which is sometimes attributed to the country's high quality of medical training compared to its neighbours. However, very little is known about what doctors know and what influences their competence.

Methods

We conducted an observational, cross-sectional study of general practitioners (GPs) in the "Grand Tunis" urban region of Tunisia. We used hypothetical patient cases presented as clinical vignettes to collect data on GPs' knowledge of five common diseases. We surveyed a sample of 177 public and 79 private GPs from November 2017 to January 2018. Using data from 1,268 vignettes, we computed several measures of clinical competence. We then compared the competence of public and private doctors and used multivariate logistic regressions to investigate competence determinants.

Findings

We found that overall, GPs correctly managed 69.56% of the hypothetical cases and correctly diagnosed 66.25% of them. There was a wide variation across cases in clinical competence of GPs, with only 54% of them demonstrating the ability to correctly manage a depression case, while 85% were able to correctly manage a TB case. Using a more stringent definition of competence, defined as the ability to identify the likely diagnosis correctly and provide the correct case management, less than half of the cases were well handled by the doctors. Next, compared to GPs working in public facilities, private GPs were 5pp less likely to manage cases correctly. Finally, no effect of characteristics such as age and gender on the overall competence of a GP was found. However, while continuing training did not seem to play a role, the place of initial medical education, specifically whether the doctor graduated from Tunis Medical School, was a major predictor of competence. In fact, once accounting for this factor, differences across public and private sectors were no longer significant.

Conclusion

We conducted an observational, cross-sectional study of general practitioners (GPs) in the "Grand Tunis" urban region of Tunisia. We used hypothetical patient cases presented as clinical vignettes to collect data on GPs' knowledge of five common diseases. We surveyed a sample of 177 public and 79 private GPs from November 2017 to January 2018. Using data from 1,268 vignettes, we computed several measures of clinical competence. We then compared the competence of public and private doctors and used multivariate logistic regressions to investigate competence determinants.

Economic and Health Impacts of Diabetes and Cancer in Africa

10:00 AM–11:30 AM Thursday, 03 March 2025

Catastrophic Health Expenditure and its Impact on the Improvement and Use of Services in Senegal (2014 and 2018 - 2019)

Thiane Gueye *Health Economics Unit, Ministry of Health and Social Action, Dakar, Senegal*

Background

Target 3.8 of SDG 3 specifically aims to "ensure that everyone has universal health coverage, including financial risk protection and access to quality essential health services and essential medicines and vaccines."

Methodology

The WHO methodology for calculating (DCS/CHE) and inequity in the use of services (Ke Xu, 2005, Adam and Ke Xu, 2008) states that a household faces catastrophic expenditures if its total health expenses are greater than or equal to 40% of its capacity to pay. The data used comes from (EHCVM) 2018/2019 on one hand and (L2S) 2014/2015 on the other hand.

Findings

In Senegal, 2.59% of Senegalese households faced catastrophic health expenditures (CHE) at the threshold of 40%, and 1.78% had become impoverished due to direct payments. During the period 2014 - 2016, household expenditures accounted for 46.9% of total health expenditures in 2014, 49.5% in 2015, and 48.8% in 2016. This significant share of household payments in healthcare expenditures reflects the heavy financial burden they bear for their healthcare. The high and recurring costs of treatments related to the management of these non-communicable diseases contribute to the increase in healthcare expenses borne by the populations.

1.4% of Senegalese households in 2014 and 1.1% in 2018-2019 made OOP payments. 1.3% of households have become impoverished due to direct health payments. In 2019, just over half of the people in the first quintile who were sick or injured (51.1%) sought healthcare services compared to (71.2%) in the fifth quintile.

The share of direct health payments as a percentage of the ability to pay decreases from 6.2% to 5.3%, and the trend of increasing households' ability to cope with health expenses is observed across all welfare quintiles.

Conclusions

Financial protection policies will need to be improved by covering medication expenses, better targeting of social insurance beneficiaries, and defining service packages.

Keywords

Catastrophic expenses, direct payments, Population

Assessing the Drivers of Non-Communicable Diseases Prevention Activities in Primary Health Care Facilities in Ghana: A Case Study of Some Selected Districts

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Background

Non-communicable diseases (NCDs) are a major public health concern, significantly contributing to morbidity and mortality rates. Primary health care (PHC) facilities are crucial in NCD prevention and management, yet most studies have focused on treatment rather than prevention, leaving a gap in understanding what drives PHC engagement in preventive measures. Emphasizing preventive activities is essential as they can reduce the burden of NCDs, lower healthcare costs, and improve population health. This study aims to identify and analyze the factors influencing PHC facilities' involvement in NCD prevention across selected districts in Ghana, guiding policy and resource allocation for enhanced prevention efforts.

Methods

A cross-sectional study was used to collect data from 210 primary health care facilities across 10 randomly selected districts in the Greater Accra and Eastern regions of Ghana. Factors such as basic amenities, basic equipment, and diagnostic capacity were assessed using the World Health Organization's Service Availability and Readiness Assessment (SARA). Data on NCD training and guidelines was also collected. Data was analysed using descriptive statistics and logistic regression in STATA18, with ethical clearance obtained (GHSERC: 013/02/23) for the study.

Findings

The results showed that among all the PHC facilities surveyed, 56.19% were CHPS compounds, 30.95% were health centres, 6.19% were polyclinics/clinics, and 6.67% were district hospitals/hospitals. Engagement in specific preventive activities varied: 31% were involved in fairground events, 54% promoted healthy eating habits, 59% conducted screening tests, and 63% carried out household awareness campaigns. Urban PHCs were significantly less likely to promote healthy eating (OR=0.30, 95% CI: 0.14-0.68) and screening tests (OR=0.31, 95% CI: 0.15-0.69) compared to rural facilities. Facilities with guidelines and training on NCDs were more likely to engage in fairground activities (OR=2.27, 95% CI: 0.87-5.89), awareness campaigns (OR=6.95, 95% CI: 2.29-21.11), and promotion on healthy eating (OR=5.32, 95% CI: 2.15-13.19). Higher scores in basic amenities (OR=0.97, 95% CI: 0.95-0.99) and diagnostic capacity (OR=0.97, 95% CI: 0.95-0.98) were linked to lower engagement in fairground activities.

Conclusion

This study reveals that PHC facilities in Ghana have a limited engagement in NCD preventive activities, with just over 60% involvement. Rural PHCs are more active in these efforts compared to urban ones, despite higher NCD prevalence in urban areas. Facilities with guidelines and training are more likely to engage in preventive activities, highlighting the need for better resource allocation and training programs. Government should adopt innovative strategies to integrate preventive activities into routine PHC functions.

The Burden of Type 2 Diabetes on the Productivity and Economy in Sub-Saharan Africa: A Life Table Modelling Analysis from a South African Perspective

Assegid Hellebo *University of Cape Town, Cape Town, Western Cape, South Africa*

Background and Aim

The prevalence of type 2 diabetes (T2D) is rapidly increasing in Sub-Saharan Africa (SSA). Recent data indicate that over one-third of diabetes-related deaths occur in those under 60, adversely affecting labour force participation and diminishing the productivity of affected workers. Africa, currently home to 1 billion people, is projected to reach 2.4 billion by 2050, with more than half of the population expected to be under the age of 25, as per United Nations forecasts. At the same time, there is a growing prevalence of diabetes mellitus in SSA, with an estimated 24 million adults affected in 2021, a number expected to be more than double by 2045. However, research gap persists in the region, including lack of insights into the disease's contribution to excess mortality, years of life lost (YLL), and productivity-adjusted life years (PALYs) lost. This population life table modelling analysis evaluated the impact of T2D in terms of PALYs on the South African working-age population.

Research Design and Methods

Life table modelling was employed to simulate the follow-up of individuals aged 20-65 with T2D in South Africa (SA). Two life table models were developed to simulate health outcomes for a SA cohort with and without diabetes. The difference in the number of deaths, years of life lost (YLL), and PALYs lost between the two cohorts represented the burden of diabetes. Scenarios were simulated in which the proportions of gross domestic productivity (GDP), productivity indices, labour force dropout, and mortality risk trends were adjusted to lower and upper uncertainty bounds. Data were sourced from the International Diabetes Federation, Statistics SA, and both publicly available and published sources. We utilised the WHO's standard annual discount rate of 3% for YLL and PALYs as well as conducted one-way deterministic sensitivity analyses.

Results

In 2019, an estimated 9.5% (7.68% men and 11.37% women) or 3.2 million total working-age people had T2D in SA. Simulated follow-up until retirement predicted 669,427 excess mortalities, a loss of 6.2 million years of life (9.3%) and 13 million PALYs (30.6%) in SA. On average, this resulted in 3.1 PALYs lost per person. Based on the GDP per full-time employee in 2019, the PALYs loss equated to US$223 billion, or US$69,875 per person.

Conclusion

This study emphasises the significant impact of T2D on society and the economy. Relatively modest T2D prevention and treatment management enhancement could lead to substantial economic benefits in SA.

Effects of the Financial Burden of Diabetes Milletus and its Associated Risk Factors on the Quality of Life of Patients in the Bamenda Health District

Ngum Charissa Belembom *Health Economics Association of Cameroon (HEAC), Bamenda, Cameroon*

Background

The costs of diabetes mellitus (DM) on individuals and households have sky-rocketed and increased globally as prevalence of the disease continues to increase especially in Africa and Cameroon in particular. This increased prevalence of DM is thought to be due to an increase in the prevalence of risk factors in the general population globally.

Catastrophe Expenditures on DM leads to a great number of negative impacts on patients' health-related quality of life (HRQoL) because of its chronicity, symptomatology, and complications. Bringing out facts on figures on the relationship between Catastrophe expenditures and Health related quality of Life, will Help in making informed decisions on the Management of the diseases.

Objectives of the Study

Main Objective

To evaluate the impact of the financial burden of diabetes mellitus on the quality of life of diabetic patients in the Bamenda Health District by comparing out of pocket expenditures with the Socioeconomic and sociodemographic characteristics of patients.

Specific Objectives:

- To describe the socio demographic and Socioeconomic characteristics of people living with diabetes mellitus.
- To evaluate the financial burden of PLWDM using catastrophic health spending formula.
- To compare the Financial burden of Diabetes Mellitus to the quality of life of the Diabetic patients.

Methodology

This study was a health-facility-based cross-sectional study in the Bamenda Health District (BHD), NorthWest Region (NWR) of Cameroon during the period of May to June, 2022. The study was conducted in three health facilities within the Bamenda Health District (BHD) namely: Regional Hospital Bamenda, District Hospital Nkwen Bamenda and Mbingo Annex Baptist Hospital Finance Junction Nkwen Bamenda

Key Findings

From the total of 100 participants a significant association between increased financial burden and decreased HRQoL was identified. 35% of people with catastrophic health expenditures reported having poor quality of life, 22% of respondents reported having average quality of life making a total of 57% of respondents with either poor or average quality. Simple linear regression analysis was done to identify the relationship between HRQOL and capacity to pay for healthcare at a P-value < 0.2. This result was considered statistically significant since it had a P value of <0001.

Conclusion

It was therefore concluded that the Financial burden of Diabetes Mellitus has a negative effect on the Health Related quality of life of patients with Diabetes Mellitus. Targeted policies on Chronic Diseases and reimbursement decisions are recommended to promote Universal Health Coverage (UHC) and to protect vulnerable populations from hardship due to Diabetes Mellitus.

Treatment costs for patients with colon cancer at Groote Schuur Hospital, South Africa.

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(1) University of Cape Town, Cape Town, Western Cape, South Africa,
(2) University of Cape Town,
(3) University of Manitoba

Background

Given the increased mortality-to-incidence ratio of colon cancer in South Africa, there is a need to improve the treatment outcomes of this malignancy by implementing relevant public health measures. However, the resources required to finance such measures cannot be determined without understanding the treatment cost burden for colon cancer. Despite this, there is a shortage of relevant information on the treatment cost of colon cancer in South Africa.

Aim and Objectives

This research estimates the direct treatment cost per stage at Groote Schuur Academic Hospital (GSH) to understand the resource requirements for colon cancer treatment in South African public healthcare. The objectives are:

- Outline the treatment components and direct cost inputs per disease stage through expert interviews based on GSH guidelines.
- Estimate the total per-patient direct medical cost of colon cancer per disease stage.
- Identify the cost drivers of colon cancer treatment at GSH.

Background

Using an ingredient-based normative costing approach, the study estimates the direct treatment cost of colon cancer at the colorectal cancer clinic and combined colorectal oncology unit in Groote Schuur Hospital from the healthcare provider's perspective. The costing methodology follows a two-step process. First, the colon cancer treatment components, such as consultations, surgery, and chemotherapy, will be outlined based on the health facility's treatment guidelines and linked to relevant cost inputs per disease stage through expert interviews. Secondly, using a mix of top-down and bottom-up costing techniques, the per-patient cost for each cost input per treatment component will be estimated and aggregated across all treatment components per stage to give the total per-patient cost of each disease stage. All costs will be presented in 2024 South African Rands and United States Dollars.

Anticipated Results and Policy Implication

The framework of colon cancer treatment components and relevant cost inputs by disease stage will help inform future colon cancer costing studies in South African public health sector and other low- and middle-income countries (LMICs). Estimating the total per-patient treatment cost for the four disease stages will provide an idea of the financial burden of colon cancer on the health facility. This data will be useful for planning and budgeting to inform colon cancer healthcare delivery and serve as evidence for further research to strengthen the implementation of relevant colon cancer control programmes. Finally, identifying the GSH-specific cost drivers of colon cancer treatment will inform further economic evaluation analysis to guide policy decision-making.

Linking Informal Health Systems, Subsidies, and Financial Barriers in African Healthcare

10:00 AM–11:30 AM Thursday, 03 March 2025

Challenges and opportunities in facilitating access to financial services to support the private health sector in Benin as part of efforts to achieve UHC

Romaric Sounouvou[1], Pascal Saint Firmin[2], Conrad Tonoukouen[1], Ghislaine Djidjoho[1] and Lucien Dossou-Gbete[3]

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The private health sector (PHS) in Benin provides more than 52% of the total healthcare services across the different levels of the health pyramid. Ensuring adequate and sustainable domestic financing for this sector would constitute a significant advancement in the efforts to implement UHC. In 2022 in Benin, the SSP benefited from 66.3 billion CFA francs (XOF) in loans compared to 75.5 billion XOF in 2021, a decrease of 12.2%, while the total volume of loans to SMEs increased by 12.4%. The credits granted to the sector represent 0.4% of the total volume of credits granted to SMEs in 2022 (BCEAO, 2023). This low funding of the SSP is due to the low funding of the private sector in general and then to factors specific to the health sector and its actors. The literature has established few pieces of evidence on the PHS.

This study aims to identify the factors of underfunding in the PHS. The methodological approach adopted is based on semi-structured interviews with one hundred PHS business leaders distributed across four departments and credit analysts representing ten commercial banks and three microfinance institutions in Benin. The data collected are in the processing and analysis phase using a logistic regression model.

The preliminary results obtained seem to indicate that, like the entire Beninese private sector, private

healthcare companies particularly struggle to provide banks with quality financing files, compliant financial statements, and fail to mobilize the guarantees required by lenders to access credit. More specifically, the determinants reducing access to financial services for private healthcare companies include an information asymmetry reflected by the low knowledge of their operating cycle and its particularities by credit institutions, the low financial and business management education of their leaders, and the apparent low profitability of their activities. Moreover, the identified differences in access to financing are influenced by the size and location of the businesses, the nature of their activities, as well as the gender of their leaders, which illustrates a significant inequity in the economic structure of Benin.

Overall, interventions aimed at better financial education for sector leaders combined with capacity building in management, technical and financial support for the preparation of financing proposals can help increase resource mobilization for the benefit of the sector.

"Subsidy is gone": Effects of Petrol Motor Spirit (PMS) Subsidy Removal on Subnational Health Financing in Nigeria

Toluwani Oluwatola[1], Tolulope Ogunsanwo[2], Ifeoluwatoyosi Amujoyegbe[3]

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(2) Federal Medical Center, Abuja, Nigeria
(3) Obafemi Awolowo University Teaching Hospital Complex, Ile Ife, Osun, Nigeria

Introduction

Subsidies exact significant fiscal burden on governments across LMICs and in many cases, they significantly outweigh public social investment in human capital development, health, education and their determinants. To free up resources for social and other economic investments, the new Government of Nigeria on 29th May 2023 announced an end to fuel (PMS) subsidy in Nigeria. In the months that followed this action led to a 25% year on year increment in government revenue. This study aims to evaluate the effects of subsidy removal on allocation to the health sector at the state level in Nigeria, one year after subsidy removal.

Methods

We obtained approved appropriation bills for the 36 Nigerian states and extracted relevant information on the budgetary allocation to the health sector for the years 2022-2024. Using 2021 as a baseline year, we adjusted the nominal allocations to real values to account for inflation, utilizing the Consumer Price Index (CPI) data from the Nigerian National Bureau of Statistics. The change in aggregate allocation to the

health sector before and after the removal of the fuel subsidy was calculated. A paired t-test was employed to test for statistical significance between allocations to the sector pre-subsidy (2022) and post-subsidy (2023-2024). All analyses were conducted using Stata 17.

Results

Following the removal of the fuel subsidy, the nominal aggregate allocation to the health sector across Nigeria's 36 states increased by 59%. However, the real aggregate allocation to the health sector across the 36 states only increased by 6.5%. Notably, 44% of the states recorded a negative real change in allocation to the health sector following the subsidy removal. The paired t-test revealed no statistically significant difference in subnational allocations to healthcare following the removal of the fuel subsidy ($p = 0.194$). This indicates that while nominal allocations increased substantially, the real increase, accounting for inflation, was modest and not uniformly experienced across all states.

Conclusion

The removal of fuel subsidy has not significantly improved health financing across Nigeria's thirty-six states. There is a need for reprioritization of health within budgets and government plans at the subnational level if subsidy removal will improve public health financing among Nigeria's subnational entities.

Provider and consumer perspectives on whether and how best to link the informal health sector to the formal health system in Nigerian slums

Iheomimichineke Ojiakor[1], Obinna Emmanuel Onwujekwe[1]

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Introduction

Informal healthcare providers (IHPs) play a crucial role in healthcare delivery, especially in low-resource and underserved areas, like urban slums. However, IHPs typically operate independently and are unregulated, leading to potential sub-optimal care. Integrating IHPs into the formal system can improve access to quality healthcare, strengthen the overall healthcare system, and enhance patient safety. Research on interventions for linking IHPs to the formal system offers valuable insights for policymakers, aiding in effective health system planning and implementation.

Aim

This study explored the views of both formal and informal healthcare providers and consumers, within Nigerian urban slums, on whether IHPs should be linked to the formal health system, and, if so, how this might be done. This provides us with innovative insights into the possible interventions necessary to develop and institutionalise sustainable linkages between the formal and informal healthcare systems in this context.

Methods

The study adopted a cross-sectional, two-stage sample design for the provider and consumer quantitative surveys. Data was collected using structured questionnaires from 1024 households and 255 healthcare providers purposively selected from 8 (eight) urban slums in Anambra and Enugu states, southeast Nigeria. Data was analysed using logistic regression models to explore the responses.

Results

Consumers prioritized "training and capacity building activities" (61%), "supervision of activities" (53%), and "referral of patients" (44%) as key aspects to be linked to the formal health system. Preferred strategies included "training" (75%), "supervision" (53%), and "regulation" (37%). The Ministry of Health was overwhelmingly preferred as the leadership structure (92%), and "government legislation" (54%) was favoured for managing the linkage. Providers showed strong support for "referral of patients" (83%) and "training" (77%), with moderate support for "joint meetings" (58%) and "data sharing" (34%). They also preferred the Ministry of Health (62%) for leadership and leaned towards "government legislation" (47%) and "written contractual agreements" (36%) for management, though these preferences were less precise. Regression analyses showed that consumers' preference for linkage was not dependent on their sociodemographic characteristics ($p>0.05$). However, providers' characteristics significantly influenced their choice of interventions, especially respondents' facility type ($p<0.05$).

Conclusion

The findings indicate that linking IHPs to the formal health system is feasible and potentially effective using the suggested interventions and governance strategies. Co-creation of the interventions and strategies should be used to design, implement, and evaluate the linkages for improved healthcare delivery systems in urban slums.

Out-of-pocket expenditure and its implications among patients with Sickle Cell Disease, diabetes, and rheumatic heart disease: Results from primary and tertiary hospitals in Tanzania

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(2) Muhimbili University of Health and Allied Sciences, Dar es Salaam, Tanzania, United Republic of,
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(4) Section for Ethics and Health Economics, Department of Global Public Health and Primary Care, University of Bergen, 5020 Bergen, Norway,
(5) Muhimbili University of Health and Allied Sciences, P. O. Box 65001, Dar es Salaam, Tanzania, Tanzania, United Republic of,
(6) Muhimbili University of Health and Allied Sciences, Tanzania, United Republic of

Background

Most Tanzanians have no health insurance, so they mostly finance their healthcare services through out-of-pocket payments. Tanzania is implementing the PEN Plus strategy to improve access to care for severe non-communicable diseases such as sickle cell disease, type 1 diabetes, and rheumatic heart disease at primary hospitals, addressing the high costs at secondary and tertiary levels. These severe non-communicable diseases result in large losses of healthy life due to early and high levels of disability and mortality in the absence of treatment. Households with members with these diseases experience a huge burden of Out-of-pocket expenditures, resulting in catastrophic health expenditures.

Objective

This study aimed to assess the implications of out-of-pocket expenditure by examining the incidence of catastrophic health expenditure incurred by patients with sickle cell disease, type 1 diabetes, and rheumatic heart disease seeking outpatient care at primary and tertiary hospitals.

Methods

From February to May 2024, we conducted a cross-sectional study among patients with sickle cell disease, type 1 diabetes, and rheumatic heart disease at primary and tertiary hospitals in Tanzania. We used a semi-structured questionnaire to collect socio-demographic information, out-of-pocket direct medical and non-medical costs, indirect costs, and household expenditures through exit interviews. We used descriptive statistics to estimate the magnitude and intensity of catastrophic health expenditures and to compare them across primary and tertiary hospitals. We then performed logistic regression to identify the factors associated with catastrophic health expenditure.

Results

Of the 845 respondents, 85% sought care at tertiary hospitals. Preliminary results showed that 15.6% of

households with patients at primary hospitals faced catastrophic health expenditures, with an overshoot of 4.8% and a mean positive overshoot of 31%. In comparison, 17% of households with patients at tertiary hospitals faced catastrophic health expenditures, with an overshoot of 11.6% and a mean positive overshoot of 69%, both defined as exceeding a threshold of 40% capacity to pay. Those with insurance were significantly less likely to experience catastrophic health expenditures than those without insurance (adjusted OR=0.11 [0.05 - 0.22], p value=0.00).

Conclusion

Seeking outpatient care for sickle cell disease, type 1 diabetes, and rheumatic heart disease imposes a financial burden on households. Expanding services to primary hospitals must be accompanied by strategies like prepayment and risk pooling to ensure financial risk protection for the most in need.

The Effect of a Public Housing Subsidy Program on Child Development among Low-income Households in South Africa: an Application of a Fuzzy Regression Discontinuity Design

Tankiso Abiel Lefeta

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Conclusion

The limited success in reducing stunted growth, particularly in developing countries, indicates a complex issue that goes beyond just inadequate nutrition. It is increasingly recognized that addressing stunting requires attention to "upstream" factors, including social determinants of health such as improving living conditions for children. Housing is a prime example of a social determinant of health, as it not only influences but is also influenced by structural determinants like social, macroeconomic, and public policies, education, income, and ethnicity, all of which interact to shape population health and well-being. While research on household environmental risk factors in child growth and development is somewhat limited, it indicates that access to adequate housing has a positive impact on early childhood development.

Studies have shown that specific housing improvements can reduce the disease burden for young children in informal settlements; however, there is still limited scientific understanding of the causal effects of public housing programs on child growth in these environments. This study helps to fill this gap by evaluating the impact of a large-scale public housing program on stunted growth. Specifically, it examines the impact of publicly provided new housing units on child linear growth by leveraging the means-tested benefit Reconstruction and Development Program (RDP) housing program implemented in South Africa.

The analysis employs continuity-based local polynomial approaches to evaluate the average effect of an RDP housing subsidy for only a subgroup of compliers who are slightly above and below the eligibility level

The findings suggest that access to formal housing is associated with a reduction in the likelihood of stunting, particularly for children from low-income households. To demonstrate the channels through which housing impacts child stunting, the study borrows from established research that studies environmental exposures and child health. These channels include the type of flooring in a housing unit, quality of water access, quality of in-house sanitation infrastructure, access to garbage disposal, and access to cleaner fuel for cooking and heating like electricity. The results indicate that the RDP housing subsidy has the potential to positively impact child health through several channels. It is important to note that the interpretation of the treatment effect of the RDP housing program estimated here is specific to the sub-group of compliers.

Nonetheless, the results suggest a strong link between access to adequate housing and child growth, especially for children in vulnerable conditions. The positive effect of the RDP subsidy provides strong grounds to increase, or at least maintain the current housing allocation, and justifies housing programs as an effective tool for addressing the root causes of environmental exposures to mitigate the stunting problem.

Catastrophic health payments in Ghana post-NHIS implementation: An analysis of service-specific health expenditures

James Akazili[1], Michel Adurayi Amenah[2], Evelyn Sakeah[1], Paul Welaga[3], John Ataguba[4]

(1) School of Public Health, C. K. Tedam University of Technology and Applied Science, Navrongo, Ghana
(2) Ghana College of Physicians and Surgeons, Accra, Ghana
(3) Navrongo Health Research Centre, Ghana Health Service, Navrongo, Upper East Region, Ghana
(4) University of Manitoba, Canada

Background

Over the past few decades, Ghana's healthcare system has focused on improving accessibility, affordability, and quality through significant reforms. Key initiatives include the Primary Health Care (PHC) strategy in the 1970s and Community-based Health Planning and Services (CHPS) in the 1990s, which enhanced rural access. Despite these efforts, challenges such as financial constraints, infrastructure deficits, and high out-of-pocket (OOP) expenditures persist. To address financial barriers, Ghana introduced the National Health Insurance Scheme (NHIS) in 2003, aiming for Universal Health Coverage (UHC) and reduced OOP expenditures. This study assesses the incidence of catastrophic health payments among Ghanaian households post-NHIS implementation and analyses their distribution across different health services.

Methods

This study utilized data from the Ghana Living Standards Surveys (GLSS) rounds 6 and 7, along with the Annual Household Income and Expenditure Survey (AHIES) 2023. To measure the incidence and severity of catastrophic health payments (CHPs) for various health services, we calculated the catastrophic payment headcount index (H) and the catastrophic payment gap index (G). We conducted the data analysis using STATA.18.

Results

The incidence and severity of catastrophic health payments have significantly increased, with the overall catastrophic headcount rising from 1.26% in 2012/2013 to 11.45% in 2022/2023 at the 10% threshold. Despite a decrease in the proportion of total health payments spent on medical products (from 75.51% to 64%), the catastrophic headcount for these expenses increased from 1.34% to 12.24%. Rural households face higher catastrophic headcounts and payment gaps compared to urban households, with rural catastrophic headcounts reaching 15.05% in 2022/2023, compared to 7.93% in urban areas. Northern regions show higher payment gaps (16.35%) than southern regions (15.72%) despite similar headcounts. The poorest households (1st quintile) are disproportionately affected, with a catastrophic headcount of 28.74% in 2022/2023, compared to just 0.65% in the 5th quintile.

Discussion/Conclusion

The findings highlight persistent financial vulnerabilities and inequities in healthcare access across Ghana, particularly in rural and northern regions. Targeted policy interventions are urgently needed to enhance NHIS coverage, improve healthcare infrastructure, and provide financial protection for the most vulnerable populations. Addressing these disparities is crucial for achieving equitable health outcomes and reducing the financial burden on Ghanaian households.

Improving Maternal and Reproductive Health through Quality Care and Strategic Interventions in Africa

10:00 AM–11:30 AM Thursday, 03 March 2025

Knowledge, Attitudes, and Practices towards Preventing and Controlling Hepatitis B Virus Infection among Pregnant Women Attending Antenatal Care at a University Hospital in Central Ethiopia: A Cross-Sectional Study

Yilma Markos Larebo[1], [2*], Abebe Alemu Anshebo[1,3], Sujit Kumar Behera[1], Natarajan Gopalan[1]

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(2) Department of Epidemiology, School of Public Health, Wachemo University, Hossana.
(3) Department of Midwifery, School of Nursing, Wachemo University, Hossana.

Introduction

Ethiopia is a country with a high endemicity of the hepatitis B virus, and the primary mode of transmission for this virus is mother-to-child transmission. However, the country lacks a comprehensive plan for viral hepatitis surveillance, prevention, and control.

Methods

A hospital-based cross-sectional study was conducted from October to November 2023 at a university hospital in Central Ethiopia. A total of 412 pregnant women were selected and included in the study using a systematic random sampling technique. An interviewer-administered questionnaire was used to collect the data. The collected data were imported into Epi-data version 3.1 and then exported to Statistical Package for Social Sciences version 25 for analysis. In the bivariate analysis, variables with a p-value less than 0.25 were included in the multivariable analysis. A logistic regression model predicted the relationship between the predictor and outcome variables. Statistical significance was considered at a p-value <0.05.

Results

The overall response rate was 94.06%. Out of the total 412 respondents, 37.6% exhibited good practices. Notably, pregnant women within the age categories of 29 to 39 years (AOR: 0.312; 95%CI: 0.153, 0.636) and ≥ 40 years (AOR: 0.170; 95%CI: 0.058, 0.497), residing in rural areas (AOR: 0.347; 95%CI: 0.171, 0.703), with smaller family sizes (AOR: 0.132; 95%CI: 0.070, 0.249), lacking information about hepatitis B virus infection (AOR: 5.153; 95%CI: 2.910, 9.125), having a positive attitude (AOR: 0.032; 95%CI: 0.018, 0.058), and possessing good knowledge (AOR: 0.375; 95%CI: 0.199, 0.707) were significantly associated with poor practices.

Conclusion

This study found that pregnant women had a low level of knowledge, attitudes, and practices about hepatitis B virus infection prevention and control. Greater understanding was necessary to effectively prevent and control the spread of infection through prioritized health education programs targeting pregnant women. These programs must focus on raising awareness through campaigns that promote knowledge and immunization for their children.

Keywords

Knowledge, Attitude, Practices, HBV, Pregnant Women, Ethiopia

How do conversations on social media help to explain financial barriers to family planning services for Rwandan adolescent girls within the prevailing cultural and legal context?

Mary Hadley *Context in Development, Nairobi, Kenya*

Purpose

Financial barriers to health services have been identified in African countries. Rwanda has a pro-poor, countrywide insurance scheme that includes a package of family planning services. However, there is lower utilisation by adolescents. This qualitative study explored conversations on social media platforms around financial barriers to family planning in Rwanda, particularly for adolescents. The study's objective was to provide direction to policy revisions to improve access to contraceptives for adolescents, to enhance their life-long potential.

Methods

A search string was used to capture conversations on social media around financing barriers to family planning services for adolescents. Key themes were identified through analysis of the content of these messages. The themes were compared with existing literature on this topic.

Results

There is a paucity of direct postings on public sites by adolescents, reflecting social stigma related to teenage sexual activity and lack of inter-generational dialogue on this subject. Key themes identified from the conversations were: prohibitive prices for socially acceptable contraceptives in the private sector, social stigma affecting access to affordable publicly available services and backfiring of well-intentioned laws and policies.

Conclusion

The financial barriers to contraceptives by adolescents are compounded by legal frameworks and social and cultural factors and their intersection. The 'relationship' between the conversations captured on social media and socio-cultural and legal context is recursive. Careful consideration to both policies and interventions is required to increase access to contraceptives for adolescents.

The extent, causes and implications of seasonality in reproductive health indicators: lessons from Rwanda

Mary Hadley[1], Silas Rudasingwa[2]

(1) *Context in Development, Nairobi, Kenya*
(2) *Rwanda Biomedical Centre, Kigali, Rwanda*

Background

Seasonality in some health indicators is a known phenomenon, such as those linked to rainfall and food availability. Health interventions, such as distribution of mosquito nets, are scheduled around the seasonal norms. However, seasonality of maternal and child health indicators is less obvious and has not been investigated in detail in Rwanda. The objective of this study is to determine the extent of seasonality of these indicators to inform policy and implementation of interventions accordingly.

Methods

Data elements for key maternal and child health indicators were retrieved from the Health Management Information System by month for the past ten years. A comparison was made on a yearly basis. Thereafter, data was retrieved from additional sources such as meteorological, marriage records, consumer price index etc. to establish a cause for the seasonality.

Results

There is strong seasonality for health deliveries, low in January and February and higher in May and June. A higher proportion of marriages are planned in July and August, which coincides with low rainfall. Other indicators follow the same trend but are not as marked.

Conclusion

The findings have implications in diverse areas; Trainings and annual leave of health professionals in maternity and neonatal units should be tailored to the seasonal workload. Routine orders for medical commodities should be adjusted for periods of high and low use to avoid stockouts. The use of an outlier detection tool in the Health Management Information System should be adapted for seasonal fluctuations in caseloads for some services.

The extent, causes and implications of seasonality in reproductive health indicators: lessons from Rwanda

Mary Hadley[1], Silas Rudasingwa[2]

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There is strong seasonality for health deliveries, low in January and February and higher in May and June. A higher proportion of marriages are planned in July and August, which coincides with low rainfall. Other indicators follow the same trend but are not as marked.

Conclusion

The findings have implications in diverse areas; Trainings and annual leave of health professionals in maternity and neonatal units should be tailored to the seasonal workload. Routine orders for medical commodities should be adjusted for periods of high and low use to avoid stockouts. The use of an outlier detection tool in the Health Management Information System should be adapted for seasonal fluctuations in caseloads for some services.

Stillbirths in Ghana: Does the quality of Antenatal care have anything to do with it?

Millicent Otopabea Awuku[1], Edward Nketiah-Amponsah[2], Isaac Osei-Akoto[2] and Kwame Adjei-Mantey[3]

(1) Ashesi University, Berekuso, Ghana,
(2) University of Ghana,
(3) University of Environment and Sustainable Development

Background and Objective

Ghana has made much progress with antenatal care coverage in the five years prior to the 2017 Ghana Maternal and Health Survey; however, the country still records high stillbirth rates. Due to the numerous health and economic consequences of stillbirth on the economy and the dearth of studies on this discourse, the study examined the effects of the quality of care a woman receives during pregnancy on stillbirth in Ghana.

Method

This study used the 2017 Ghana Maternal Health Survey, a nationally represented data and employed the Cox proportional hazard model, as stillbirth connotes a sense of survival.

Key Findings

The study found that receiving better quality Antenatal care (ANC) reduces the risks of stillbirth. An increase in the number of services a woman gets during ANC decreases the hazard of stillbirths by 81%. In addition, the study revealed that the age of the woman, educational background, frequency and timing of antenatal care visits significantly influenced the risks of stillbirth.

Conclusion

The results from the study suggest that receiving better quality antenatal care improves maternal health in Ghana. Therefore, a policy that enhances the quality of ANC is key to achieving the SDG target of improving maternal health by 2030.

The Rising of Cesarean Section Rate in Private Health Facilities in Rwanda: Financial Implications and Potential Cost Savings from Reducing Non-Clinically Indicated Procedures

Ntwali Ntwali[1], Parfait Uwariraye[2] and Regis Hitimana[1]

(1) Rwanda Social Security Board, Kigali, Rwanda
(2) Financing Alliance for Health, Kigali, Rwanda

Background

A caesarean section is a lifesaving procedure with high rate of maternal mortality and morbidity compared with vaginal births (VD). Its utilization rate has increased significantly over the past two decades, rising from 2.2% in 2000 to 15.6% in 2019-20 across all health facilities in Rwanda with a four-time higher rate in private health facilities (PHF) than in public health facilities. The reason behind that discrepancy has not yet been documented even though evidence indicates a rise in non-clinically indicated caesarean sections globally and this has significant financial implications on the services purchasers. WHO recommends a caesarean sections rate threshold of 10-15%. A recent rapid assessment on purchasing mechanism in PHF has provided critical insights on this endeavour.

Methodology

A mixed-research approach with both quantitative (services utilization and claims costs) and qualitative was used. 368 CS and 278 VD claims were collected retrospectively over six months period (July-December 2023) and estimated standard costs were generated from the Standard treatment guidelines (STG) issued by MOH and current PHF tariff items and compared to actual spent costs as reported to identify the cost driver, and then validated by experts. A cost saving assumption in Rwandan Francs (Frw) was generated for 2022-2023 fiscal year with C/S rate of 56.8%, assuming that all C/S and VD were covered by a health insurance and performed in private hospitals and using three different target scenarios with reduced rates including WHO threshold and others (30% and 20%).

Findings

The number of C/S in private hospitals increased from 4,571 in 2020 to 6,066 in 2023 which corresponds to about 33% of increase. The standard costs For CS ranged from 243,616 FRW in general clinics to 302,239 Frw in private hospitals and from 82,388 Frw in general clinics to 161 447 in private hospitals for VD. While computing cost saving assumptions, the cost ranged 402,964,296 Frw (30% target) and 734,920,642 Frw (15% target) to be incurred by purchasers and these could be allocated to other lifesaving procedures.

Conclusion

The preference of CS over VD in PHF is associated with cost escalation tendency. There is a need of immediate policy action to review the provider payment mechanism and to reinforce compliance with evidence based global clinical practices promoting safer and more cost-effective childbirth methods.

Driving High-Quality Antenatal Care (ANC) using an "All-or-None" Checklist: Lessons from a Maternal Health Quality Improvement Collaborative in Lagos, Nigeria.

Olasunmbo Makinde[1], Kendra Njoku[2], Kristin Nmazua[3] and Layi Olatawura[3]

(1) Health Strategy and Delivery Foundation, Ikoyi, Lagos, Nigeria,
(2) IHI,
(3) Health Strategy and Delivery Foundation

Background

There is sufficient evidence that demonstrates that countries with poor quality and low ANC coverage have worse maternal outcomes. Thus, prioritizing quality ANC has the potential to unlock significant returns for every mother and her newborn towards ending preventable maternal mortality. However, gaps persist in the delivery of quality ANC across health facilities in both the public and private sectors in Lagos, Nigeria.

Aims and Objectives

This study explores the effect of the utilization of an Antenatal Care Checklist as a quality improvement initiative to improve maternal outcome.

Methodology

Intervention: Project Aisha aims to reduce maternal deaths and obstetric complications in Lagos by 20% from 2022 to 2025 by utilizing a Quality Improvement approach- the Model for Improvement, across a Maternal Health Quality Improvement (MHQI) collaborative made-up of 23 primary and secondary level health facilities in both public and private sectors. To address identified gaps in the quality of ANC services, the MHQI collaborative utilized appropriate tools e.g. fishbone and process map, to develop innovative solutions (change ideas). A key change idea is the design and adoption of an "Antenatal Care Checklist" to promote adherence to evidence-based ANC service processes, prompt interpretation of findings, enhanced clinical decision-making and informed clients. Other supporting change ideas include training of HCWs on the use of checklist, availability of checklist in ANC folders, provision of appropriate medical (ANC) equipment, and adoption of a comprehensive ANC health talk curriculum. These solutions were tested using an iterative improvement cycle (Plan-Do-Study-Act).

Data collection: Weekly clinical audit was conducted using "all-or-none" approach where a pregnant woman receives all eligible ANC services at every ANC visit to be regarded as received "Quality ANC". Collected audit data was analysed using excel and presented on annotated run-charts to assess the effect of the checklist.

Results

After a nine-months implementation period, collaborative facilities successfully tested and implemented solutions and demonstrated improvements in the quality of ANC services from a baseline score of 20% to 82%. In addition, we observed prompt identification of maternal complications (such as preeclampsia, obesity in pregnancy), swift clinical decision making (such as prompt referral at the primary level of care) and empowered clients

Conclusion

Prioritizing comprehensive ANC processes while integrating prompt clinical responses is crucial to achieving improved quality ANC services. The use of the Antenatal Care Checklist demonstrated gains towards averting maternal complications and ultimately maternal mortality.

10:00 – 11:30 AM Thursday March 13, 2025

Health financing reforms for advancing Rwanda's Universal Health Coverage agenda (organized session)

Regis HITIMANA[1], Okore Okorafor[2], Matiko Riro[3]

(1) Rwanda Social Security Board
(2) USAID Ireme / MSH,
(3) Clinton Health Access Initiative

Description

Rwanda's journey towards Universal Health Coverage (UHC) is a remarkable example of how a low-income country can achieve significant progress in providing equitable and accessible healthcare for all its citizens. Over the past two decades, the country has made substantial strides in rebuilding and reforming its health sector, with UHC as a central goal of its development agenda.

The cornerstone of Rwanda's approach to UHC has been implementing the community-based health insurance (CBHI) scheme, which covers almost 90% of the population. This scheme has been complemented by innovative domestic financing, contextualised provider payment mechanisms and a robust benefits package design that have kept healthcare affordable, sustainable, and accessible, as reflected in its sustained high coverage over the years amidst financial challenges. An additional approach to making healthcare more accessible and affordable is Rwanda's people-centred approach to policy design. This includes revising copayment policies to reduce out-of-pocket expenses for the most vulnerable populations, thus improving financial protection and access to essential health services.

This session will explore the merits and designs of key health financing reforms, from revenue collection and pooling to strategic purchasing functions. It will provide insights into the practical examples and steps taken and potential impact on advancing UHC agenda. By sharing Rwanda's experience, the session aims to create valuable discussions and deliberations that will provide lessons for other countries policymakers, healthcare professionals, and researchers interested in advancing UHC in their contexts, particularly in low-resource settings.

The objective of this session is to share the experience of ongoing and upcoming health financing reforms expected to advance Rwanda's Universal health coverage Rwanda.

The session will be chaired by Dr Regis Hitimana and will include four presentations listed below and will be moderated by the Rwanda Social Security Board.

- Given country's needs around maavlaria control and prevention and the growing suite of interventions, amidst worsening economic situations, what is the future of malaria control in countries?
- Towards People-Centred Copayment Policy for Improved Access and Financial Protection in Rwanda's community-based health insurance
- Towards a Sustainable Provider Payment Mechanism: Crafting a Capitation Model that fits Rwanda's Primary Healthcare Context in Rwanda
- Setting up a Health Benefits Package design ecosystem for community-based health insurance in Rwanda.

The session will include 2 discussants Mr Okore Okorafor Management Science for Health – Rwanda and Dr Matiko Rio (Clinton health Access Initiative) who will reflect on the potential impact of the reforms in the context of Rwanda.

Innovative domestic financing mechanisms to advance the universal health coverage agenda in Rwanda: the case of the national community-based health insurance

Ina Kalisa[1], Innocent Murindabigwi[2], Eric Rubyagiza[3], Alexis Rulisa[3], Bonaparte Ruhamya[2] and Regis Hitimana[1]

(1) Rwanda Social Security board, Kigali, Rwanda,
(2) Rwanda Social Security Board, Kigali, Rwanda,
(3) Rwanda Social Security Board (RSSB), Kigali, Rwanda

Financing universal health coverage is challenging in Low -and -Middle -Income Countries, particularly in context of high informality. Rwanda adopted the Community-based Health Insurance (CBHI) to provide access to quality health care services at an affordable cost to the population in the informal sector. However, the trends of revenues were not keeping pace with rising cost of care resulting in consistent deficit. Main traditional sources of revenues included flat contributions for self-funded members, government allocations, subsidies for the poor and most vulnerable people and income from other health insurances. In 2020, a Prime Minister Order (PMO) determining additional subsidies for the scheme was issued to address its financial sustainability.

Aims and Objectives

This study aims to describe the innovative domestic financing mechanisms used, assess their revenue

potential for CBHI sustainability and document the policy process associated with their design and implementation.

Methods

CBHI revenue data since the publication of the PMO were analysed using descriptive statistics to determine if they were implemented, if actual revenues were raised, and if there was potential to improve CBHI's financial sustainability. A qualitative analysis was conducted guided by five criteria (revenue adequacy and stability, efficiency, equity, ease of collection and political acceptability) was also conducted with key stakeholders to document the selection process and design decisions.

Findings

Subsidies from nine (9) of the (13) new sources of income were transferred to CBHI. Revenues from new sources represented an increasing share of CBHI income (from 13% in 2020 to 39% in 2023) and resulted in the scheme improving its financial position and recording a surplus. The scheme's fund balance increased from a deficit worth Rwf 24.9 billion in 2020 to a surplus equivalent to Rwf 8.3 billion in 2023. Levies applied on revenues from petrol and gas oil trade companies and telecommunication companies, and the new salary tax showed greater potential to increase the scheme's revenues in the short term.

Conclusion

While these innovative financing mechanisms are feasible options and can provide a relatively steady, sustainable and equitable way of generating additional revenues for CBHI, they are still small compared to growing health needs. They must, therefore, be reviewed regularly and used to complement traditional sources of revenues of the scheme, which should be adjusted to grow with the economy where applicable and premiums paid based on more objective measures such as income.

Towards People-Centred Copayment Policy for Improved Access and Financial Protection in Rwanda' Community based health insurance.

Lysette Umutesi[1], Ina Kalisa[2], Jean Marie Vianney Hakizayezu[3], John Etuk[4] and Regis Hitimana[2]

(1) Rwanda Social Security Board, Kigali, Kigali, Rwanda,
(2) Rwanda Social Security board, Kigali, Rwanda,
(3) Rwanda Social Security Board (RSSB), Kigali, Rwanda,
(4) Clinton health access initiative, Kigali, Rwanda

According to the WHO, healthcare spending has seen the largest spike compared to other economic sectors, particularly in low- and middle-income countries. With a 6% annual growth rate, healthcare accounts for 10% of the global gross domestic product.

Rwanda has made efforts to enhance healthcare access and reduce financial barriers for its citizens in alignment with the goals of universal health coverage (UHC), emphasizing financial risk protection and access to quality healthcare. Community-based Health Insurance has been a central effort that has significantly extended healthcare to Rwandans and increased access to health services through full health subsidy for the lowest income population and 10% and RwF 200 of healthcare costs as copayment at hospital and health centre levels, respectively, for other categories.

Copayments, as a cost-sharing mechanism, are intended to prevent the overutilisation of healthcare services and ensure scheme sustainability. However, these payments can be unaffordable to some population groups, leading to catastrophic health spending especially in low-income households, from seeking necessary medical care.

Aims and Objectives

This study examines how a copayment policy change would enhance healthcare utilization and financial protection by assessing CBHI members' copayment contributions and estimating the cost feasibility and implications for the CBHI scheme if a copayment is subsidised for members when costs exceed a predetermined threshold.

Methods

We conducted a descriptive analysis of CBHI hospital claims for the fiscal year 2022/23, to evaluate patient copayment, across all socio-economic groups. We also analysed the impact of copayment subsidies using various thresholds and projected the implications for future costs and sustainability.

Findings

The analysis revealed a total copayment amount of Frw 6,313,498,151 from 2,915,564 service utilizations at hospital level in 2022/23. If the scheme were to increase copayment subsidies, the impact of varying the cut-off per visit from Frw 10,000 to Frw 100,000 on the scheme's overall expenditure would range from 0.61 to 2.80 %.

Conclusion

Rwanda's Health Financing Policy demonstrates how healthcare can be made affordable and equitable, advancing the UHC goal. The study highlights the substantial individual copayment contributions that may hinder access to healthcare. It also shows that a people-centred copayment policy would enhance access and financial protection while having minimal impact on the scheme's overall expenditure.

Towards a Sustainable Provider Payment Mechanism: Crafting a Capitation Model that fits Rwanda's Primary Healthcare Context in Rwanda

Alexis Rulisa[1], Jean Marie Vianney Hakizayezu[1], Ina Kalisa[2] and Regis Hitimana[2]

(1) Rwanda Social Security Board (RSSB), Kigali, Rwanda,
(2) Rwanda Social Security board, Kigali, Rwanda

Rwanda introduced Community Based Health Insurance (CBHI) in 1999, covering closer to 90% of the population in 2023. The CBHI sustainability plan developed in 2021 recommended, among key strategic purchasing reforms, to change the Provider Payment Mechanism (PPM) in primary healthcare facilities from Fee-For-Service (FFS) to capitation meant for efficiency and sustainability. The study shows how the capitation design was tailored to fit the peculiarities of Rwanda's PHC landscape.

Methodology

Quantitative historical data of payment from CBHI to health centres (HCs) and health posts (HPs) in the fiscal year 2023-202 was used to design the PPM. A general formula "number of eligible members assigned to the HC times the capitation rate" was adopted to determine the capitation amount to be paid. Specific adjustments were made to cater for the fact that HCs are in different utilization zones thus different capitation rates (per zone). Plus, members are allowed to visit out-of-network health facilities, whereby facilities closer to the hospital tend to receive many patients for transfer purposes, thus resulting in lower payments per member. Regression analysis was used on historical payment data to estimate model parameters. The modelling process takes the following steps: 1) assign a utilization group to each HC, 2) assign to each HC a distance to the hospital, and 3) run the regression model using members, HC utilization estimates and inflow members as other model inputs.

Findings

While the model has two parameters, the 1st parameter was estimated to be 912, 1,246 and 1557, depending on whether the HCs are in low, medium and high utilization groups, respectively. The second parameter, catering for inflows, was estimated to be 907 and 1,239 for HCs whose distance to the hospital is below or above 1km, respectively. Projections show that nearly 90% of the HCs are within a 30% deviation of historical payments. The fixed fee per encounter at the HP level ranges from FRW 910 to FRW 1,630, depending on the provided services. The capitation amount will be paid before the beginning of the month for HCs, while HPs will receive their payments at the end of the month. Ambulance services will continue to be paid on FFS basis.

Conclusion

The adjustment of the general capitation formula to Rwanda's context is key to ensuring fairness among health facilities, improving efficiency in health services delivery, and ensuring resource predictability.

Setting up a Health Benefits Package design ecosystem for community based health insurance in Rwanda

Cindy Muhoza[1], John Etuk[2], Alexis Rulisa[1], Regis Hitimana[1]

(1) Rwanda Social Security Board (RSSB), Kigali, Rwanda,
(2) Rwanda Social Security board, Kigali, Rwanda

Rwanda's health system has made remarkable progress in expanding access to health services, with nearly 90% of the population insured under the Community-Based Health Insurance (CBHI) scheme. To ensure the continued provision of equitable, accessible, and quality health services, the Government of Rwanda has initiated several reforms, including establishing a governance structure to review and define priority services for the CBHI scheme, starting with cancer services and ensuring the sustainability of the Health Benefits Package (HBP) design.

The research aims to examine Rwanda's HBP governance framework and design process to identify its strengths and areas for improvement and draw lessons to be emulated by other governments or organizations involved in similar practices.

Methods

This study employed a mixed-method approach, which includes reviewing policy documents and administrative reports related to HBP governance and process design to identify the best practices, evaluate current strategies that have proven effective, and formulate sustainable improvements. Qualitative data was gathered through interviews with the HBP committee, the assessment team, the in-country experts and specialists, and other key stakeholders to assess the coordination among the various teams and its implication on the HBP design.

Findings

The analysis examined the role of Rwanda's governance structure and decision-making processes and ensuring policy implementation. The current governance structure of Rwanda's HBP facilitated the completion of the initial assessment of cancer management in Rwanda, its subsequent appraisal, and the

endorsement of the Ministry of Health for inclusion into the CBHI benefit package.

The study is still ongoing, the finding on the health benefit package system design, the evidence used, decision-making process and progress made so far, will be available before AFHEA25.

Conclusion

Developing a sustainable governance structure is essential to enhance transparent and inclusive decision-making in health benefits package design; this study identified the successes and limitations of Rwanda's HBP design process, which could potentially form lessons base for countries seeking to define benefits packages for their insurance scheme.

The Impact of Public Financial Management [PFM] on Health Outcomes: What does the Evidence Say? (organized session)

10:00 – 11:30 AM Thursday March 13, 2025

Helene Barroy *WHO, Yann Tapsoba, Financing Alliance for Health / African Frontline First*

Description

There is growing interest and awareness of the potential positive relationship between PFM and health outcomes. Broadly, PFM has long been accepted as critical to strengthening allocative and operational efficiency. Building on this argument, the theoretical assumption then argues that strengthened PFM systems influence how and what funds are allocated to health sector priorities, which subsequently impacts the quality and access to health services. As a result, more people have access to improved services without exposing them to financial hardship, subsequently improving health outcomes. However, upon further examination, while the theoretical explicit and implicit foundations are there, little empirical evidence has been generated to unpack the link between the two.

On this basis, this session will launch an interactive discussion to unpack the implicit understanding of the relationship between PFM and health outcomes, getting us closer to an explicit examination of the link based on empirical evidence. Thus far the evidence is small but growing, therefore this session will contribute to this ongoing work by focusing on two empirical papers that focus on establishing the relationship, if any, between PFM systems and health outcomes.

The first presentation will examine the impact of PFM dimensions on health outcomes, covering a sample of SSA countries between 2005 and 2018. The findings indicate that PFM quality, approximated by PEFA scores, reduces maternal and under-five mortality. Predictability and control in budget execution are the PFM dimensions associated with the highest effect on maternal and under-five mortality. In addition, the analyses show that PFM quality reduces maternal and under-five mortality in countries that prioritise health budget allocations.

The second presentation examines the relationship between public financial management (PFM), the financing of health interventions and health outcomes. Specifically, the presentation focuses on the relevance of public sector health financing and examines the effect of PFM on under-five mortality. The analysis reveals that PFM quality reduces the U5 mortality rate with about 14 deaths per 1,000 live births, and this increases with the share of health financing channelled through the public sector. The paper unpacks this relationship further in the LAC region, with similar results as the global sample.

Finally, selected discussants will respond to the two presentations, highlighting country(s) case studies, key lessons, emerging questions, and raising any evidence gaps or limitations, all with the objective of determining the relevance of these findings for the next steps and shaping PFM systems to better serve health systems.

Public Financial Management and health in Sub-Saharan Africa: evidence from a quantitative review over 2005-2018

Yann Tapsoba

Financing Alliance for Health / African Frontline First, Ouagadougou, Burkina Faso

Background

PFM theory argues that the management of public funding influences health services provision, and thus impacts health outcomes. Through the budget cycle, PFM impacts the quality, access, and coverage of health services and this translates into improved health outcomes. Despite this theoretical foundation, the relationship between PFM quality on health outcomes is not well-demonstrated, with little empirical literature available.

Objective and Methodology

The objective of this paper is to examine the relationship between PFM quality on health outcomes by using pooled ordinary least squares (OLS) estimator, covering a sample of Sub-Saharan African countries over 2005-2018.

Findings

The findings indicate that PFM quality, approximated by PEFA scores, reduces maternal and under-five mortality but it does not significantly affect NCDs mortality in a context of low prioritization of these diseases in the allocation of health budget. Predictability in public funding and effective budget execution are the PFM dimensions associated with the highest effect on maternal and under-five mortality. In addition, the analysis shows that PFM quality reduces maternal and under-five mortality in countries that

place a high priority on health in their budget allocation. It does not significantly affect mortality indicators in countries with a low budget priority on health.

Discussion

Countries would need annual increases in their average PEFA score of 7.5 percent for maternal and 8 percent for under-five mortality to reach SDGs on maternal and child health. Expected outputs or outcomes are important for motivating decision makers to commit to PFM reforms, which are generally long complex and require long-term capacity building. The study demonstrates that PFM, when combined with high level political commitment backed by budget allocations, translates into positive results for the population. Specifically, the study shows the significance of improving levels, effectiveness, and regularity of budget implementation as a critical driver for the sector's outputs. Governments should prioritize actions to unpack causes of chronic budget under-execution in health and identify solutions.

Public Financial Management, Health Financing and Under-Five Mortality: A Comparative Empirical Analysis

Moritz Piatti-Fünfkirchen *World Bank*

Background/Objective

This study examines the relationship between public financial management (PFM), the financing of health interventions and health outcomes. Specifically, the paper econometrically tests whether the effect of PFM on under-five mortality depends on the relevance of public sector health financing

Methodology

Employing OLS on a sample of 215 observations indicates that a one unit increase in PFM quality reduces the U5 mortality rate with about 14 deaths per 1,000 live births. For countries that channel at least, 75 percent of health expenditures through the government system this rate increases to 17 deaths per 1,000 child births.

Key Findings

Results are robust to using an alternative dependent variable, adding year fixed effects, a sensitivity test where the health financing threshold is varied and a falsification test that verifies whether findings are driven by unobserved governance aspects. Furthermore, the paper provides a comparative analysis

for Latin America and Caribbean (LAC), a region which remains mostly overlooked in the literature. The findings for LAC are broadly consistent with the global sample, though less pronounced and without a differential effect for countries across the financing threshold. Overall, the evidence indicates that the pursuit of universal health coverage and the progress toward related SDGs will be more costly if enabling systems are not in place.

How can enhanced PFM contribute to better health outputs: the examples of Ghana and Ethiopia

Kingsley Addai Frimpong *WHO*

In his intervention, Kingsley Addai Frimpong, Health Economist of WHO Country office in Ethiopia, will respond to the three presentations, highlighting key lessons, emerging questions, and raising any evidence gaps or limitations, all with the objective of determining the relevance of these findings for Ghana and/or Ethiopia for the next steps and shaping PFM systems to better serve health systems.

Discussion

As a senior Public Finance Expert with the World Health Organization will, Hélène BARROY, will offer insights into practical ways forward for policymaking and research.

Social Inequalities, Maternal Health, and Resource Mobilization in French-Speaking African Countries

The mobilization of resources for the resilience and sustainability of family planning services in the Central African Republic

Dr Romaric ZARABO[1], TAKOULOU Timotée TAKOULOU Timothée[2]

(1) Bangui, Centrafrique, Central African Republic
(2) Ministry of Health, Bangui, Centrafrique, Central African Republic

Background

The mobilization of resources for Family Planning in the Central African Republic (CAR) remains a concern as the State contributes only 1% and Technical and Financial partners 99%. The State has made efforts recently, but this insufficient funding has always been supported by the TFPs, namely UNFPA, the World Bank, and the Buffet Foundation. There is certainly a need to increase FP coverage, funding, but especially human health resources for the implementation of the FP program (advanced strategy and mobile clinic) as well as community engagement.

Objectives

Analyse the financing system for Family Planning services to improve and access Family Planning services. The specific objectives assigned to this work are as follows: Describe the financing of the FP program and identify resource innovations for sustainable financing of the FP program in the Central African Republic (CAR); Propose innovative mechanisms to diversify and mobilize both domestic and foreign resources; Suggest mechanisms for efficiency in the use of financial resources allocated to family planning services and reporting related expenses.

Methodologies

The qualitative and quantitative approaches are intended to capture the positive and negative factors in mobilizing resources for the provision of family planning services at the community level. This is a cross-sectional study that used mixed methods to collect and analyse data from different sources of family planning funding in CAR The Excel tool is used in the analysis to produce trend parameters such as the average.

Findings

It should be noted that over the past three years, the State has included in the Finance Law a budget line of 100,000,000 FCFA in 2022 and 2023 and disbursed 50,000,000 in 2022 and 25,000,000 F in 2023. This year, the government spent up to $500,000 on contraceptive products through the Buffet Fund, so the funding places a high priority on family planning. This contribution will reinforce the efforts of partners. Thus, we find that the partners' funding is greater than the share of the state budget allocated to support the family planning programme. The table below shows the share of partners contributing to purchase family planning products.

Health system and clandestine abortion in Burkina Faso

Bila Blandine Gouo

Institute for Health Sciences Research, Ouagadougou/Burkina Faso, Ouagadougou, Burkina Faso

Background

Post-abortion care is part of the healthcare packages provided in public health facilities in Burkina Faso to any woman experiencing a spontaneous or induced abortion. An analysis of the circumstances surrounding certain abortions sheds light on the phenomenon.

Methodology

Three unrecorded speeches by caregivers noted in the field notebook on the margins of interviews during the initial contacts in the qualitative evaluation of the PSSR (December 2022), manually analysed, support this analysis.

Findings

R1 The high demand record for abortion care recorded between March and May is justified by the end-of-year holidays and "Valentine's Day."

R2 Among the women and young girls who become pregnant, some wish to have an abortion a few months later even though they do not meet the criteria to benefit from a therapeutic abortion according to the law. Similarly, women indicated for an abortion get lost in the complexities of the process.

R3 Some limitations of the referral system for ISG (spontaneous abortion) patients to appropriate healthcare facilities promote recourse to clandestine abortions.

Conclusion

Illegal abortions with uncertain outcomes can be reduced through more appropriate measures and better guidance for women in need of safe abortion services in healthcare facilities.

Evaluation of the costs of sexual and reproductive health services borne by households in Burkina Faso

Danielle Belemsaga/Yugbaré, Siaka Lougue, Relwendé Nacanabo, Rachidatou Compaore, Kadari Cisse, Henri Gautier Ouedraogo and Seni Kouanda

Institut de Recherche en Sciences de la Santé/ Institute of Research in Health Sciences (IRSS), Ouagadougou, Burkina Faso

Background

The costs borne by households affect the use of services, including sexual and reproductive health services. Our article aims to measure the costs of family planning (FP), safe abortion (SA), and legally authorized safe abortion (LSA) services borne by households.

Methods

We conducted a cross-sectional study comparing intervention (132) versus control (32) in 2022 on the costs of services in basic healthcare facilities (BHF) for clients of FP, SA, and LSA services authorized by law in Burkina. We conducted a descriptive analysis of the median direct, indirect, and total costs in CFA francs (XOF). Direct costs are the costs directly attributable to care and non-medical direct costs (transport costs, food expenses, and gifts given to healthcare staff). Indirect costs are the opportunity cost of the time spent in health facilities for obtaining care, estimated by monetary valuation considering the daily income per capita of Burkina Faso.

Findings

The total costs borne by households are respectively in the intervention and control FS for FP 300 FCFA (347/394) and 216 FCFA (209/210); the SA 6163 FCFA (33/104) and 1530 FCFA (7/8); and the LSA authorized by law 57922 FCFA (76/77). The costs of services for family planning clients and antenatal care clients are not significantly different for clients of intervention and control health facilities. Clients (64/394) incurred 650 FCFA for the direct medical costs of FP services despite the free FP since 2020 due to stock shortages.

Conclusion

The costs of PF, SA, and LSA services authorized by law supported by households must be reduced with a decrease in stockouts and the implementation of universal health insurance.

Socio-economic factors associated with dental caries in a population of schoolchildren living in precarious and non-precarious environments in Abidjan, Côte d'Ivoire

Abou Dramane Sangare[1], Marie-Pascale Koffi-Pregnon[2], Konin Juste Abraham Atta[2], Nzebo Marcellin Nouaman[2], Mamadou Samba[3] and Jean-Claude Guinan[2]

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(3) Félix Houphouët-Boigny University, Abidjan

Background

Dental caries continues to be a burden on the healthcare services of many countries, mainly in Africa, despite the availability of effective preventive measures. It remains a public health problem and an important factor contributing to the poor general health, especially of children. The reduction of the prevalence of dental caries is therefore desired. It can be achieved by relying on socio-economic determinants that are indicative of inequalities in oral health, in order to achieve greater equity.

Objective

analyse the socio-economic factors associated with dental caries in schoolchildren in precarious and non-precarious environments in Abidjan, Côte d'Ivoire.

Methods

The cross-sectional analytical study was conducted in primary schools located in both precarious and non-precarious areas of the city of Abidjan. The study population consisted of students aged at least 5 years. The variables studied concerned socio-economic characteristics, oral health behaviours, and dental status. The socio-economic factors associated with the level of hygiene and the presence of dental caries were investigated using logistic regression with a significance level set at 5%.

Findings

A total of 343 students participated in the study, of which 58.3% were enrolled in non-precarious an 2/3 of the surveyed children did not have health insurance. Less than 3/4 of the students had unsatisfactory oral hygiene. The prevalence of dental caries was 44.9%. Students living in non-precarious environments had better oral hygiene than those living in precarious environments (OR = 1.7; 95% CI = [1.05 – 2.7]). Students with parents belonging to the lower socio-economic class developed 0.6 times fewer cavities than those whose parents belonged to the higher or middle socio-economic class (OR= 0.6; 95% CI = [0.40-0.98]).

Objective

The precarious living environment and a moderate or high economic class appear in this study as factors that can negatively influence children's oral health. The various strategies considered to improve the oral health of populations should prioritize primary healthcare, with a strong emphasis on health education and prevention.

Keywords

Keywords: Oral health, social inequalities, children, socio-economic determinants, Côte d'Ivoire.

Integrated Patient care

10:00 – 11:30 AM Thursday March 13, 2025

Factors influencing access, quality, and utilization of primary health care for patients living with hypertension in West Africa - A scoping review.

Kezia Naa Amerley Akosua Amarteyfio

Ghana College of Physicians and Surgeons, Accra, Ghana

Introduction

Hypertension, one of the most prevalent non-communicable diseases in West Africa, can be well managed with good primary care. This scoping review aims to explore what is documented in the literature about factors that influence primary care access, utilization, and quality of management for patients living with hypertension in West Africa.

Methods and Analysis

This scoping review employs the approach described by Arksey and O'Malley in 2005. This review employs the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for scoping reviews to present the results.

The searched databases were PubMed, Embase, Scopus, Cairn Info, and Google Scholar, looking at papers published between the 1st of January 2000 to the 31st of December 2023. Studies were selected based on the inclusion and exclusion criteria.

Methods

Factors influencing hypertension control at primary care facilities can be grouped into macro, meso, and micro factors. Macro (wider contextual) factors include health policy and its implementation, meso (health system) factors include lack of essential antihypertensive medications, inadequate tools, equipment, and other supplies, financing systems e.g. out-of-pocket payments, insufficiently trained health workers; and micro (community and patient factors) include financial barriers, health-seeking behaviour, and community and household support. These factors are interconnected and complex and should be addressed as a whole, to reduce the burden of hypertension in West Africa.

Results

Factors influencing hypertension control at primary care facilities can be grouped into macro, meso, and micro factors. Macro (wider contextual) factors include health policy and its implementation, meso (health system) factors include lack of essential antihypertensive medications, inadequate tools, equipment, and other supplies, financing systems e.g. out-of-pocket payments, insufficiently trained health workers; and micro (community and patient factors) include financial barriers, health-seeking behaviour, and community and household support. These factors are interconnected and complex and should be addressed as a whole, to reduce the burden of hypertension in West Africa.

Conclusion

This review provides insight into the factors that enable and or hinder access, utilization, and quality of primary care in West Africa. Although most of the findings were barriers, there were a few enablers that could be leveraged to improve primary care for hypertension in West Africa.

The implementation cost analysis of a COVID-19 test and treat program: real-world evidence in Ghana, Malawi and Zambia

Emily Macharia[1], Maame Amoakohene[2], Jonathan Mtaula[2], Mwaba Mulenga[3], Anthony Bless Dogbedo[2], Yamikani Gumulira[2], Caroline Boeke[2], Okechukwu Amako[2], Norman Lufesi[4], Lawrence Ofori-Boadu[5], Daniel Mingle[5], Krishna Udayakumar[1], Lloyd Mulenga[6] and Wenhui Mao[7]

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Background

Access to effective oral treatments for COVID-19 saves lives and limits the impact of future surges. The Quick Start consortium successfully supported the rapid establishment of COVID-19 test and treat programs, in 8 countries in Africa and Asia making nirmatrelvir/ritonavir accessible to patients while also facilitating countries to strengthen essential capacities required to operate test-and-treat programs and prepare for future health emergencies. To inform future policy decisions on allocation of resources, this analysis aims to assess the implementation cost of COVID-19 test and treat program in selected countries.

Methods

We took the health system perspective to assess the implementation cost of the program from selected QuickStart sites in Ghana, Malawi and Zambia that cover various subnational regions and facility levels operating from December 2022 to May 2024. A micro-costing tool was developed to collect key cost elements, such as commodities, supply chain, personnel, and program management cost. Additional time-and-motion estimates were collected from healthcare workers to assess the workload of performing different tasks. We also collected output data, such as number of tests performed and number of treatments, to assess the cost per test or treatment.

Key Findings

We obtained the cost information from 18 facilities in the three selected countries. In Malawi, the monthly average cost ranged from US$1,396 to US$4,213 per month per facility. The cost per test performed varied from US$17 to US$64, while the cost per treatment course initiated ranged from US$287 to US $1,953. In Ghana, the monthly average cost ranged from US$ 867 to US$ 4,965. The cost per test performed ranged from US$ 65 to US $ 329 while cost per treatment course initiated ranged from US$ 88 to US$ 1,500. In both countries, personnel cost is the major cost driver, contributing about 60-80% of total cost. Monthly cost and cost per test performed or treatment initiated varied significantly depending on the total number of tests performed and treatment courses dispensed by different facilities in different months. We will report results from Zambia and we also intend to model different scenarios such as task shifting to estimate potential cost savings.

Conclusion

This study provides real-world evidence on the cost of implementing a COVID-19 test and treat program in low resource settings to inform policy makers on resources required to routinely offer COVID-19 test and treat services at a time when the management of COVID-19 globally transitions from emergency response to routine care.

Conceptualising an individual patient simulation model to evaluate the economic impacts of integrated care for cardiometabolic multimorbidity in Kenya

Elvis Omondi Achach Wambiya, James Odhiambo Oguta, Duncan Gillespie, Catherine Akoth, Robert Akparibo and Peter Dodd

University of Sheffield, Sheffield Centre for Health and Related Research (SCHARR), Sheffield, United Kingdom

Background

The rising burden of cardiometabolic multimorbidity and lack of evidence on the economic impact of sustainable integrated care models highlights the need for economic evaluations using decision analytic models (DAMs). Developing a conceptual modelling framework is an important step towards the development of public health economic DAMs aimed at informing policy decisions. This paper details the process and outcomes of the conceptual model development process of a DAM to evaluate the economic impact of an existing integrated care model in Kenya.

Methods

The primary health integrated care project for four chronic diseases (PIC4C), implemented in the western region of Kenya, was used a case study. The development of the conceptual model was guided by Squires et al. (2016)'s conceptual modelling framework which outlines key stages in the development process including: 1) aligning the framework to the decision-making process, 2) identifying relevant stakeholders, 3) understanding the problem, and 4) developing and justifying the model structure. The process involved systematic literature and document review and key stakeholder engagement through key informant interviews, a workshop, and continuous engagement.

Results

A total of 17 key stakeholders were interviewed while 15 stakeholders participated in the workshop. The key

aspects of integrated care considered important for modelling were integrated community-based primary care screening, referral, and treatment; health worker training; and medication supply chain strengthening. The multimorbidity context for the model was cardiovascular disease (CVD) and diabetes comorbidity. Based on the nature of the intervention and the complexity of the disease conditions and their complications, we settled on an individual patient state-transition simulation model. The proposed starting population is adults aged 24 years and above who are either disease-free, with CVD and/or diabetes, and stratified by non-modifiable (age, sex, blood pressure, BMI) and modifiable (tobacco use) risk factors. Complications considered for modelling the natural history of cardiovascular disease included coronary heart disease, stroke, myocardial infarction, and heart failure. General considerations recommended by the stakeholders for the development of the health economic model included the epidemiological context, equity considerations including age, socioeconomic status, gender, and geography, level of healthcare delivery, and scalability of the integrated care model.

Conclusion

Involving local stakeholders in the conceptual model development was crucial in contextualising it to the Kenyan setting. The conceptual modelling process helped to understand patient interactions with the healthcare system within an integrated care model and standard of care, subsequently identifying mechanisms of impact and points of resource use.

Systematic Review of the Evidence on the Impact of financing in the Provision of surgical care in Low and middle-income countries

Trusharkumar Parmar *London School of Economics and Political Science*

Background

Providing equitable and efficient surgical care in low—and middle-income countries (LMICs) is a critical aspect of the global health agenda to improve overall population health outcomes and Universal Health Coverage (UHC). Despite global commitments, significant disparities exist, with 5 billion people lacking access to safe and affordable surgical care and 33 million facing catastrophic health expenditures. The Lancet Commission considers surgical care fundamental in achieving global health goals and UHC. It strongly advocates that investing in surgical care is affordable and propels economic growth.

Aim

To systematically review the evidence on the impact of financing on the provision of surgical care in LMICs

Objectives

- To identify and summarize existing evidence on the impact of financing on surgical care
- To investigate the effectiveness of these mechanisms
- To understand the associated barriers and challenges with these mechanisms
- To offer recommendations for policy and practice based on findings

Methods

A systematic search from the four databases searched for this study, Medline, Embase, Econlit, and Global Health, was conducted, and studies published between 2000 and 2024 were included. The search results were assessed for pre-specified selection criteria and were critically evaluated for quality. Two independent reviewers screened the studies. Narrative synthesis instead of meta-analysis was done considering the heterogeneity of the data.

Key Findings

Health financing interventions, particularly public health insurance and free healthcare services, significantly enhance access to surgical care in LMICs, reducing direct and indirect costs.
Despite these interventions, challenges such as hidden costs and disparities in access persist, especially for the poorest households and rural populations.
Some financing mechanisms, like case-based payments, successfully reduced costs and controlled the overuse of procedures. In contrast, others, like user charges, posed barriers to access, highlighting the need for context-specific policy frameworks.

Main Conclusion

To bridge the critical gap in provision of surgical care in LMICs, health financing mechanisms play a critical role. This systematic review highlights the significant positive impact of health financing policies, particularly insurance coverage, on improving access to surgical care, enhancing quality, and reducing financial burdens in low- and middle-income countries. However, it also reveals the need to address hidden costs and prevent potential overuse of services. Policymakers must adopt comprehensive, adaptive, and inclusive strategies that ensure full financial protection, equity, and quality in surgical care, while employing robust governance mechanisms to guide the continuous evolution of these policies in response to emerging challenges and opportunities.

Rethinking accountability mechanisms as a means of strengthening governance in the Primary Healthcare Centres in Nigeria.

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(2) Health Policy Research Group, University of Nigeria, Enugu, Enugu, Nigeria,
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(6) Health Policy Research Group, Enugu, Nigeria,
(7) Department of Global Health and Development, London School of Hygiene and Tropical Medicine, London, United Kingdom

Background

Primary Health Centres (PHCs) in Nigeria are inconsistently funded and often deficient of critical consumables (drugs, medical supplies and diagnostic equipment), funds and staff. This is underpinned by lack of investment, weak governance, fragmented and dysfunctional accountability mechanisms and political inference. Rent-seeking remains a major issue recognized by local key stakeholders and this is enabled by poorly implemented accountability mechanisms. This study explored the potential for these mechanisms to be adapted and redesigned to better fit with broad institutional structures and the local socio-political context in order to improve governance and access to, and quality of essential health services.

Method

We employed a qualitative approach, conducting 8 weeks of participant observation in 6 PHCs and 2 Local Government Health departments (n=2). We followed this up with in-depth interviews (N = 30) with facility health managers, policy makers and Health Facility Committee Chairmen in Enugu, south east, Nigeria. Data were analysed thematically, followed by interpretation drawing on Brinkerhoff health system accountability framework.

Results

Staff at PHCs have multiple intersecting social relationships with formal and informal actors at different levels of the political and health care systems. Flows of funds, supervision and monitoring, reporting, capacity building, programme implementation, infrastructure development and supply of medical equipment and drugs are mediated by the formal rules and these social relations. However, payment of salaries and security are not mediated by social relations but provided solely by the Local Government Area and Ward Development Committee respectively. This disrupts and distorts the existing accountability mechanisms, creating multiple conflicts of interests and political interferences by multiple actors. These

processes often lead to ineffective formal complaint and feedback mechanisms, undermining trust in the system. The laws regarding financial budgeting (non-involvement of health workers), disbursement (and monitoring (irregular audits), external supervision are also shaped by these relationships. The spaces to create accountability mechanisms are squeezed by these forces, but there is possibility for improvement by implementing public financing management, establish clear policies addressing conflict of interest, fostering professionalism and improve compliant/feedback mechanisms.

Conclusion

Examining the intricate web of accountability mechanisms by identifying the role of the formal vis-à-vis informal mechanisms and gaps in accountability mechanisms, can help to improve governance mechanisms through addressing rent seeking, respond to acute health systems deficiencies and promote a just and sustainable primary healthcare system.

Innovations in African Healthcare: Decolonization, Policy, and Equity Initiatives

11:30 AM–1:00 PM Thursday, 03 March 2025

Political economy analysis of multi-stakeholder collaboration in formulating a new universal health coverage (UHC) policy in Senegal: Recommendations for a successful reform

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(1) Japan International Cooperation Agency,
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(4) London School of Hygiene & Tropical Medicine,
(5) London School of Hygiene & Tropical Medicine, London, United Kingdom

Background

Health financing reform is recognised as inherently complex and political, necessitating collaboration among diverse stakeholders with often conflicting interests. Recent studies have highlighted the usefulness of political economy analysis in gaining critical insights into real policy change. However, there remains a dearth of research on the contextual conditions and underlying processes of effective collaboration necessary for successful reform.

Objectives

In Senegal, the government has embarked on evaluation of its universal health insurance programme and subsequent formulation of a new universal health coverage (UHC) policy since 2019. Taking this ongoing reform, we analyse the collaboration processes in the health financing policymaking and elicit practical recommendations for its implementation.

Methods

This qualitative case study retrospectively disentangles the collaboration processes among different stakeholders in formulating the new policy, and prospectively assesses expected outcomes during its implementation as a result of such collaboration. This is facilitated by an analytical framework integrating the political economy framework by Campos & Reich (2019) with the collaborative governance framework by Emerson (2012) and its associated hypotheses. We conducted 24 key informant interviews with a wide range of stakeholders involved in the policymaking, and reviewed related policy documents to understand the system contexts and stakeholders' perceptions of the collaboration processes and outcomes.

Findings

The Senegalese UHC agency, which is leading the policymaking alongside its supervising ministry, the Ministry of Family and Solidarity, effectively mobilised external resources necessary for drafting the new policy. Development partners have also committed to the formulation process, providing crucial support with local expertise. However, although a ministerial order has defined the stakeholders relevant to the policy drafting, key stakeholders including the Ministry of Health, the Ministry of Finance and the Ministry of Labour have not substantially engaged, and the Ministry of Health is now formulating a similar but separate policy. Furthermore, notable tension persisted between the government and interest groups, especially community health insurers and service providers. This discord is undermining beneficiaries' trust and enrolment in the programme, posing significant challenges for the implementation of the new policy.

Conclusions

Insufficient collaboration in the policymaking process could hamper its effective implementation, despite the fact that the policy itself is designed to improve equity and sustainability of the health financing system. To address this, the government of Senegal should prioritise their efforts to harmonise inter-ministerial coordination and mitigate distrust and tension among the stakeholders to regain public trust in the programme.

Joint human and animal health campaigns in Chad: Improving health service equity for mobile pastoralists

Hamit Kessely[1], Jean Bernard Gbangou[2], Damien Revault[2], Monique Lechenne[2]

(1) Centre de Support en Santé Internationale, N'Djaména, Chad, Chad
(2) Swiss Tropical and Public Health Institute, Allschwil, Switzerland

Introduction and Objective

Providing health services to mobile populations, such as those in Chad who migrate with livestock to access seasonal resources, is a significant challenge. These communities' access to healthcare is further complicated by cultural practices and beliefs, which influence the acceptance of health interventions. For over 30 years, Chad has implemented a strategy of joint human and animal health campaigns to address these issues. These campaigns aim to build trust with nomadic communities, improve vaccination coverage for children, women, and livestock, and enhance knowledge about disease prevention. The Chadian Ministry of Public Health and Prevention (MPHP) and the Ministry of Livestock (MoL) organize these campaigns, supported by the Swiss Tropical and Public Health Institute (Swiss TPH) and its national partner, the Centre de Support en Santé Internationale (CSSI), within the framework of the Support Program to Health Districts in Chad (PADS). To facilitate the adoption and sustainability of these mixed campaigns, the partners developed an implementation guide, which has been officially approved by the relevant ministries.

Methodology

The planning of joint interventions begins with a thorough context assessment using a transdisciplinary approach to identify potential barriers to healthcare delivery. This allows for the development of locally adapted Information, Communication, and Education (IEC) strategies and the collection of information on the seasonal movements of pastoral groups, which is essential for timing and locating interventions. The preparation for field visits involves coordinated efforts from all ministries and partner programs to maximize benefits for all stakeholders.

Results and Discussion

In 2021, nomadic vaccination campaigns in the Kyabé and Oum-Hadjer districts of Chad vaccinated 4,084 children aged 0 to 59 months. Additionally, 325 pregnant women received prenatal consultations, 848 women of childbearing age were vaccinated against tetanus, and over 11,000 people received information on COVID-19 prevention. On the animal side, 8,755 cattle were vaccinated against anthrax and other diseases. These results demonstrate that joint human and animal interventions are well-accepted by pastoral communities and effectively extend health services to hard-to-reach populations. While these campaigns are costly and dependent on external funding, cross-sector collaboration can reduce costs compared to independent interventions.

Conclusion

Mixed campaigns enhance access to basic health services for pastoral communities. The implementation guide will support health districts in planning and securing partner support to meet the health needs of nomadic populations. It may also serve as a resource for similar efforts in other countries.

How cross-country learning collaboratives enhance technical assistance to improve the infrastructure of and strengthen safe blood systems: experience from Liberia, Malawi, and Rwanda

Julie Wieland1, Onyekachi Subah2, Thomas Muyombo3, Bridon M'baya4, Adaora Osi-Ogbu5, Yewande Ogundeji5, and Olasunmbo Makinde6

(1) Health Strategy and Delivery Foundation
(2) National Blood Safety Program, Liberia
(3) Blood Transfusion Division, Rwanda
(4) Malawi Blood Transfusion Service, Malawi
(5) Health Strategy and Delivery Foundation, Nigeria
(6) Health Strategy and Delivery Foundation, Ikoyi, Lagos, Nigeria

Background

Access to blood transfusions is a life-saving medical intervention for a range of health conditions, including malaria- and HIV/AIDS-associated anaemia, hepatitis, and postpartum haemorrhage (the biggest cause of maternal mortality). But blood systems—usually in low- and middle-income countries (LMICs) spearheaded by a national blood transfusions service (NBTS) often face challenges with access to and availability of safe blood. While many LMICs are undertaking health infrastructure transformations, they are experiencing diminishing funding from external assistance, necessitating knowledge sharing and learning among them. Safe blood systems often face common challenges, variation in maturity and development along the blood transfusion chain providing fertile ground for collaboratives to enhance health infrastructure interventions.

Method

Through the USAID Health Systems Strengthening Accelerator, key blood system stakeholders from NBTSs in Liberia, Malawi, and Rwanda participated in demand driven cross-country collaboratives (both virtual and in-person) to exchange knowledge, best practices, and learnings on the challenges to safe blood availability and prioritized blood systems reforms to improve timely access and availability of safe blood. With experts from Zimbabwe National Blood Service, Namibia Blood Transfusion Service, the Coalition of Blood for Africa, and the African Society for Blood Transfusion, the events fostered action-oriented learning

focused on health infrastructure topics including blood donor mobilization and retention, hemovigilance, and safe blood data generation and use for performance management and decision-making.

Results

Collaborative learning has enabled the three countries to tackle common health infrastructure challenges and make progress in implementing the guidelines and protocols, where the tacit or "how-to" knowledge and experience-sharing across countries was missing. For example, Liberia has incorporated a blood donor satisfaction survey into their routine collections. Malawi is creating an offline data collection and management system, developing school ambassador programs for blood donor retention, and exploring cost-effective solutions to meet the high demands and funding needs. Rwanda is adopting marketing strategies learnt from Namibia BTS, incorporating blood management system updates, and increasing the number of published research to increase visibility of the blood system and its impact on health.

Conclusion

The cross-country collaboratives facilitated by Accelerator provided an opportunity to enhance country implementation activities, linking the collaboratives with technical assistance provided. Our experience and results of using collaboratives to tackle safe blood infrastructure challenges suggest that collaboratives can also be an effective method for addressing other health system challenges where the what (policies, protocols, guidelines, etc.) is clear, but the how is murkier.

Towards Decolonizing Medicine and Healthcare: The Place of African Health and Healing Traditions

Geoffrey Nwaka *Abia State University, Uturu, Nigeria, Ututu, Nigeria*

Traditional medicine and therapeutic techniques have a long history in Africa for treating a wide range of human and animal health conditions. Sadly, this rich body of knowledge has for a long time been undervalued because of the dominance of Eurocentric mindsets and practices. But current research confirms that many of today's medicines are derived from tropical African medicinal plants, and that traditional medicine can provide a lead to scientific breakthrough in modern medicine and drug discovery. We argue that global health science needs to integrate the health traditions of local communities in Africa.

With colonialism, modernity and the emphasis on the use of pharmaceutical drug, vaccination and other form of biomedicine, traditional medicine now has to contend with the dismissive bias of doctors and government official who claim that the practice of traditional medicine does not conform with the scientific

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With colonialism, modernity and the emphasis on the use of pharmaceutical drug, vaccination and other form of biomedicine, traditional medicine now has to contend with the dismissive bias of doctors and government official who claim that the practice of traditional medicine does not conform with the scientific

principles of modern medicine, least of all the spiritual and cultural aspects of healing that sometimes involve divination, rituals, belief in witchcraft, and so on. These officials tend to distrust traditional medicine, and to insist on the need for to validate, codify and standardize it practice in order to ensure greater safety and efficacy. They therefore often hesitate to provide the regulatory and legislative framework for integrating traditional medicine into the national health system Unfortunately, modern or orthodox medicine, with all its obvious merits, is not readily accessible and affordable to a large percentage of the populations, especially in the rural areas; and even in cities, most people tend to combine traditional and modern medicines, especially during epidemics like HIV/AIDS EBOLA and COVID19, and in respect of such ailments as insanity for which Western medicine has not provided ready cure.

The paper underscores the value and continuing relevance of traditional medicine and other aspects of Africa's rich cultural heritage. It stresses the need to promote comparative medicine and collaboration between scientists and practitioners of modern medicine on the one hand, and on the other those who hold and use traditional medical knowledge, so that the traditional and the modern will complement and enrich each other, and thus advance the prospect of attaining Universal Health Coverage.

Priority Setting for Evidence-Informed Policy and role of HTA during Pandemic Preparedness and Response in Africa: A scoping Review

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(2) University of Nigeria Enugu Campus, Enugu, Nigeria
(3) London School of Hygiene & Tropical Medicine, London, United Kingdom

Background

Pandemic preparedness and response are vital components of global health security. These are particularly crucial in regions that are vulnerable to outbreaks of infectious diseases, such as Africa. Public health emergencies are a current threat to the population considering their potential devastation. The recent COVID-19 pandemic illustrates this well. Despite efforts to improve pandemic preparedness, gaps remain in evidence evaluation and priority setting. Learning from past experiences and adopting evidence-based strategies can enhance pandemic preparedness in African countries.

Aims and Objectives

To assess and document the status of priority setting and pandemic preparedness in Africa, to support the development of key recommendations for future pandemic/outbreak responses.

Methods

A scoping review was done, applying the Arksey and O'Malley framework. We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR) guidelines in reporting the findings. We used Covidence software and applied the following steps: identifying the research questions; identifying relevant studies; selecting eligible studies; charting the data; and collating and summarising the results.

Key Findings

At the continent level, the establishment of Africa CDC gives it the mandate to guide the African Union and its member states on the prevention, control, and management of diseases and health-related events. However, there is no specific policy on priority setting for pandemic/public health emergency (PHE) preparedness. Africa CDC usually adopts WHO policy to avoid duplication. Although several African countries have developed plans for responding to public health emergencies, these plans do not provide detail on the priority-setting process to be used. Governments mostly learned from each other. There is little discussion on the allocation of resources to the different health services provided or consumables needed. The use of epidemiological modelling, forecasting and cost-effectiveness analysis provided important evidence to support decision-making during the COVID pandemic in the African region, but the capacity to conduct such analysis was low. Relevant data needed for priority-setting requirements may be unavailable or of poor quality.

Conclusions

At both the African continent and country levels, some structures implicitly carry out priority setting during pandemics. However, and despite encouraging developments, the priority-setting processes are not clearly defined in most countries. This could be due to inadequate capacity and the absence of supporting legislation specific to priority setting. This calls for continued support for countries and the African Union to appreciate the importance of explicit priority-setting mechanisms and related tools such as HTA.

Keywords

Priority-setting, HTA, Africa

Innovative Approaches to HIV and TB Management in Africa

11:30 AM–1:00 PM Thursday, 03 March 2025

Mortality reduction and financial risk protection benefits of expanded TB control in Ethiopia: findings from a modelling study

Lelisa Fekadu Assebe *MSH, Addis Ababa, Ethiopia*

Objectives

Tuberculosis (TB) represents a large public health threat globally. The economic burden of seeking TB care places people at a high risk of financial hardship. The WHO TB Strategy aims to end TB and to fully shield households from catastrophic costs (CCs) by 2035. The impact of expanded TB control on reducing TB deaths and CCs across income quintiles was assessed in Ethiopia.

Design	Settings	Participants
TB impact modelling study	Ethiopia	TB-affected house-holds.

Interventions

Three TB strategies were investigated: active case finding; enhancing implementation of directly observed therapy, short-course (DOTS) for drug-susceptible TB (DS-TB); and improving multidrug-resistant tuberculosis (MDR-TB) care.

Outcome Measures

the TB Impact Model and Estimates (TIME) model was used to project the impact of these interventions on TB incidence and mortality. Using TIME outputs and patient-incurred costs, we projected the reductions in TB deaths and CCs through scale-up of TB control strategies per year and over 2018-35. Intervention impact was quantified as changes in the number of households incurring deaths and CCs relative to the baseline.

Results

In Ethiopia, around 757,000 TB-related deaths and 601,000 cases of CCs would occur over 2018-35 (base-case scenario). The scale-up of active case finding could reduce TB deaths and CCs by 27 and 32%, respectively; enhancing DOTS for DS-TB would avert 25% of deaths and 15% of CCs; and improving MDR-TB care would avert up to 1 and 6% of deaths and CCs in the base-case, respectively. Both mortality and financial protection benefits would be greatest for the poorest two quintiles.

Conclusions

Improving the delivery of TB control strategies, such as active-case finding and DOTS for DS-TB, could reduce mortality and financial hardship for affected households. Ensuring that TB-affected households are given universal access to person-centered care and adequate financial protection is essential in the combat against TB.

Keywords

Tuberculosis; financial protection; catastrophic costs; extended cost-effectiveness analysis.

Prevalence, associate factors and Mitigating Interventions of Stigmatization towards People Living with HIV/ADS (PLHA) in Africa: A Systematic Review Protocol

Edward Mawejje *Makerere University School of Public Health, University Research Council, LLC-Uganda, Kampala, Uganda*

Background

25.6 million people living with HIV in the African region with 380,000 people died from AIDS related illness. Africa houses HIV-related stigma is one of the major determinants of health. Frequently cited as a 'hidden' burden of disease, it is recognized as a major barrier to HIV prevention and treatment efforts. A nuanced understanding of HIV-related stigma prevalence and associated risk factors is critical for developing stigma-reduction interventions to optimize HIV-related outcomes. Hence it is imperative to estimate its prevalence, associated factors, and mitigation interventions to populate evidence for more robust policy reforms, multi-stake holder engagement and HIV-stigma service integration to enhance 2025, 2030 target expedition. A strong global commitment exists to eliminate HIV-related stigma and while multiple elimination strategies have been tried, the evidence of impact is not properly documented. Analyzing intervention experiences to date is useful for identifying lessons that can inform more effective and efficient interventions moving forward. The identification of effective interventions to reduce stigma that can be integrated into national responses is crucial to the success of the global AIDS response. The systematic review aims at determination of prevalence, associated and multilayered Stigma mitigation factors among People Living with HIV/AIDS (PLHA) in African continent

Methods

The study compiled and registered PROSPERO CRD42024507615, will search for relevant studies from MEDLINE, CINAHL, PsycInfo, PubMed, SCOPUS, Web of Science, Cochrane, and grey literature on Google scholar using a detailed pre-determined search strategy. Eligible studies published between 2015 and 2023 in English as authors are proficient in the language, will include excludes commentaries, editorials, symposium

proceedings, and scoping reviews The Mixed methods Appraisal tool (MMAT) will critically assess the included studies' methodological quality. A thematic synthesis approach will be used to synthesize data from included studies.

Expected Results and Findings

Conclusion

The systematic review will provide robust information on the context specific multilevel HIV stigma reduction interventions in Africa hence support policy makers, HIV/AIDS professionals, and researchers to understand current prevalence and common associated factors to Stigmatization toward PLHA in Africa.

Keywords

HIV Stigmatization, PLHA, systematic review, Africa and Protocol.

Optimal HIV Recency Testing among Eligible People Living with HIV (PLHV): Continuous Quality Improvement (CQI) Scale up at Busia Health Centre four (HC IV) in Busia District.

Edward Mawejje *Makerere University School of Public Health, University Research Council, LLC-Uganda, Kampala, Uganda*

Background

Globally, ambitious three pronged 95-95-95 targets were set for 2025. However, as of the Uganda Population Health impact assessment UPHIA, 2020 report, Uganda's awareness of HIV positive status among adults >15 years inclusive PLHV remains suboptimal at only 90%, highlighting a sub-optimal achievement.). Goal of ending the AIDS epidemic by 2030, requires surveillance scale up to detect new HIV infections, HIV 'recent infections' past 12 months with suboptimal coverage leading to high levels of HIV viral load hence viral transmission to their sexual partner(s) and babies. All TxNew >15 years must receive a same day recency test either at facility or community service points upon consent, (MOH 2020). Thus, suboptimal HIV recency testing results hinder progress towards achieving HIV epidemic control by 2030, zero new HIV infections, exacerbating stigmatization, and contribute to an increase in related deaths.

To improve HIV recency testing among all eligible newly diagnosed PLHV above 15 years from (2/10) 20% in November 2023 to (18/18)100% by end of April 2024.

Methods

Work improvement team (WIT) at Busia Health Centre IV in Busia district with population size of 2098

people living with HIV, conducted a rapid data survey that aggregated data on measures of Health systems strengthening; client hesitancy, Recency supplies stock outs, presence of Continuous quality improvement interventions (CQI), HIV recency testing uptake and knowledge, status of data management. QI team capacity building on HIV recency concepts, Integration of baseline HIV recency testing and robust data management inclusive timely data entries into PIRS and EMR data synchronization.

Results

By end of April 2024, Busia Health Centre IV achieved 100% recency testing coverage from 20% by end of November 2023, hence integration of mandatory HIV recency testing into HIV combination prevention and testing practices will accelerate National progress towards achieving HIV epidemic control by 2030.

Conclusion

Resilient CQI and data management initiatives are key to scaling up implementation. Therefore, these innovations should be scaled up to other similar settings for improved program gain and sustainability.

Strengthening Diagnostic Approaches: Utilizing X-Ray for Improved Childhood TB Notification in Stool-Negative GeneXpert Cases in Akwa Ibom, Nigeria

Steven Batur *KNCV Nigeria, Abuja, Nigeria and Okoh Adakole, KNCV nigeria*

Background

Tuberculosis (TB) remains a significant health challenge, particularly among children in high-burden regions. GeneXpert, while effective, often yields negative results in paediatric stool samples, leading to missed diagnoses. This study evaluates the use of chest X-ray (CXR) as an adjunct diagnostic tool to improve childhood TB notification in cases where GeneXpert results are negative.

Methods

The study was conducted in Akwa Ibom, Nigeria, from January to December 2023. Paediatric patients (ages 0-14) presenting with symptoms suggestive of TB and who tested stool-negative on GeneXpert were subjected to CXR. The CXRs were evaluated by trained radiologists for signs consistent with TB. Patients with suggestive CXR findings were further assessed clinically and through contact tracing. Data on TB notification rates before and after the implementation of CXR were compared.

Results

A total of 300 children with stool-negative GeneXpert results underwent CXR. Out of these, 85 (28.3%) had CXR findings indicative of TB. Subsequent clinical evaluation and contact tracing confirmed TB in 72 (24%) of these cases. The introduction of CXR led to a significant increase in childhood TB notifications in Akwa Ibom, from 120 cases per 100,000 children (pre-implementation) to 175 cases per 100,000 children (post-implementation), representing a 45.8% increase. The use of X-ray as a supplementary diagnostic tool resulted in a 22.5% increase in childhood TB notifications compared to relying solely on GeneXpert stool results.

Conclusion

The integration of chest X-ray as a supplementary diagnostic tool significantly improves the detection and notification of childhood TB in cases where GeneXpert results are negative. This approach has the potential to enhance TB control efforts, ensuring timely diagnosis and treatment of TB in children, thereby reducing TB-related morbidity and mortality in high-burden settings.

Automated Health Expenditure Analysis: Adapting an HIV-Based Tool for TB with Broader Disease Applications for South Africa

Sithabiso Daphne Masuku[1], Raymond Mashishi[2], Khumo Modiba[1], Anthony Odama[2], Zwebuka Khumalo[2], Joshua Karume[3], Teresa Guthrie[4] and Gesine Meyer-Rath[5]

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Introduction

Analysing South Africa's healthcare expenditure is essential due to its significant investments in HIV and tuberculosis (TB) programs. The country has the largest HIV program globally and is scaling up its response to TB, a leading cause of death. The 2017-2020 South African National AIDS Spending Assessment (NASA) included TB expenditures for the first time, identifying funding gaps and improving financial planning. To meet the need for a versatile expenditure analysis tool that can be adapted for additional disease areas, we developed BASLY-Reloaded (BASLY-R), a tool utilising C# and VB-NET in conjunction with SQL Server to extract and organise HIV and TB expenditure data from the Basic Accounting System (BAS) maintained by the National Treasury. We describe the development of BASLY-R, specifically its adaptation for TB expenditure analysis, and highlight its versatility for broader disease expenditure.

Methods

BASLY-R processes Excel-formatted public sector financial records derived from BAS, to produce analysable outputs for national and provincial TB expenditure data. This flexible tool allows users to analyse data for one or multiple provinces and/or government departments across a number of years based on their specific analytical needs. Adding a new disease is a two-step process: 1) identifying and classifying search terms according to programmatic activities and NASA codes, which is a collaborative and iterative process involving multiple stakeholders, and 2) assigning these search terms to programmatic areas and NASA codes. The tool then uses the predefined list of search terms to capture TB-related expenditures and categorises each expenditure item by programmatic area and NASA codes. We tested BASLY-R's robustness and accuracy by comparing the 2022/23 TB expenditure with the National Department of Health (NDoH) official figures for the same period, based on the NDoH's own internal data collection and reporting systems.

Results

Preliminary results show an 8% variation in 2022/23 TB expenditure by BASLY-R (R461.1M/USD24.99M) compared to NDoH's R498.88M/USD27.04M. Variation between BASLY-R and NDoH data was more pronounced at the provincial level. The programme areas with the highest expenditure were TB diagnostics (26%), followed by TB control (25%) and drug-sensitive TB treatment (25%).

Conclusion

Our evaluation of BASLY-R's accuracy in extracting 2022/23 TB data confirmed its effectiveness in comprehensive expenditure capture and facilitated resource allocation analysis across TB programmes. Additionally, we have shown that this tool can be adapted for disease areas other than HIV, improving and expediting much-needed expenditure tracking in the South African healthcare sector.

Measuring Quality of Life

11:30 AM–1:00 PM Thursday, 03 March 2025

Health-Related Quality of Life in Children with Sickle Cell Anaemia in Malaria-Endemic Regions: The Impact of Disease States and Malaria Prevention Strategies

Carol Kamya[1], Idro Richard[2], Ochanda Perez[1], Kalibbala Dennis[4], Gondwe Thandile Nkosi[3,5], Akun Pamela R[2], Kamija Phiri[3,5] Feiko O ter Kuile[8], Oddvar Kaarboe[1], Robberstad Bjarne[1]

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Objectives

To assess the health-related quality of life (HRQoL) of children with sickle cell anaemia (SCA) in Uganda and Malawi during sick attacks and steady disease states and explore how HRQoL is affected by malaria chemoprevention with weekly dihydroartemisinin-piperaquine (DP) or monthly sulphadoxine-pyrimethamine (SP).

Methods

This cohort study was nested within a clinical trial of malaria chemoprevention comparing weekly DP against the standard of care with monthly SP among children with SCA in Uganda and Malawi. We measured the HRQoL using standardised EQ-5D tools during steady states (baseline and at the study end) and sick attacks. Multivariate ordinary least squares regression was used to identify factors associated with HRQoL.

Results

Six hundred thirty-three children with SCA from Uganda and Malawi were enrolled (mean age 8.1 years (SD 3.7). HRQoL was relatively high during steady states but deteriorated during sick attacks. HRQoL was associated with age and hospitalisation. During steady states, HRQoL was higher among older children; however, older children had a lower HRQoL during sick attacks. Having been hospitalised was negatively associated with HRQoL. Children reported the most problems with pain and discomfort. There were no differences in the HRQoL of children between treatment arms.

Conclusion

HRQoL of children with SCA was relatively high during steady states/routine visits but substantially deteriorated during sick attacks, especially because of severe pain and discomfort. HRQoL is influenced by a child's age and hospitalisation frequency. Results from this study provide information that may be used to calculate quality-adjusted life years for economic evaluation.

Integrating Women's Voices in Quality of Care (QoC): Does Anonymity Matter?

Solomon Chinedu[1], Chiagozie N AbiakamP[2], Astrida Tshabalala[2], Elisabeth Ezekiel[2], Olabisi Dabiri[2], Seyi Malumi[2], Nneka Mobisson[2] and Imo Etuk[2]

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Background

Feedback from patients, especially women, is essential for enhancing the quality of care provided at healthcare facilities and improving their experience of care. However, obtaining objective feedback that genuinely mirrors the perspectives of patients may be difficult, particularly in low and middle-income countries. The 'Anonymity Paradox' suggests that patients consider anonymity crucial for giving honest feedback without facing any negative consequences. Conversely, healthcare providers often perceive anonymity as a significant barrier and are concerned that anonymous feedback might impede their ability to validate the accuracy of such feedback and effectively address any potential problems.

Aims and Objectives

The study assessed how reviewer anonymity influences the polarity of patient feedback, and compared anonymous and non-anonymous patient feedback and ratings across different dimensions of quality care to identify differences.

Methods

The study, inspired by MSD for Mothers' funded Project AISHA, collected reviews (dataset) from 1491 women (634 anonymous, 857 non-anonymous) in Lagos (583) and Kaduna (908) States in Nigeria using NaviHealth.ai™, mDoc Healthcare's geo-coded digital directory of healthcare services and providers. These women provided digital feedback on their experience of care at 39 public and private healthcare facilities from November 2023 to June 2024. The dataset included ratings and qualitative feedback based on an adaptation of the six dimensions of quality care by The Institute of Medicine (IOM) (safety, timeliness, effectiveness, patient-centered care, privacy & confidentiality, and equity), with anonymity status. The influence of anonymity was analysed using descriptive statistics, while sentiment analysis was conducted using natural language processing (NLP).

Key Findings

The findings suggest that anonymity matters in the perception and reporting of quality care. The results showed that anonymous reviewers rated facilities lower (average rating of 3.68 out of 5) compared to non-anonymous reviewers (3.84). This trend was consistent across all six quality dimensions. Sentiment analysis revealed that 9.5% of anonymous reviews were negative, significantly more from public facilities

(+8.5%), compared to 3.7% from non-anonymous reviewers. Non-anonymous reviewers also gave 4.3% more positive feedback, notably from private facilities (+20.7%). Additionally, anonymous reviewers often cited wait times and staff shortages, while non-anonymous reviewers more frequently praised staff attitude and facility cleanliness.

Conclusion

The absence of anonymity of reviewers may result in more objective assessment, while reviewers who are identifiable may feel the burden of accountability and so provide more positive judgments, potentially skewing overall ratings and misrepresentation of actual quality of care.

The Health-Related Quality of Life (HRQoL) and Predictors among Patients with T2DM using EQ-5D-5L Instrument at a Tertiary Healthcare Facility in Nigeria

Charles C Ezenduka

University of Nigeria, Enugu Campus, Enugu, Enugu, Nigeria and Chinelo Esther Obi, Health Policy Research Group, Enugu, Nigeria

Background

Diabetes remains a leading non-communicable disease (NCD) in Nigeria with significant health and economic burden. Quality of life measures in chronic diseases is critical for informed health policy decisions to enhance the efficiency of disease management and control. This study evaluated the health-related quality of life (HRQoL) among patients with Type 2 diabetes using the EQ-5D-5L instrument, as well as the determinants of health status among the patients.

Methods

A cross-sectional study was conducted on a total of 210 patients with type 2 diabetes mellitus (T2DM) attending diabetic outpatient clinic at the Parklane Teaching hospital in Enugu, SE Nigeria, between July and September 2021. Using the EQ-5D-5L questionnaire instrument, patients were asked to evaluate their health status around the five dimensions (5D) and a visual analogue scale (VAS). The Zimbabwe value set was used to evaluate the patients' responses to obtain the EQ-5D score, while multiple regression technique was used to assess associations between the variables to determine the predictors of health status.

Results

A total of 202 eligible participants were finally assessed, with a mean age of 62.5 (± 11.84) years. Up to 85% was over 50 years, with majority (62.5%) as females. A third of the respondents had no formal education. About half were unemployed and/or retired. Majority (68.5%) had co-morbidities, mostly cardiovascular diseases. Up to 65% have had diabetes for less than 10 years, mostly managed with only anti-diabetes medications (64.5%). More than 50% had little to no problem with walking while 65.5% reported same under self-care. About 21% reported severe problems under usual activities. Only 24.5% reported having problems with pain/discomfort. The mean EQ-VAS and utility valuations of respondents were 65.21% (±15.1) and 0.78 (±0.2) respectively. Respondents' education and employment status independently and significantly predicted EQ-VAS by 2.09, (95%CI:0.22-3.96; p=0.029) and by 2.03 (95%CI:0.08-3.96; p=0.041) respectively. Education positively predicted the EQ-5D utility index by 0.3(95%CI:0 – 0.06, p=0.033).

Conclusion

The relatively low utility scores among the patients highlight the significant impact of diabetes on the quality of life of diabetes patients in the study area, which is worsened by poor education, and unemployment. While pain/discomfort appears to be the major problem for most of the patients, anxiety/-depression was not predicted by sociodemographic and clinical characteristics. Findings will contribute to the existing but limited information on the relevant data for estimating the cost-effectiveness of interventions for enhanced efficiency of diabetes management and control.

Comparing generic and disease-specific quality of life instruments in sleep health: A dimensionality assessment using factor and latent path analysis

Billingsley Kaambwa *Flinders University, Adelaide, Australia*

Introduction

Generic quality of life (QoL) instruments, designed to evaluate QoL in any population, are the most widely used in evaluations. However, there is an ongoing debate about the suitability of such instruments in condition-specific populations, especially as they are not sensitive enough compared to instruments designed explicitly for these populations. Frameworks such as the International Classification of Functioning, Disability, and Health (ICF) have been used to demonstrate the conceptual overlap between these instruments. However, the extent to which generic instruments can be correctly substituted for condition-specific ones is unclear in people with sleep disorders. This study compares the latent traits measured by two generic instruments (EQ5D-5L and ICECAP-A) and two sleep-specific ones (Functional Outcomes of Sleep Questionnaire and Epworth Sleepiness Scale).

Methods

This study analysed data from 2,060 Australians with sleep disorders (mean age 52 years). Correlation between instrument dimensions was assessed using Kendall's rank and Spearman correlation coefficients. Latent traits related to each instrument dimension were identified using exploratory factor (EFA) and confirmatory factor analysis (CFA), with factor loadings 0.4 deemed significant. Latent path analysis (following EFA and CFA) was conducted to assess the latent trait structure and test hypothesised structural relationships defined according to the ICF framework.

Results

The correlation between generic and sleep-specific instrument dimensions was low to mild (Kendall's rank correlation coefficient range: 0.06 – 0.45; Spearman correlation coefficient range: 0.05 - 0.57). In the EFA (where three factors were deemed optimal), none of the generic instrument dimensions loaded onto the same latent traits as the sleep-specific instrument dimensions. The path coefficients for the structural relationship between the EFA factors ranged from 0.12 to 0.28, suggesting that only up to 28% of the variation in one factor could be explained by another. The CFA models, based on ICF classifications, did not converge. It was, therefore, impossible to obtain CFA path coefficients.

Conclusion

These results suggest that there is less conceptual overlap between generic and condition-specific than assumed in the literature. Therefore, the choice of instrument for use within condition-specific populations is not without consequence. Generic and condition-specific instruments should be considered complements and not substitutes.

A context-specific protocol for developing a quality-adjusted life year value set for Nigerian adult population

Abdulmuminu Isah[1], Chinelo Esther Obi[2], Iheomimichineke Ojiakor[3], Chibueze Anosike[1], Onochie Chigozie Eze[1], Kingsley Ude[1] and Obinna Emmanuel Onwujekwe[3]

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(3) Health Policy Research Group, University of Nigeria, Enugu, Enugu, Nigeria

Background

National value sets are used as reference figures in the evaluation of the quality of life of individuals in a study, irrespective of their disease conditions. Despite the number of health economic studies from Nigeria that have assessed the quality of life (QoL) of their participants, there is no known validated value set for the contextual evaluation of the participants' QoL. A nation-specific value set guides policymakers in evidence-based decision making, especially in resource allocation.

Aim

The aim of this protocol is to develop a methodological framework for the determination of an EQ-5D-5L quality-adjusted life year (QALY) value set for Nigeria.

Methods

A cross-sectional study will be conducted in the six geopolitical zones of Nigeria, considering the income levels (low, medium, and high) and population sizes of different regions. The participant's health preference state will be determined using their health state, preference weight, and utility values with the aid of the EQ-5D-5L, EuroQol visual analogue scale, composite time trade-off, discrete choice experiment, and standard gambling. The sampling will note societal preferences such as age, sex, geopolitical location, marital status, and income level. The EQ-VT protocol will be adopted throughout the study process. Data will be collected through face-to-face interviews and electronic means. Collected data will be stored on a secured server and analyzed using both descriptive (frequencies and percentages for categorical data and mean ± standard deviation for continuous variables) and inferential (regression models) statistics.

Expected Results

A total of 1000 participants will be expected to participate in the study (projected response rate ≥ 85%). All the components of the protocol will be pretested and piloted, with the appropriate adjustments made as necessary. It is expected that the protocol will be used in the development of a QALY values set for the Nigerian adult population.

Conclusion

The protocol that will guide the development of a QALY value set for the Nigerian adult population has been produced for health economic evaluation in the country.

2:00 – 3:30 PM Thursday March 13, 2025

Finding the right level of financial autonomy of primary care service providers for responsive and people-centred health systems (organized session)

Inke Mathauer *WHO, Hélène Barroy, WHO*

Description

The issue of provider financial autonomy in the public sector – which relates to level of control and influence that health facility managers have to mobilize, allocate, and spend financial resources – has been long discussed in the health financing literature. Yet, most studies to date focused on hospital autonomy. Attention has recently shifted to primary care, and there is increasing recognition about the importance of financial autonomy for effective financing and delivery of primary care services. In its absence, providers are unable to respond to local priorities and needs. While there is need to mitigate the fiduciary risks associated with entrusting facilities with more funds and spending authority, the imperative of fiscal control has trumped the push for autonomy in many countries, especially at the primary care level.

The purpose of this session is to deepen our understanding of the processes of granting more financial autonomy or reducing it and how and why this happens, whilst sharing country experiences. Financial autonomy, and more broadly provider autonomy of public providers, is a key element of health system governance and requires appropriate institutional design for health systems to be fair and sustainable, more so in a context of a growing private health care provider market and population expectations for good quality of care. This session aims to explore the prerequisites as well as the implications of different levels of financial autonomy of primary health care providers as one factor for effective purchasing and provision of primary care services to ultimately to drive progress toward the UHC objective.

As a learning objective, the session seeks to contribute to developing a more explicit theory of change about the role of financial autonomy of primary healthcare providers. This will help to open the black box of financial autonomy and shed more light on the right level of financial autonomy in a given context, how to find this level, as well as on the requirements (including staff capacities to manage public resources) needed to enable financial autonomy, such as PFM systems as well as accountability mechanisms. The objective is to clarify the future policy and research agenda and inspire the audience to build a learning community around this subject. For instance, an important question is how to balance facility autonomy of an individual facility vis-à-vis primary care network autonomy.

The envisaged audience are researchers, health policy makers and analysts, practitioners, and development partners.

Financial autonomy of primary care providers in low- and middle-income countries: assessing the evidence to inform the development of a typology and conceptual framework

Sophie Witter *IGHD, Queen Margaret University, Edinburgh, United Kingdom*

Background

Provider autonomy is increasingly asserted as an important attribute in health systems, but is rarely interrogated in-depth, particularly at primary care level. This presentation will examines the current state of evidence on the role of financial autonomy in primary care, focusing on the public sector in low- and middle-income settings (LMICs).

Methods

The presentation draws on a mixed methods study, including a scoping review of the literature (91 documents), 12 expert interviews and the knowledge of the research team. Findings were also discussed with health financing and public financial management experts at a meeting in 2023 to deepen the reflections.

Results

We examine the reforms which have been associated with triggering or at least raising the profile of financial autonomy as an important attribute, including strategic purchasing reforms, decentralisation and public financial management (PFM) changes. We highlight important considerations for design and implementation of financial autonomy at primary level and propose an evidence-based typology structured by the budget cycle, which defines specific dimensions of financial autonomy along a continuum. Finally, we examine what evidence exists on the impacts of financial autonomy and develop a conceptual framework to highlight key considerations in terms of contextual influencers of financial autonomy, prerequisites for it to be deployed, and the potential positive and negative effects of financial autonomy at primary care level. This can be used to encourage future research in this area

Conclusions

We conclude that financial autonomy at primary care level can contribute to facility performance, if tailored to contextual factors and supported by accountability mechanisms. However, while financial autonomy is prima facie a positive attribute, the understanding of autonomy over what, for which purposes and by whom is still not clearly addressed in the literature, along with the implications for purchasing and public financial management (which is key to enable financial autonomy, as well as being affected by it).

This is the first study to our knowledge providing an in-depth understanding of provider financial autonomy at primary care level in LMICs, and moves the field forward with its typology and conceptual

Enhancing Financial Autonomy at Primary Health Care Facilities in Tanzania: Insights from Direct Facility Financing (DFF) Implementation

Peter Binyaraku *Ifakara Health Institute, Dar es Salaam, Tanzania, United Republic of*

Background

Direct Facility Financing (DFF) is increasingly being implemented in low- and middle-income countries as a mechanism to directly fund primary health care (PHC) facilities. The primary goals of DFF are to streamline resource allocation, promote fiscal decentralization, and grant autonomy to health facilities to enhance their service readiness, provision and responsiveness. This study aims to assess the facilitators and barriers to financial autonomy at the PHC level within the context of DFF implementation.

Methods

A mixed-methods approach was employed, incorporating both a scoping review and qualitative research. The scoping review encompassed all available literature on DFF in Tanzania. The qualitative component of the study was conducted in two districts within Singida region. It involved 16 in-depth interviews with healthcare workers, accountants, and managers, as well as 4 focus group discussions with community representatives from health facility governing committees (HFGCs). The qualitative data were analysed using thematic content analysis.

Findings

The review revealed that few studies in Tanzania have assessed the level of financial autonomy under DFF. Key facilitators of financial autonomy in the context of DFF include: the design feature of direct fund transfers to frontline providers; budgeting practices initiated at the facility level; accessibility and utilization of financial systems for budgeting and planning; institutional setups at the PHC level, such as existing bank accounts and community engagement through HFGCs; and availability of accredited pharmacies (prime vendors) for drug procurement within each region. However, several barriers constrain financial autonomy under DFF, including: inadequate financial management knowledge and a lack of accountants in most facilities; delays in the disbursement of funds; complex procurement and approval processes; and public financial management (PFM) rigidity in spending caps and restrictions on reallocations.

Conclusion

Efforts are still needed to fully achieve financial autonomy through DFF in Tanzania. Addressing the identified barriers, particularly by improving financial management capacity and streamlining fund disbursement and procurement processes with appropriate accountability mechanisms, could enhance the autonomy under DFF. Strengthened support systems for financial management are also crucial for sustaining financial autonomy and improving health service delivery at the PHC level.

What does the new Facilities Improvement Financing Act of 2023 bring for autonomy of public health facilities in Kenya?

Elizabeth Wangia *Ministry of Health, Nairobi, Kenya*

This presentation will review Kenya's evolving experience in facility autonomy before and after the Facilities Improvement Financing (FIF) Act of 2023, enacted in the context of a wide-ranging reform of the Kenyan government through its Bottom-Up Economic Transformation Agenda (BETA). Since the political devolution, and new constitution, which established the county governments in Kenya, varying interpretations of the constitutional provision for a consolidated county fund led to limited degree of autonomy for public health facilities. In several cases this provision has been used to maintain control with county policy makers vis a vis health facility, although some progress was being made through enactment of county facility financing laws.

The Facilities Improvement Financing Act, 2023 brought an opportunity to harmonize approaches to legislation enabling facilities' ability to retain and manage funds. It mainly provided for an efficient, secure and accountable mechanism for the collection, retention and management of revenue derived from health services rendered at public health facilities; the appropriation, management and use of budgeted health services revenue to facilitate quality service delivery in public health facilities.

Its objectives also included establishing a governance framework to facilitate effective planning, coordination, mobilization and access of financing, promoting equitable health facilities improvement financing, and providing for a unified system to guide financial management in public health facilities. It further delineated the roles and responsibilities of various entities, national, county and health facilities, in facility financing.

The presentation will assess the existing situation with regard to autonomy of health facilities at different levels, and the potential impact of overall financing of health facilities from the county budgets, as a result of increased collection and retention at source. It will identify the additional value and advantages the new law brings for facility financial management as well as the unique challenges of domesticating and implementing the legislation in a devolved setting.

The presentation will also highlight how the proposed facility autonomy reforms work in tandem with the other pillars of the health reform (the Primary Health Care Act, the Social Health Insurance Act and the Digital Health Act) to enable health facilities and the health system to deliver on the broader health system objectives of providing comprehensive health services and making progress towards universal health coverage.

Decision Models and Quality of Care

A Comparative Analysis of Bayesian and Frequentist Methods for Assessing Sleep Quality of Life Instrument Validity

Billingsley Kaambwa *Flinders University, Adelaide, Australia*

Background

The growing use of quality-of-life instruments in health economics demands rigorous validation to guarantee accurate and reliable measurement of health impacts. Item response (IRT) and classical test (CTT) theories are two approaches widely used for validating quality-of-life instruments. Applying Bayesian rather than frequentist techniques in IRT and CTT validation exercises is seen as a natural way of expressing uncertainty by assigning a prior distribution designed to reflect a priori knowledge. However, little is known about the performance of IRT/CTT Bayesian versus frequentist techniques when validating quality-of-life instruments and whether this performance differs by type of instrument (i.e., generic versus condition-specific). This issue is addressed within the context of validating three generic instruments (EQ5D-5L, AQoL-4D and the ICECAP-A) and two condition-specific ones (Functional Outcomes of Sleep Questionnaire and Epworth Sleepiness Scale).

Methods

We analysed data from 1,510 Australians with sleep disorders to compare Bayesian & frequentist validation methods. CTT assessed discriminant and convergent validity using confirmatory factor analysis (CFA) based on variance-extracted estimates. Quality-of-life dimensions were assumed to load onto two broad latent traits ('body functions' and 'activities and participation') defined using the International Classification of Functioning, Disability, and Health framework. IRT focused on item discrimination. Quality-of-life dimensions were ranked according to their discrimination values and by type of instrument. Agreement in findings between Bayesian and frequentist techniques was assessed using Concordance correlation coefficients and Krippendorf's alpha.

Results

Bayesian validity estimates were more conservative and were, on average, about 15% lower than frequentist values. Agreement between Bayesian and frequentist results was higher for condition-specific

Discussion

Our results suggest that within sleep disorder research, the choice between Bayesian or frequentist CTT/IRT techniques is more consequential when validating generic instruments, particularly in sleep-specific populations. Given the demonstrated advantages of Bayesian techniques in capturing individual-level variability and accommodating prior information, their integration into the psychometric testing of generic quality-of-life instruments in sleep disorder research warrants further exploration.

From Data to Decision: Transforming Nigeria's Community-based delivery of Health Services with Real-Time Mobile Solution using ANRiN App

Kehinde Adeniyi[1], Ojuolape Solanke[1], Femi Adegoke[2], Ritgak Tilley-Gyado[3], Michelle Mehta[4], Kamal Adamu Ibrahim[3], Eubert Vushoma[3]

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Background

The Health Management Information System in Nigeria has undergone significant development, resulting in broad coverage; however, challenges persist in delivering timely and reliable data for informed decision-making across different levels of healthcare. The National Health Management Information System faces limitations in capturing vital service delivery information, leading to data gaps, and health workers may often disregard standard protocols and aids.

Methodology

Addressing these issues, the Accelerating Nutrition Results in Nigeria (ANRiN) Project mobile and web application, supported by the Power of Nutrition Trust Fund, has emerged as a transformative solution. This Android-based app facilitates real-time data collection even in areas with limited internet access, syncing with a central server when online. It enables community and facility health workers to input beneficiary data, including geolocations, and provides follow-on service notifications within defined areas, ensuring adherence to treatment protocols. The ANRiN app is paired with a web application for data integration and visualization. In addition, user support is offered via an online issue tracker and live help desk sessions.

Results

Through the numerous analytical products generated by the app, programme implementers attest to more informed use of data for decision making. Presently, 7,780 health workers utilize the app, impacting over 2 million children treated for diarrhoea and are dewormed, as well as pregnant women receiving vital services such as iron-folic acid supplementation and intermittent presumptive treatment of malaria in pregnancy. To date, over 8 million women and children have received nutrition services through the use of the mobile application. The app's regular updates enhance its functionalities, available on Google Play Store. Notably, the app transcends mere reporting, incorporating geo-tagged service points and anomaly detection, ensuring quality care while deterring false reporting incentives.

Conclusion

Ultimately, the ANRIN app bridges data gaps, improves service quality, and fosters data-driven decision-making, bolstering Nigeria's health information system.

A Systematic Review of the Application of Decision Analytic Modelling to Cardiovascular Disease Prevention in Sub-Saharan Africa

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Objectives

To examine the application of decision analytic modelling to cardiovascular disease (CVD) prevention in sub-Saharan Africa (SSA).

Methods

The systematic review was conducted and reported using PRISMA 2020 guidelines, with review protocol preregistered on PROSPERO (CRD42023457106). Model-based economic evaluations of interventions targeting CVD prevention among adult populations in SSA countries were included. An iterative process was used to develop the search strategy, which was applied on seven databases. The final search was performed on September 12, 2023. All articles were screened by two reviewers, data extracted using Microsoft Excel and narrative synthesis conducted. Quality assessment was performed using Philips checklist.

Results

From an initial 2033 search results, we included 27 articles from eight SSA countries. South Africa had the highest number of studies (seven) while Uganda had only one. Majority of the studies focused on primary prevention (mostly pharmacological interventions), while six studies each focused on lifestyle risk factors and health systems strengthening interventions. Thirteen studies were Markov models, seven were microsimulation models, while three studies each used multistate life table and WHO CHOICE modelling methods. Ischemic heart disease and stroke were the commonest CVD outcomes. The Framingham risk equation was the most used to model the 10-year CVD risk among patient cohorts. Seven studies incorporated equity dimensions in the modelling, which were assessed mainly through subgroup analysis. The mean quality score of the papers based on the Philips checklist was 70.6% and ranged from 48.2% to 86.8% (median= 74.1%). Most studies reported data challenges while only three studies conducted model validation.

Conclusions

The review finds paucity of studies modelling the impact of interventions targeting primordial prevention and those aimed at improving access to CVD prevention. There is a need to conduct equity-informative economic evaluation of CVD prevention interventions to inform the design of universal health coverage interventions in SSA.

A Model for Assessing Financial Programs' Digital Maturity in Health Systems

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Background

Studies have shown that most digital maturity models are fraught with weaknesses such as an overly emphasis on technology, neglected crucial organizational and human factors; and a lack of both necessary depth and breadth for comprehensive evaluation. Hence, there is no agreed-upon model for assessing digital maturity for health financing programs, especially in low- and Middle-income countries (LMICs), including Nigeria. The failure to identify appropriate dimensions for evaluating the digital maturity

Aims and Objectives

Given the foregoing, our study designed a comprehensive model that can be used to assess the digital maturity levels of facilities implementing health financing programs in Nigeria.

Methods

The development of our model was in two (2) phases. First, we conducted a literature review to identify relevant indicators and dimensions of digital maturity. Secondly, we conducted subject matter and expert interviews with State Social Health Insurance Agencies (SSHIA) and State Primary Health Care Development Agency (SPHCDA) gateways to triangulate and extend the findings from the literature review.

Key Findings

This study developed a 3-dimensional model comprising of the infrastructure, resources, and operations; processes and systems; and people, skills, and attitude domains. The Infrastructure, Resources, and Operations domain assesses the level of technological infrastructure, budget management for digital initiatives, efficiency of service delivery, and communication channels' alignment with digital platforms. Process and Systems assesses the level of project management methodologies, innovation in digital solutions and strategies, quality and timeliness of digital reporting mechanisms, data management, storage, and security practices, and integration of digital tools within internal processes. Lastly, people, skills, and attitude evaluate receptiveness to digital transformation, leadership's commitment to driving digital initiatives, human resource capabilities in the context of digital skills, recruitment practices supporting digital workforce expansion, and opportunities for continuous learning and skill development.

Conclusion

The developed digital maturity model provides a comprehensive framework for evaluating health financing programs' digital maturity in LMICs. By encompassing three critical dimensions, this model addresses existing gaps in current methodologies. By adopting this model, healthcare organizations can better understand their digital capabilities, identify areas for improvement, and strategically plan for advancing their digital maturity.

Health Financing, Efficiency, and Policy Impact in Sub-Saharan Africa

2:00 PM–3:30 PM Thursday, 03 March 2025

Methodological Issues in Implementing Sub-National Public Expenditure Reviews in the Contexts of limited fiscal decentralization and complex funds flow: The Case for Malawi.

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Background

The Malawi health budget was decentralized from the central level to district councils in 2005/06 Financial Year. This fiscal decentralization, however, is limited to district councils only and does not extend to sub-district units making it difficult to trace expenditures at sub-district facilities and link the same to services, population, and programmes. The Ministry of Health has prioritised key reforms on direct facility financing and service delivery integration that require sub-district expenditure data. However, the current available methods for conducting sub-district public expenditures reviews (PER) are not amenable to the Malawi situation because they assume availability of disaggregated data for sub-district health facilities and assume cost-centre status of the sub-district facilities. We therefore proposed novel methods for conducting sub-district PER and used them to undertake a sub-national PER in Zomba and Mangochi Districts of Malawi.

Objectives

To test methods for accounting of health expenditures in the context of limited fiscal decentralization at the sub-district level and apply them to PER study.

Methods

1. We defined total district health expenditure as follows:

Total District Health Expenditure = *Council Level Health Expenditures + Health Facility Expenditures*
Health Facility Expenditure = *PersonalEmoluments + medicines + Blood + laboratory consumables + utilities + stores + Motor VehicleMaintenance + EquipmentMaintenance + BuildingMaintenance + OtherExpenditures*

2. We obtained information from the district IFMIS. For data that could not be found in IFMIS, we used the following:

(i) Facility Personal Emoluments expenditures were tracked at the point of payment into individual bank accounts and using duty stations for each employee.

(ii) Medicines and blood supplies expenditures were tracked using sales data from the Central Medical Stores Trust and the Malawi Blood Transfusion Services sales data.

(iii) For laboratories, we tracked each procurement to obtain quantities procured and the associated payments.

(iv) Buildings and equipment maintenance costs were tracked from the administrative records.

(v) Any other facility level expenditure was distributed using outpatient utilisation data.

3. We aggregated all expenditures at district level

Key Findings

The study found that there is funding inadequacy at the facility and district level covering only 30-50% of the needed resources; government health facilities lack budget autonomy; central-level control of district health budgets; lack of equity consideration and data in budget planning; insufficient development cost allocations; and widespread issues like overstocking, product expiration, and stockouts of essential drugs.

Conclusion

The findings of this study demonstrate the potential for tracing and accounting for health expenditures at the sub-district level, even in the context of limited fiscal decentralization and data.

Technical efficiency of district hospital in the context of free healthcare for pregnant woman and under-five years old children in Burkina Faso

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(2) Financing Alliance for Health / African Frontline First, Ouagadougou, Burkina Faso
(3) The World Bank, Yaoundé, Cameroon

Background

This study focused on district hospital (HD) in the context of policy of free care for pregnant women and children under five years of age. Its purpose was to estimate the HD technical efficiency score and determine the factors that influence it.

Methods

We conducted a secondary data analysis of the National Health Information System (NHIS) for the period from 2016 to 2018.This study, however, used the Simar and Wilson method despite the fact that the second method is more commonly used. It consists of resampling of the original data and makes it possible to assign, estimate and deduct the bias resulting from the bounded nature of DEA scores. The estimation of scores used as input variables the per capita financial allocations (which include the cost of benefit, medical examinations, drugs used) received in the contest of policy of free healthcare for pregnant women and children less than five years of age and the number of HD beds. Outputs variables included the number of births (eutocic and dystocia) + caesarean sections performed and the number of children less than five years of age under the exemption measure.

Results

The results show that over in 2016, 2017 and 2018 2(6.67), 4(10.81), 3(8.11) HD were efficient. The average HD technical scores were 0.29, 0.38 and 0.44 respectively in 2016, 2017 and 2018. This indicates that the outputs (services) produced could have been increased by 0.71, 0.62 and 0.56 in those years. A second stage of analysis was also conducted to determine the factors that explain the technical efficiency of CMAs. It results from this analysis that variables such as the number of new contacts per inhabitant, the number of inhabitants per health and social promotion centre (CSPS) that characterize the demand for care are those that significantly and positively influence the technical efficiency of HD.

Conclusion

These results reinforce the idea that policies to encourage demand for care could improve the efficiency of HD. However, they do not seem to be the only lever to activate. The weakness of efficiency despite the context of the exemption measure leads to the recommendation to investigate the supply side of care, particularly in the management of resources and the organization of care in order to detect possible determinants. This requires the availability of quality data. It would be interesting to institutionalize efficiency monitoring in the national health system.

The perception of primary care facilities on the autonomy to execute direct health facility financing resources: The case of Tanzania

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(2) Ifakara Health Institute, Dar es Salaam, Tanzania, United Republic of
(3) Results for Development, Nairobi, Kenya

Background

Direct Facility Financing (DFF) if well implemented could be an effective tool to realign resources with priority services at the primary health care. The introduction of DFF in low-income countries aim to increase the visibility and the autonomy of the frontline primary care facilities in delivering health services. Tanzania formally introduced DFF in 2017 with the objective of unlocking the flow of funds reaching the lowest level of service delivery so that the facility will have the autonomy to plan, budget and execute financial resources based on population need. While directing funds directly to facility bank accounts is crucial in facilitating the ability of service providers to deliver quality services, this objective will not be realized if there are constraints that hinders the autonomy of health providers to fully execute the DFF resources that are flowing to their bank account.

Aim

This study aims to explore provider perception on the degree of the autonomy to execute DFF funds and document challenges that they face in practicing the autonomy in DFF execution.

Methods

This is a qualitative study using focus group discussion (FGDs) and in-depth interviews (IDIs) that were administered to staff in selected facilities from two local government authorities in Singida region. The FGDs and IDIs tools focused on questions on facility staff perceptions on their autonomy to use DFF funds and the factors that affect facility autonomy to execute DFF funds.

key Findings

Facility staff acknowledge the importance of the DFF initiative and reported the autonomy to execute DFF funds had resulted in improved medicines availability and better service delivery. However, several factors have been identified as barriers in practicing the autonomy to fully execute the allocated DFF funds. These include delays in funds disbursement hence exerting pressure on fund utilization, complex procurement and approval administrative processes, rigid spending caps, and restrictions on budget reallocations.

Conclusions

While DFF proves to be an effective initiative to better align financial resources to priority services and increase provider autonomy to deliver priority quality services, attention needs to be put on addressing the barriers that may hinder provider autonomy to fully execute DFF funds. Public financial management rules and regulations should be tailored to address potential barriers that might hinder the ability of primary care facilities to use the allocated DFF funds to advance healthcare delivery and achieve optimal health outcomes in Tanzania.

Effectiveness of excise tax policies to reduce cigarette consumption and smoking prevalence (to be updated)

Estelle Dauchy *University of Cape Town, South Africa*

Background

Raising cigarette tax is considered the most effective tool to reduce consumption. However, the effectiveness of tax policy to reach its state objectives of improving health and raising revenue critically depends on the strength of tax systems.

Objectives

This study evaluates how non-price aspects of excise tax systems affect the effectiveness of excise tax policies to reduce cigarette consumption and smoking prevalence using cross-country data from 2008 to 2022. Specifically, we assess whether estimates of the price elasticity of cigarette demand depend on non-price aspects of tax systems, such as tax system designs, tax shares and affordability. We also assess whether the WHO's recommendation of a minimum tax burden is a sufficient condition to reduce cigarette demand.

Data and Methods

We combine the WHO's databases on tax system structures, tax and prices for 182 countries from 2008 to 2022 and generate tax system scores using the methodology proposed by the University of Illinois at Chicago. The scores provide an overall assessment of the performance of cigarette tax systems that combine four aspects including cigarette prices, changes in affordability, tax burdens, and excise tax structures. We estimate the impacts of tax systems scores on cigarette demand and smoking prevalence.

Findings

We find that scores measuring the strengths of excise tax systems and designs have improved over years and across countries, though not uniformly. The overall score has the highest impact to reduce adult smoking prevalence. A one unit increase in scores leads to a -0.03 to -0.83 percentage points reduction in smoking prevalence, or a -2\% to - 6.6\% reduction in cigarette sales volumes, depending on individual scores.

Conclusions

Affordability reduction, price increases, and tax shares among retail prices are the most effective policy measures among the system. The effectiveness of price increases to reduce cigarette demand critically depends on being combined with tax shares among prices (tax incidence).

Productivity of health public expenditure in West Africa

Abdoulaye Balde *Universite Cheikh Anta Diop, Dakar, Senegal*

The purpose of this article is to analyse the evolution of the efficiency of public health expenditures in West Africa. The analysis is conducted using a DEA approach. The efficiency of healthcare expenditures is estimated non-parametrically by executing a VRS (Variable Returns to Scale) model with an output orientation. Next, the calculation of the Malmquist index is carried out by distinguishing between the pre-MDG periods (1995-1999) and MDG periods (2000-2015).

To this effect, the efficiency scores obtained by the different output-oriented models and under the variable returns to scale (VRS) technology show on average that all countries have increased their level of efficiency during the implementation of the MDGs. In fact, Cape Verde remains the most efficient, with a score located on the production frontier regardless of the estimated model. Other countries like The Gambia, Ghana, Nigeria, and Senegal, depending on the periods and models, are situated on the production efficiency frontier.

The Malmquist index shows on average that productivity gains have increased during the MDG period compared to the previous period. It is also noted that the factor productivity gains achieved are more due to changes due to technical progress than to changes due to efficiency, regardless of time period.
As part of the SDG agenda, countries must improve the efficiency of public health spending to accelerate progress.

Cost-Effectiveness of Health Interventions and Disease Management in LMICs

2:00 PM–3:30 PM Thursday, 03 March 2025

Cost-effectiveness of diagnostic-therapeutic strategies for visceral leishmaniasis in eastern Africa: Ethiopia and Kenya Case Studies

Elias Asfaw, Simon Njenga, Cherinet Bayuh, Rezika, Albert Picado, Joy Malongo, Monique Wasunna, Jane Mbui, Eleni Ayele

Conclusions

Globally, visceral leishmaniasis (VL) causes 500,000 new cases and over 20,000 deaths every year (WHO 2017). Of these, 28 – 38% of VL reported cases do not have a laboratory confirmation in high burden countries. Diagnostic and treatment access have been critical challenges for averting the new cases and

treating the disease. Leishmaniasis disease is causing a huge impact for the poor communities and limited resource countries, including eastern Africa. This is mainly attributed to complex epidemiological profile, unreliable access to diagnostic and treatment. An improved RDT (rk28 RDT and treatment (MF&PM) is being developed to improve access for early diagnosis and case management.

Objective

The study aims to assess cost effectiveness of using rK28 RDT and/or MF&PM combination to manage VL cases as compare to current practices (rK39 RDT & SSG&PM combination) in eastern Africa from a healthcare provider perspective.

Methods

A comprehensive costing and decision analytical model of the VL diagnosis and treatment options was conducted. An ingredients micro-costing approach was employed to estimate the cost of visceral leishmaniasis care.

Results

The mean cost of VL diagnosis rk39 RDT, rk28 RDT and splenic aspiration is USD 7.39, USD 6.84 and USD 6.55 respectively in surveyed health facility in Ethiopia; while in Kenya, the mean cost of VL diagnosis using rk28 RDT and rk39 RDT is USD 67.58 and USD 68.54 respectively. In Ethiopia and Kenya, human resource and supplies were the major cost drivers for the provision of VL diagnosis in Ethiopia. Drugs (28%), hospitalization (28%) and human resource (23%) are the main cost inputs for the treatment of MF & PM region in Ethiopia; while in Kenya, hospitalization costs contribute the lion share of the VL treatment.

The two alternatives in the decision model (considering rk28 RDT plus MF &PM combination as compared to rk39 RDT plus SSG & PM combination) are undominated in Ethiopia and Kenya. Although the extent of effect varies, both in Ethiopia and Kenya, the main factors affecting most cost-effective algorithm were cost of rk28 RDT, cost of rk39 RDT, sensitivity and specificity of splenic aspiration and sensitivity and specificity of DAT. Other model parameters including the efficacy of MF&PM, efficacy of SSG&PM, MF&PM cost, SSG&PM cost did not have an effect on the base case result. The results from cost effectiveness analysis complement the ongoing clinical studies considering the value-for-money, and directly benefit the people living in VL endemic areas in Africa.

Cost-benefit analysis of haemodialysis in patients with end-stage kidney disease in Abuja, Nigeria

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Cost-benefit analysis of haemodialysis in patients with end-stage kidney disease in Abuja, Nigeria

Daniel Ogbuabor

University of Nigeria Enugu Campus, Enugu, Nigeria and Yakubu Adole Agada-Amade, National Health Insurance Authority, Abuja, Abuja, Nigeria

Background

Significant gaps in scholarship on the cost-benefit analysis of haemodialysis exist in low-middle-income countries, including Nigeria. The study, therefore, assessed the cost-benefit of haemodialysis compared with comprehensive conservative care (CCC) to determine if haemodialysis is socially worthwhile and justifies public funding in Nigeria.

Methods

The study setting is Abuja, Nigeria. The study used a mixed-method design involving primary data collection and analysis of secondary data from previous studies. We adopted an ingredient-based costing approach. The mean costs and benefits of haemodialysis were derived from previous studies. The mean costs and benefits of CCC were obtained from a primary cross-sectional survey. We estimated the benefit-cost ratios (BCR) and net benefits to determine the social value of the two interventions.

Results

The net benefit of haemodialysis (2,251.30) was positive, while that of CCC was negative (-1,197.19). The benefit-cost ratio of haemodialysis was 1.09, while that of CCC was 0.66. The probabilistic and one-way sensitivity analyses results demonstrate that haemodialysis was more cost-beneficial than CCC, and the BCRs of haemodialysis remained above one in most scenarios, unlike CCC's BCR.

Conclusion

The benefit of haemodialysis outweighs its cost, making it cost-beneficial to society and justifying public funding. However, the National Health Insurance Authority requires additional studies, such as budget impact analysis, to establish the affordability of full coverage of haemodialysis.

Cost-effectiveness of surgical interventions in low- and middle-income countries: A systematic review and critical analysis of recent evidence

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Background

Cost-effectiveness evidence is a critical tool to support resource allocation decisions. There is growing recognition that the development of benefit packages for surgical care should be guided by such evidence, particularly in resource constrained settings.

Methods

We conducted a systematic review of evidence (Medline, Embase, Global Health, EconLit, and grey literature) on the cost-effectiveness of surgery across low- and middle-income countries published between January 2013 and January 2023. We included studies with minor and major therapeutic surgeries, and minimally invasive intraluminal and endovascular interventions. We computed and compared the average cost effectiveness ratio (ACER) for different surgical interventions to the respective national gross domestic product per capita to determine cost-effectiveness and to common public health interventions.

Results

We identified 87 unique studies out of 20,007 articles screened. Studies spanned 23 countries, with China (n=20), Thailand (n=12), Brazil (n=8), and Iran (n=8) accounting for about 55 per cent of the evidence. Overall, the median ACER across procedure groups ranged from I$17.2/disability adjusted life year (DALY) for laparotomies to I$170,186/DALY for bariatric surgeries. Most surgical interventions evaluated were cost-effective (89 per cent) or very cost-effective (76 per cent). Low complexity surgical interventions compared favourably to common public health interventions.

Conclusion

These findings reinforce the growing body of evidence that investments in surgery are economically smart. There remains however paucity of high-quality evidence that would allow decision-makers to assess the comparative cost-effectiveness of surgery and to determine best buys across a wide range of specialties and interventions. A concerted effort is needed to advance the generation and utilisation of economic evidence in the drive towards scale-up of surgical care across low- and middle-income countries.

Cost analysis of the management of end-stage renal disease patients in Abuja, Nigeria.

Yakubu Adole Agada-Amade1, Daniel Ogbuabor2

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(2) University of Nigeria Enugu Campus, Enugu, Nigeria

Background

Although the treatment for end-stage renal disease (ESRD) under Nigeria's National Health Insurance Authority is haemodialysis (HD), the cost of haemodialysis is understudied in Nigeria. Therefore, this study estimated the provider and patient direct costs of haemodialysis and managing ESRD in Abuja, Nigeria.

Method

The study was a cross-sectional survey from both healthcare provider and consumer perspectives. We collected data from public and private tertiary hospitals (n = 6) and ESRD patients (n = 230) receiving haemodialysis in the selected hospitals. We estimated the direct providers' costs using fixed and variable costs. Patients' direct costs included drugs, laboratory services, transportation, feeding, and comorbidities. Additionally, data on the sociodemographic and clinical characteristics of patients were collected. The costs were summarized in descriptive statistics using means and percentages. A generalized linear model (gamma with log link) was used to predict the patient characteristics associated with patients' cost of haemodialysis.

Results

The mean direct cost of haemodialysis was $152.20 per session (providers: $123.69; and patients: $28.51) and $23,742.96 annually (providers: $19,295.64; and patients: $4,447.32). Additionally, patients spent an average of $2968.23 managing comorbidities. The drivers of providers' haemodialysis costs were personnel and supplies. Residing in other towns (HD:b=0.55, r = 0.001; ESRD:b=0.59, r=0.004), lacking health insurance (HD:b = 0.24, r = 0.038), attending private health facility (HD:b = 0.46, r<0.001; ESRD: b=0.75, r<0.001), and greater than six haemodialysis sessions (HD:b = 0.79, r < 0.001; ESRD: b=0.99, r<0.001) significantly increased the patient's out-of-pocket spending on haemodialysis and ESRD.

Conclusion

The costs of haemodialysis and managing ESRD patients are high. Providing public subsidies for dialysis and expanding social health insurance coverage of ESRD patients might reduce the costs.

Evaluating the Cost-effectiveness of alternative perennial malaria chemoprevention schedules for children under two years in Cameroon

Kinga Bertila Mayin.[1], Promise Aseh2, Silke Fernandes[3], Joseph Tankwa[4], Lanyuy Gillian Dzekashu[5], Eyvonne Ngequih Ngequih Tumasang[6], Akindeh Nji7, Matthew Chico[3], Gillian Stresman[8], Jonna Messina Mosoff[4], Roly Gosling[3], Wilfred Mbacham[9], Catherine Pitt[10] and Lucy Paintain[3]

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(9) Health Economists Association of Cameroon (HEAC) and Centre for Health Implementation and Translation Research, Fobang Institutes, Cameroon,
(10) London School of Hygiene & Tropical Medicine, London, United Kingdom

Background

In 2021, Cameroon accounted for 2.3% of global malaria deaths with >2 million cases reported annually: 65% of Cameroon cases where among children under 5 years old. In 2022, the World Health Organization recommended the provision of perennial malaria chemoprevention (PMC) to infants and young children with flexibility around the number and timing of doses, and the target age group. In response, Cameroon launched a 5-dose PMC schedule delivered alongside the Expanded Programme on Immunization (EPI) and an 8-dose schedule in selected districts with donor and non-governmental organization (NGO) support. To support national and international policy development, we assessed the incremental costs and cost-effectiveness of 8-dose versus 5-dose PMC schedules in Cameroon from a provider perspective.

Methods

We collected data in two rounds: (i) March-May 2023, and (ii) March-June 2024 on resource use and cost to implement PMC and to treat outpatient and inpatient malaria from the NGO, the Ministry of Public Health at the national, regional, district level, and 15 selected health facilities in Soa, Nkolbisson, and Ntui Health districts in the Centre region of Cameroon through key informant interviews and review of financial and activity records. We captured personnel cost through observations of health-worker time during in-centre and outreach EPI clinics. We combined step-down and micro-costing to estimate cost per PMC dose delivered and cost per malaria case treated. Impact on malaria cases averted will be measured via a cohort study (interim results expected September 2024) and used to estimate disability-adjusted life years (DALYs). Using an annual discount rate of 3%, we report cost and the incremental cost per DALY averted. We explore uncertainty and heterogeneity using sensitivity analyses.

Findings

Preliminary results suggest the cost per EPI visit varies by health facility and point of delivery (facility-based or outreach clinic). Since costs of training, reporting, and supervision are the same for both 5-dose and 8

dose delivery schedules, the incremental costs of implementing the 8-dose schedule comprise only the relatively low costs of the medicine, materials, and health worker time associated with additional doses. The more intensive PMC schedule is also expected to reduce further the costs of malaria treatment to the health service. Thus, switching from a 5-dose to an 8-dose PMC schedule is anticipated to be cost-effective. Analysis is ongoing, full results will be available soon.

Conclusion

Our findings will provide evidence on the hypothesis that a more intensive delivery schedule for a preventive intervention may be both more impactful and cost-effective, at relatively modest additional cost.

Equity and Cost Analysis in Malaria Control Across Africa

2:00 PM–3:30 PM Thursday, 03 March 2025

Equity-Informed Priority Setting for Malaria Control in Africa: Finding from Ghana and Malawi.

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(3) Africa Centres for Disease Control and Prevention

Introduction

Malaria is a major public health threat that is closely related to socioeconomic inequality and poverty. In high malaria burden countries, inequalities in service coverage, morbidity, and mortality have persisted. Unequal access to malaria diagnostic and treatment services leads to worse treatment outcomes and high financial risk. This study is aimed to evaluate the health and equity impact of public financing of malaria interventions in Ghana and Malawi.

Methods

We employed an extended cost-effectiveness analysis to assess the health and financial risk protection (FRP) impact of four malaria interventions: Long-Lasting Insecticidal Nets (LLIN), Indoor Residual Spraying (IRS), Artemisinin-based Combination Therapy (ACT), and Seasonal Malaria Chemoprevention (SMC). The interventions were modelled with an incremental coverage increase of 10% to simulate the impact of public financing over a one-year period (2022). The outcome measures include deaths averted, out-of-pocket (OOP) costs averted, and cases of catastrophic health expenditure (CHE) averted.

Results

Public financing of malaria interventions demonstrated substantial health and FRP benefits. In Ghana, ACT was projected to avert 1,099 deaths and mitigate $16 million in private expenditures, and prevents 78,842 cases of CHE at a cost of $22 million. In Malawi, ACT averted 637 deaths and saved $1.3 million and prevents 8,706 CHE cases at a cost of $2.5 million. Similarly, LLINs in Ghana avert 578 deaths, saves $8.18 million in private expenditure, and averts 41,222 CHE cases at a cost of $13.7 million. Similarly, in Malawi, LLIN averts about 336 deaths and saving $ 663,303 in private expenditures, while preventing around 4,364 cases of CHE at a cost of $ 9,081,397. Furthermore, public financing of the SMC policy averts 31 deaths, reduces about half a million $ in private expenditures, and prevents 3,125 cases of CHE in Ghana. The poorest quintiles experienced the highest benefits, reflecting a progressive pattern in health and FRP outcomes. The number of malaria deaths averted reached about 70-71% in the lowest two quintiles in both Ghana and Malawi, in contrast to 10% in Ghana and 14% in Malawi in the highest two quintiles.

Conclusions

Public finance of malaria interventions such as ACT and LLIN leads to greater improvement in both maximizing population health (deaths averted) and FRP (averting cases of CHE). Equity considerations are crucial, as there is a progressive pattern in the health and FRP benefits of malaria intervention, with those in the poorest subgroups benefiting the most.

Keywords

Malaria, Extended Cost-Effectiveness Analysis, Equity, Health Economics, Ghana, Malawi, Resource Allocation

The quality of amoxicillin on the pharmaceutical market in Ouagadougou: a threat to public health

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Introduction

In a context of weak monitoring and testing of the pharmaceutical supply chain, the medication is

vulnerable to deliberate counterfeiting. Amoxicillin is an antibiotic widely used for the treatment of infections in Burkina Faso. In this context, it is important to characterize the counterfeit amoxicillin on the drug market in order to inform the decisions of health authorities.

Method

We collected amoxicillin samples from 50 randomly selected drug vendors located in Ouagadougou in 2023. Upon receipt, the samples were subjected to a visual inspection in the laboratory. We conducted quality tests using TLC chromatography to determine the amoxicillin content of the collected samples.

Findings

In total, we collected 16 samples from pharmacies located in healthcare facilities, 18 from private pharmacies, and 16 from street vendors. In 70% of cases, the manufacturing date was not indicated. Out of the 50 samples tested, one in three (30%) amoxicillin samples was underdosed or falsified (SF). By type of seller, half (50%) of the samples purchased from street vendors were of SF quality. Furthermore, 1 out of 5 samples (20%) from pharmacies is of SF quality.

Conclusion

The prevalence of SF-quality amoxicillin in Ouagadougou is high. This represents a significant risk to the populations. In this context, information campaigns could be a useful political tool to inform the population about visual signs.

Equity-Informative Economic Evaluation of Next-Generation Long-Lasting Insecticidal Nets for Malaria Prevention in Uganda: A Comprehensive Application of Multiple Methods

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Background

Equity considerations are becoming increasingly important in economic evaluations, yet the best methods for incorporating equity remain uncertain. To address this, we present a case study from Uganda that examines the application of various equity-informative economic evaluation methods in a low- and middle-income country (LMIC) setting.

Aims

This study assesses the cost-effectiveness and equity impacts of next-generation long-lasting insecticidal nets (LLINs) within the context of the LLINEUP2 trial, a cluster-randomized study embedded in Uganda's 2020-21 Universal Coverage Campaign (UCC). The trial compares the impact of pyrethroid-pyriproxyfen LLINs with pyrethroid-piperonyl butoxide (PBO) LLINs across 64 clusters in 32 districts, representing 25% of the country.

Methods

We estimated the financial and economic costs of the UCC, including LLIN costs, from a societal perspective. LLIN coverage was evaluated through cross-sectional community surveys. Interrupted time series analysis was used to estimate the cumulative effects on malaria incidence over two years post-LLIN distribution. A 3% discount rate and a two-year time horizon for costs and effects were applied, with malaria death effects modelled beyond this period. Incremental costs per malaria case and per DALY averted were calculated, and variations in cost, incidence, and cost-effectiveness across different regions were assessed. Uncertainty was examined using deterministic and probabilistic sensitivity analyses. We will perform additional analyses using multiple equity-informative economic evaluation methods including extended-cost effectiveness analysis and equity weighting.

Results

Pyrethroid-PBO LLINs and pyrethroid-pyriproxyfen LLINs cost $2.51 and $2.28 per net, respectively. The estimated cost of delivering LLINs through the UCC was $0.70 per net delivered. There was no difference in efficacy between the two arms. Next-generation LLINs were estimated to have reduced malaria incidence by 22% after the first year but had no significant effect during the second year. Compared to the counter-factual scenario of LLINs having not been distributed, distribution of next-generation LLINs cost $3.66 per malaria case averted and $8.67 per DALY averted over two years. Equity analyses will be completed before October.

Conclusion

Considering plausible cost-effectiveness thresholds, mass distributed next-generation LLINs were highly cost-effective. Preliminary analyses suggest targeting high-transmission areas may reduce inequality in

malaria disease and cost burden Despite their effectiveness lasting only one year, next-generation long-lasting insecticidal nets remain highly cost-effective compared to most malaria control interventions, underscoring their value in public health strategies.

Costs of implementing perennial malaria chemoprevention in three health districts in Côte d'Ivoire

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Introduction

Ministries of health (MoH) face many choices about which interventions to implement where. Given resource constraints, understanding costs to their health services, particularly of new interventions, is important. In 2022, the World Health Organization recommended Perennial Malaria Chemoprevention (PMC) for young children in areas of moderate or high malaria transmission. The Plus Project supported Côte d'Ivoire's MoH to deliver PMC at scale through the Expanded Programme on Immunization (EPI) in three health districts in the east, centre, and north of the country starting in April 2023. We aim to estimate the financial and economic costs to providers of delivering PMC, explore variation in these costs, and discuss implications for decision-making around PMC and other interventions.

Methods

We collected quantitative and qualitative data on resource use from national, regional, district, and health facility levels through key informant interviews, review of financial and activity records, observations of EPI clinics, and health facility registers. We purposively sampled 12 health facilities providing PMC to include those expected to reflect maximum variation in the costs of delivering PMC. Our sample included facilities across all three districts (n=4 per district), of different types and sizes, in rural and urban areas. Data were collected in March-June 2023 and May-June 2024, covering the first PMC implementation year and the preceding year. We estimated the cost per dose of PMC administered and the cost per EPI visit at each health facility, and explored how these costs varied across health facilities. We explore factors associated with this variation in univariate and multivariate analyses and analyse cost drivers. We use thematic content analysis of qualitative data to explain and interpret our quantitative cost estimates.

Results

Preliminary findings indicate that the costs of each EPI visit vary substantially across health facilities, driven by facility level, number of EPI visits, and clinic type (facility or outreach). Resources used in PMC implementation comprise the time of health workers and other staff, medicines (sulfadoxine/pyrimethamine tablets used for PMC), non-medical supplies, and capital (vehicles and buildings) associated with PMC meetings and training, monitoring and supervision, supply chains, and PMC administration. Interviews and health worker observations indicate that the integration of PMC into EPI clinics did not excessively increase workloads. Analyses are ongoing.

Conclusion

Variation in resource use and costs across health facilities has important implications for PMC implementation, budgeting, cost-effectiveness analyses, and decision-making about continuation and scale-up of PMC in Côte d'Ivoire and other countries.

Malaria Parasites Density among Blood Donors in Southern Senatorial District of Cross River State, Nigeria

Yochi Egeonu *University Of Calabar, Calabar, Cross River State, Nigeria*

Background

Plasmodium parasites may be harboured by blood donors without clinical signs of malaria. Blood from such donors establishes a well-known serious risk to transfusion recipients such as pregnant women, under-five children, sickle cell disease patients. Transfusion-transmitted malaria (TTM) is a public health problem in tropical and Sub-Saharan Africa. Malaria is a protozoan parasite infection caused by Plasmodium species. The aim of this study was to determine the Malaria parasite density among blood donors in southern senatorial district of Cross River State. A cross-sectional descriptive study design was used for this study with a quantitative approach. The study population were blood donors aged 18 and 65 (males and females).

A multi-stage sampling technique was used to select 342 respondents from private, secondary and tertiary health facilities. A semi-structured questionnaire was administered for socio-demographic data. Blood samples were obtained from donors. Thick and thin blood smears were prepared from blood samples and was viewed microscopically to identify malaria parasites. Data were analysed using Microsoft Excel 2007 and Statistical Package for Social Sciences (SPSS) software version 23.0.

The results showed that majority of the blood donors who participated in the study were adults aged 28-37 years 160 (46.8). Mean age of subjects was recorded as 33.30 ± 9.58 years. The ratio of male 314 (91.8%) to female 28 (8.2%) was about 11:1. The major occupation of the subjects identified were students 87 (25.4%)

Malaria parasite prevalence of the subject was 82(24.0%). Subject aged 18-27 years (342.24) had the highest mean parasite density. Plasmodium falciparum were the only species encountered in the study (100%). Educational level (p =.031) and occupation (p =.035) were significantly associated with mean parasite density of blood donors with malaria parasite. The mean parasite density of voluntary, family and paid donors were in the ratio of 1:2:5. and is statistically significantly associated with blood donation practices of blood donors with malaria parasite (p=<.001), Perceived malaria preventive measures identified by blood donors were, sleeping under insecticide treated net, use of insecticides to spray the house, treatment with anti-malarial drugs wearing long sleeved clothes, clearing bushes around the home, fumigation, health education, making fire and smoke.

The study recommends health education on malaria, its risk factors, health implications, prevention and surveillance of all activities from donor recruitment through post transfusion.

Health Insurance Impact on Utilization, Inequalities, and Fiscal Strategies in Africa

2:00 PM–3:30 PM Thursday, 03 March 2025

From Policy to Practice: Examining Private Sector engagement in National Health Insurance Schemes to achieve Universal Health Coverage in Sub-Saharan Africa

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Introduction

Universal Health Coverage (UHC) aims to ensure that all individuals receive necessary health services without financial hardship, particularly in low- and middle-income countries like those in Sub-Saharan Africa. National Health Insurance Schemes (NHIS) are pivotal in achieving UHC by pooling resources and spreading the financial risks associated with healthcare. In Sub-Saharan Africa, where private healthcare providers deliver a significant portion of services, their engagement in NHIS is crucial for the success of UHC. This study aims to integrate and synthesize the existing fragmented research on the topic, undertaking a comprehensive analysis of the regulatory frameworks, engagement strategies with the private sector, and the enablers and barriers to their participation in health insurance schemes.

Methodology

Malaria parasite prevalence of the subject was 82(24.0%). Subject aged 18-27 years (342.24) had the highest mean parasite density. Plasmodium falciparum were the only species encountered in the study (100%). Educational level (p =.031) and occupation (p =.035) were significantly associated with mean parasite density of blood donors with malaria parasite. The mean parasite density of voluntary, family and paid donors were in the ratio of 1:2:5. and is statistically significantly associated with blood donation practices of blood donors with malaria parasite (p=<.001), Perceived malaria preventive measures identified by blood donors were, sleeping under insecticide treated net, use of insecticides to spray the house, treatment with anti-malarial drugs wearing long sleeved clothes, clearing bushes around the home, fumigation, health education, making fire and smoke.

The study recommends health education on malaria, its risk factors, health implications, prevention and surveillance of all activities from donor recruitment through post transfusion.

This study employed a mixed method approach involving narrative literature review, policy analysis and qualitative research (utilising key informant interviews) to examine the role of private sector engagement in NHIS across Sub-Saharan Africa, focusing on Nigeria, Rwanda, Ethiopia, Kenya and Senegal. A systematic search of relevant databases and grey literature was conducted, followed by a critical appraisal using the Mixed Methods Appraisal Tool (MMAT). Key informants (including public officials involved in policy development, private health care providers, and representatives from professional bodies) were purposively selected based on their expertise, roles, and involvement in the private health sector and/or health insurance schemes within the target countries.

Results

The study identified several regulatory mechanisms essential for integrating private providers into NHIS, such as accreditation and decentralization, though these processes often face challenges related to bureaucracy and inefficiency. Engagement strategies like accreditation, tariff negotiations, and capacity-building initiatives were found to be effective, though hindered by financial and bureaucratic barriers. Key enablers included financial incentives, political support, and technological integration, while barriers included low billing rates, delayed payments, and complex regulations.

Conclusion

The successful engagement of private healthcare providers in NHIS is critical for achieving UHC in Sub-Saharan Africa. While financial incentives and robust regulatory frameworks can enhance participation, challenges like delayed payments and bureaucratic inefficiencies must be addressed. Implementing the study's policy recommendations could significantly advance UHC goals in these countries, contributing to improved health outcomes across the region.

Effects of health insurance on health care utilization and inequalities

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Improving access to healthcare is at the heart of action strategies aimed at achieving sustainable development goals. Improving access to healthcare is at the heart of action strategies aimed at achieving sustainable development goals.

The methodology used is divided into two parts. The use of data from the 2019 Demographic and Health Survey (DHS) provides an initial estimate based on the theoretical model of healthcare utilization proposed by Anderson (1995) with the probit model to measure the effects of the free healthcare policy. Based on the probit model and the extension of the Oaxaca-Blinder method proposed by Fairlie (2017), the decomposition of the existing inequality index was carried out in the second estimation. The results from the probit regression and decomposition first show a positive relationship between the free healthcare policy and the use of services. Next, we observe a 25% gap in healthcare utilization in favour of populations covered against health risks. Finally, even though there are inequalities in favour of women, children, and the elderly, the results show that income-related inequities persist.

Keywords

health insurance, free healthcare policy, coverage, use of care, inequalities.

NCD reimbursement trends by the National Health Insurance Fund (NHIF) toward Universal Health Insurance (UHI) in Tanzania.

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Background

Non-communicable diseases (NCDs) account for 74% of global deaths annually, with cardiovascular diseases accounting for 13.72%. In Tanzania, the burden of NCD has been on the rise and hypertension has a prevalence of 26% and hyperglycemic conditions 20%, accounting for nearly one-third of all deaths (27%). Tanzania is strengthening its health systems through Universal Health Insurance (UHI), the financial burden of NCDs on the National Health Insurance Fund (NHIF), is not fully determined.

Objective

To assess the reimbursement of major NCDs (Cardiovascular Diseases, Diabetes Mellitus, Cancers, Chronic Renal Diseases, Chronic Respiratory Diseases, and Mental Illnesses) at the NHIF in Tanzania from January 2021 to December 2023.

Method

A cross-sectional study design, employing quantitative methodologies to analyse secondary claims data within the NHIF database. It targeted NHIF beneficiaries with at least one major NCDs claim from January 2021 to 2023, identified through the ICD-10 classification system. The data were analysed using R Statistical software (version 4.4.0). The descriptive statistics were used to report and summarize the reimbursement trend of the major NCDs while tables visualized the data. Ethical clearance was obtained from the Institutional Review Board at MUHAS, and approved by the NHIF.

Findings

This study found that females and the old age group (50-65, 65 and above) accounted for most NCD reimbursement, with NCD-related claims remarkably increasing from 1,293,668 claims in 2021 to 8,748,323 claims in 2023. Claims related to cardiovascular and diabetes conditions were the most prevalent, followed by a significant increase in claims for cancers and chronic renal diseases. The majority of these claims were filed from private facilities, constituting 47.9% in 2021 and 40% in 2023. Claims from government facilities showed a rising trend over the study period. The overall NCD reimbursement rose from 35.2 billion (USD$ 14 million) in (2021) to TZS 235.8 billion (USD$ 94.3 million) in 2023. Cardiovascular and diabetes conditions received substantial reimbursements. Notably, claims associated with cancer had the highest average reimbursement per patient, which increased from TZS 1,110,464 (USD$ 444.2) in 2021 to TZS 1,166,545 (USD$ 466.6) in 2023. Despite a downward trend, the average reimbursement per visit for cancer remained higher than other NCDs, decreasing from TZS 486,510 (USD$ 194.6) in 2021 to TZS 319,153 (USD$ 127.6), thus rendering it the costliest NCD to manage.

Conclusion and Recommendation

The study unveils a significant increase in reimbursements for NCDs, hence the NHIF should incorporate preventive interventions in its benefit package.

Determinants of Satisfaction among Community-Based Health Insurance (CBHI) Members in Ethiopia

Adamu WondimeTekahu *Ethiopia Health Insurance Service, Addis Ababa, Ethiopia*

Introduction

Ethiopia's Community-Based Health Insurance (CBHI) program aims to reduce financial barriers to healthcare access for citizens. The program's success depends on member satisfaction, which is crucial for continuous enrolment and the program's sustainability. This study seeks to fill evidence gaps by

identifying the predictors of satisfaction among CBHI members in Ethiopia.

Objective

The study aimed to identify the predictors of satisfaction among CBHI members in Ethiopia and provide actionable recommendations to enhance satisfaction.

Methodology

A cross-sectional design was used, involving household surveys of 4,008 CBHI members. Three-stage stratified sampling was employed to select households from eight regions and two city administrations. Binary logistic regression was used for the analysis, with significant associations considered in the multivariate analysis, where significant predictors were determined with p-values < 0.05.

Results

The study found that the overall satisfaction level among CBHI members is 68%, which is significantly lower than the target of 85% set by the National Health Insurance strategy. Key predictors included awareness, perception, residence, enrolment duration, and utilization of health services. Members with good awareness (69.3%) were more satisfied than those with poor awareness (64.3%). Members with a positive perception of the program were 3.79 times more likely to be satisfied compared to those with a negative perception. Rural members were more satisfied than urban members, with satisfaction rates of 69.1% and 65.9%, respectively. The level of satisfaction decreased with the duration of CBHI enrolment. Members who utilized health services reported higher satisfaction (69.0%) compared to those who did not (60.0%).

Conclusion

The overall national satisfaction level of CBHI members is significantly lower than the target set by the Health Insurance System strategy. Significant predictors of satisfaction include awareness, perception, residence, enrolment duration, and health service utilization. To enhance satisfaction among CBHI members, the following recommendations are proposed:

- Improve Awareness: Develop targeted strategies using mass media, especially local channels.
- Enhance Positive Perception: Disseminate success stories and provide clear information about CBHI benefits.
- Improve Healthcare Service Quality: Ensure the availability of services to avoid out-of-pocket expenses.
- Encourage Service Utilization: improve benefits and mitigate barriers to access, to build trust of the program among members.

- Focus on Long-term Enrolment: Address concerns to retain members over time.
- Strengthen Monitoring and Evaluation: enhance evidence-based decision making to improve satisfaction.

Fiscal Space Analysis is only a starting point, so what comes next? The Nigerian Vulnerable Group Fund Tries to Grow

Elaine Baruwa *Member, Rockville, MD and Bolanle Bukola Olusola-Faleye, Member, Abuja, Federal Capital Territory, Nigeria*

Background

Nigeria's National Health Insurance Authority (NHIA) Act of 2022 introduced the Vulnerable Group Fund (VGF) to provide health care coverage for 83 million vulnerable Nigerians and mitigate reliance on out-of-pocket expenditures. A fiscal space analysis has outlined the potential options for increasing VGF funding. Still, the economic climate is poor – Nigeria's 73 percent debt ratio for 2023 means it spends three-quarters of its earnings to service debt - so the competition for government resources is challenging. Nonetheless, NHIA needs to explore ways to mobilize funding. A comprehensive fiscal space expansion strategy is required to prioritize short- and medium-term opportunities against the program's potential absorptive capacity and political feasibility.

Methods

A fiscal space analysis quantified the following sources: increased budgetary allocation, earmarks from multiple government revenue sources, including telecommunications mobile airtime tax, value-added tax, pro-health taxes, international remittance levies, increasing health insurance scheme efficiency, and financial collaboration with existing social protection and poverty reduction programs. Three expansion scenarios were estimated: business as usual, moderate, and ambitious, covering 1, 15, and 57 million people, respectively. An expansion strategy was developed based on the estimates and their associated political feasibilities.

Results

Four activities were identified as critical components of a fiscal space expansion strategy. (1) An accountability framework must be developed and implemented to demonstrate the current program's effectiveness, efficiency and capacity and provide advocacy evidence for expansion. (2) An investment case that includes social, political, economic, and health status arguments for investing in the VGF must be developed. (3) A political economy analysis must identify supporters and challengers across all stakeholders, including ministries of finance and economic development and local government, social

development, telecommunications, and financial sectors. (4) The NHIA and VGF must align with the broader health sector priorities at all levels of government, national, state, and local, to mobilize revenues across existing decentralized health and social development budgets.

Conclusion/Discussion

Quantitative analysis is only a starting point—expanding fiscal space for the vulnerable group fund will require a multisectoral strategy and multidisciplinary approach, including advocacy and communication, policy and legal analysis, and professional lobbying. The NHIA's comprehensive fiscal space expansion strategy reflects these requirements and approaches along with a comprehensive stakeholder engagement strategy for identifying the technical needs for resource mobilization and demonstrating effective resource to create a "virtuous cycle" that increase the Fund's size over time to meet its ambitious financial risk protection goals.

Adolescent Health and Well-Being: Policies, Interventions, and Determinants in Sub-Saharan Africa

2:00 PM–3:30 PM Thursday, 03 March 2025

Social Determinants of Health: Examining the Impact of Menstrual HealthFactors on Adolescent Girls' Well-Being in Uganda

Rebecca Prah[1], Stephen Lagony[2], Levicatus Mugenyi[3], Kate Nelson[4], Katherine Thomas[4], Catherine Kansiime[5], Fred Matovu[6], Helen Weiss[4] and Giulia Greco[4]

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Background and study aim

Period poverty, characterized by inadequate access to menstrual products, safe and private sanitation facilities, and menstrual health education, affects millions of females worldwide. Period poverty results in poor menstrual health, emotional distress, and depressive symptoms, significantly impacting the overall subjective well-being (SWB) of females. Evidence shows that age and gender disparities in SWB exist among adolescents, with older girls reporting lower well-being compared to younger girls and boys, possibly due to the challenges of puberty and menstruation. This study examines how menstrual health factors influence the well-being of adolescent girls in Uganda, within the broader context of social determinants of health.

Methods

This study leverages data from MENISCUS, a cluster-randomized trial that evaluated a school-based menstrual health (MH) intervention across 60 schools in the Wakiso and Kalungu districts of Uganda. Participants completed self-administered questionnaires that collected information on household socio-economic factors, mental health issues (using the Strengths and Difficulties Questionnaire (SDQ)), menstrual practices and experiences, and measures of happiness and life satisfaction to determine their subjective well-being. The analysis employs descriptive statistics and mixed-effects regression modelling to identify menstrual health factors affecting adolescent girls' subjective well-being, with adjustments for school-level clustering.

Key Findings

Most participants (90%) were females aged 15-18 years and had started menstruation. Approximately 65.43% of them reported being happy, while 69.46% were satisfied with life. Life satisfaction was higher among older adolescents aged 19-24 years(75%). Happiness was higher among girls aged 15-18 years (65.93%) compared to younger (60.71%) and older (58.33%) adolescents. Life satisfaction and happiness decreased with smaller households, eating fewer meals, lower socio-economic status, lower SDQ scores, and being a day student. Girls who experienced pain during their last menstrual period, were teased about menstruation by boys and girls, were anxious about the next menstrual period, and did not have a support system for menstruation reported lower life satisfaction and happiness. A mixed-effect regression modelling to identify menstrual factors that predict adolescent girls' happiness and life satisfaction is currently ongoing and the results will be ready before the conference.

Main Conclusion

Negative menstrual experiences, such as teasing, pain, lack of support, and anxiety about the next menstruation influence adolescent girls' subjective well-being in Uganda. Addressing these issues through menstrual health programs and socio-economic interventions is crucial for enhancing the overall well-being of adolescent girls.

The effects of a school based menstrual health intervention (MENISCUS) on menstrual health factors and its modification by socio-economic status amongst girls in secondary schools in Uganda

Stephen Lagony[1], Kate Nelson[2], Levicatus Mugenyi[3], Rebecca Prah[4], Katherine Thomas[2], Belen Torondel[5], Denis Ndekezi[3], Ratifah Batuusa[3], Christopher Baleke[3], Titus Ssesanga[3], Robert Bakanoma[3], Prossy Namirembe[3], Aggrey Tumuhimbise[3], Beatrice Nanyonga[3], Rodah Nambi[3], Edward Obicho[3], Denis Ssenyondwa[3], Agnes Akech[6], Shamirah Nakalema[6], Giulia Greco[2], Helen Weiss[2] and Fred Matovu[7]+

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Introduction

Poor menstrual health has potential economic, social and health consequences. We recently completed the MENISCUS cluster-randomized controlled trial in 60 secondary schools in Uganda to evaluate whether a multi-component menstrual health intervention improves education, health and well-being outcomes among female students. 30 schools were randomized to receive the MENISCUS intervention which included puberty education, drama skits, provision of menstrual-health kits, training in pain management including provision of analgesics and improvements to water, sanitation and hygiene facilities in schools. We evaluated what effect the intervention had on menstrual health (trial secondary outcomes) and the effect modification by socio economic status (SES).

Aim

Assessing the impact of the intervention on menstrual health outcomes.

Methods

We fitted a random-effects regression model adjusting for school-level clustering and baseline measures of outcome values. Effect modification by SES was assessed through fitting an interaction term. SES was determined using participant responses to household materials and assets questions. 3047 girls were included in the analysis, of whom 1201 (39.4%) were categorized as low SES.

Findings

The mean number (out of 9) knowledge questions answered correctly was higher among girls in the intervention versus control arm (6.2 vs 5.6, adjusted incidence ratio (aIRR)=1.10, 95%CI 1.07-1.14; p<0.001). In both arms, the mean number of correct questions was greater among girls with higher SES (intervention: high vs low SES: 6.3 vs 6.0; aIRR=1.04, 95%CI 0.99-1.08, p=0.09; control: High vs Low SES: 5.7 vs 5.5; aIRR=1.00, 95%CI 0.96-1.05, p=0.89). Similarly, the mean number (out of 3) attitude questions with positive response was higher among girls in the intervention than control arm (2.3 vs 1.9, aIRR=1.22, 95%CI 1.16-1.28; p<0.001), and this was not moderated by SES. The mean score on self-efficacy to manage menstrual health needs (SAMNS) was higher (better) in the intervention arm (6.9 vs 6.4, adjusted mean difference (aMD)=0.53, 95%CI 0.35-0.70; p<0.001), with no effect-modification. The mean menstrual practice needs score (MPNS) in terms of perceived menstrual management practices and environments met was higher in the intervention arm (2.4 vs 2.3, aMD=0.10, 95%CI 0.06-0.15; p<0.001), and there was evidence of a stronger intervention effect among girls in the low baseline SES group (p<0.001).

Conclusion

This trial provides strong evidence that a menstrual-health intervention improved menstrual health among girls in secondary schools in Uganda. Girls with lower SES at baseline benefitted more in terms of their menstrual practice needs being met than those with high SES at baseline.

Adolescent health and wellbeing in Malawi: a political economy analysis of an intersectoral policy.

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Introduction

Adolescent health and wellbeing is a multifaceted construct, and includes good health and nutrition, agency and resilience, community and connectedness, and education & employment, and safety and support. Thus, addressing adolescent health and wellbeing cuts across traditional public sector boundaries and involves multiple stakeholders, agencies, and budgets - between the school and healthcare systems, or public and donor resources for example. In this paper we describe a political economy analysis of adolescent wellbeing in Malawi, barriers and strategies to a more coordinated policy making and implementation.

Methodology

We conducted a qualitative case study between July and October 2024. We interviewed 14 purposively selected policy makers, youth leaders, and development partners working in the fields of health, youth development, gender, and education. We reviewed 25 policy documents across the same sectors. Drawing on the Walt and Gilson's (1994) Policy Triangle Framework, we analysed the content, context, process, and actors in adolescent wellbeing. Qualitative data were transcribed, coded using NVIVO and analysed using reflexive thematic analysis.

Results

The Malawi's Vision 2063 is the overarching long-term national framework for all policies in Malawi, of which adolescent wellbeing is an enabler to the country's development through human capital development. Adolescent wellbeing specific issues including health and nutrition, education and skills development, protection, resilience, and agency, are elaborated through sector specific relevant policies such as Youth

Friendly Health Services Strategy and Adolescent Girls and Young Women Strategy. Despite the multisectoral policy framework, power struggles between government ministries hinder collaboration across sectors. The lack of collaboration is compounded by the low government resourcing towards adolescent health and wellbeing; leaving development partners who have suboptimal integration, to finance activities and drive the agenda while having objectives which are not fully aligned to the priorities of domestic, politically legitimated decision makers. Furthermore, politics amongst donors, as each races to fund their own flagship activity, further perpetuates the lack of collaboration. Thus, the implementation of policies is generally fragmented and in silos, undermining the impact on adolescent health and wellbeing.

Conclusion

The Malawi's Vision 2063 collaborative framework for long-term adolescent health and wellbeing and youth development is yet to be realised, owing to lack of coordination across all stakeholders. While donors provide the much-needed financing, there is need for cross-sector governance frameworks to coordinate their contributions, to ensure optimal and sustained implementation of activities.

Preventing sexual violence among adolescents and young people (AYP) in Kenya: An INSPIRE-aligned analysis of the 2019 Violence Against Children Survey (VACS)

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Background

Sexual violence against adolescents and youth (AYP) remains a public health concern in Kenya. With guidance of a WHO technical package (the INSPIRE framework) to address sexual violence in low-resourced settings, this study; (1) explores the prevalence of sexual violence and patterns of help-seeking behaviour, (2) examines associations between INSPIRE-aligned predictors (positive parenting, receipt of life skills training, endorsement of gender inequitable attitudes, endorsement of intimate partner violence, experience of physical/emotional violence at home, experience of cyberbullying) and sexual violence experience and disclosure.

Methods

Using Kenya's 2019 VACS, this study mapped the prevalence and patterns of sexual violence and help-seeking behaviour among 13- to 24-year-old AYP. Logistic regression models were then fitted to predict past-year sexual violence and informal disclosure among adolescent girls and young women (AGYW).

Results

Compared to adolescent boys and young men (ABYM), AGYW reported a higher prevalence of lifetime sexual violence (25.2% versus 11.4%). More AGYW than ABYM informally disclosed sexual violence experience (46% versus 23%). Knowledge of where to seek formal help after experiencing sexual violence was similar between females and males (33.7% of ABYM and 33.1% of AGYW). However, more females than males sought formal help after sexual violence experience (11.3% versus 6.8%). Gender inequitable attitudes [AOR 3.07 (1.10–8.56); p=0.03], experiencing emotional violence at home [AOR 2.11 (1.17–3.81); p=0.01], and cyberbullying [AOR 5.90 (2.83–12.29); p=0.00] were identified as risk factors for sexual violence among females. Life skills training [AOR 0.22 (0.07–0.73); p=0.01] and positive parental monitoring [AOR 0.31 (0.10–0.99); p=0.05] were found to be protective against sexual violence among young women. Positive parental monitoring [AOR 3.85 (1.56–9.46); p=0.00] was associated with an increased likelihood of informal disclosure among AGYW.

Conclusion

While demonstrating the centrality of the INSPIRE framework in sexual violence prevention, this study underscores the need to develop and strengthen policies and programs on life skills training, male-favouring gender inequitable attitudes, and positive parenting as well as improve awareness and access to post-violence response and support services.

Keywords

Adolescent Girls and Young women (AGYW); Adolescent Boys and Young Men (ABYM); Disclosure; Help-seeking; Sexual violence.

Estimating Utility Tariffs for the Child Health Utility 9 Dimension (CHU9D) tool Among Adolescents in Uganda.

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Background and Aim

Accurate measurement and valuation of health outcomes are crucial for economic evaluations. The Child Health Utility 9D (CHU9D) is a preference-based measure (PBM) that assesses the quality of life of children and adolescents across nine dimensions. As with other PBMs, utility values are required. While CHU9D utility values exist for the UK, Australia, Netherlands, and China, they are none in Africa. This study aims to estimate CHU9D values among adolescents in Uganda.

Methods

The study employs a combined profile case best-worst scaling (BWS) and composite time trade-off (cTTO) approach to derive Ugandan-specific CHU9D values. The BWS survey included 50 CHU9D-defined health states and involved 438 adolescent boys and girls from 12 secondary schools in Wakiso and Kalungu districts, Uganda. These were randomly selected from a school-based menstrual health cluster-randomized trial (MENISCUS) in Uganda. The cTTO method involved valuing 5 CHU9D health states by randomly selecting 127 parents/caregivers of these adolescents through an interviewer-led composite TTO survey. Participants of both surveys were also asked about their health and quality of life. Data analysis, utilizing latent class modelling and multinomial logit models, is ongoing, with results expected before the conference. While the cTTO method generates utility values on the 0-1 QALY scale, the BWS method does not. The cTTO values will be used to anchor the BWS values onto the 0-1 quality-adjusted life years (QALY) scale using the mapping method.

Results

The BWS participants had an average age of 17 years (SD: 0.85), with 74.2% being females. Most (91.74%) understood the tasks well, and 75.23% found them easy or very easy. Quality of life was rated as excellent or good by 70%, and about 60% considered themselves healthy. Chronic diseases were reported by 22.71%, and 11.93% had disabilities. 74% of the cTTO participants were females, 66% were87erw parents, and 33% were other caregivers, with a mean age of 41 years (SD: 7.5). Quality of life was rated as good or excellent by 52.76%, while 59.06% reported being healthy/well. Mean cTTO values for the 5 CHU9D health states ranged from 0.16 to 0.45 (SD: 0.44). Most understood the cTTO tasks well, with 22.05% finding them very easy, 49.61% easy, and 14.96% difficult.

Conclusion

The study offers Ugandan-specific CHU9D values, filling a literature gap. Both parents/caregivers and adolescents engaged well with the cTTO and BWS tasks.

Factors associated with the utilization of family planning services among women aged 15-49 in Côte d'Ivoire

Sonia Angeline Gbratto-Dobe *Université Félix Houphouet Boigny of Abidjan, Abidjan, Côte d'Ivoire*

Background

Primary healthcare is a driving force for improving access to healthcare services in a country. Family planning (FP), considered an essential component of primary health care and reproductive health, plays a major role in reducing maternal and newborn morbidity and mortality and transmission of HIV (WHO and USAID, 2008). For more than a decade, Côte d'Ivoire has been committed to improving women's sexual and reproductive health (INS, 2021). This commitment should enable women of childbearing age to exercise their right to make decisions about using a family planning service. However, the prevalence of utilization of FP services at national level is still low, at around 22%. (INS, 2021).
This paper aims to analyse the factors associated with the utilization of FP services among women aged 15-49 years in Côte d'Ivoire, to better design strategies and deal with this problem.

Methods

We used data on 14,877 aged 15 to 49 years old of the Demographic and Health Survey - 2021 conducted in Côte d'Ivoire. The dependent variable is represented by whether (or not) the woman effectively uses any method of family planning (FP). Covariates included demographic and socio-economic factors. Logistic estimates were carried out using Stata 18. Univariate analyses provided a summary descriptive table of the study variables. Pearson's Chi-squared test of independence and, bivariate logistic regression was used to assess the association between each of the covariates and the utilization of FP services. Significant variables were used to build the final models. Post-estimation tests (Pearson and Hosmer–Lemeshow chi2) were used to analyse the goodness of fit of the final model.

Results

Out of 14,877 women, 20.78 % used any method of family planning (FP); with respectively 91.24% and 8.76% of women aged 40 or below and women aged more than 40 years old. Just 57.12% of these women who use FP methods live in urban areas and 20.28% of them have access to FP information. Moreover, only 10.90% were exposed to the need to use FP services.

Woman's age, education level, desire for more children and occupational status were significantly associated with the utilization of FP services in Côte d'Ivoire. Her access to FP and exposure to need to use FP method were also significantly associated with the utilization of FP services. Household's size, number of children under 5 in the household, number of children in alive and age of household head were significantly associated with the utilization of FP services.

In this study, women who were educated (OR=1.57/2.00/1.99, p<0.001), working (1.26, p<0.001), had access to information on FP (OR=1.29, p<0.001), had many children in alive (1.53, p<0.001), had a large household (OR=1.36, p<0.001), were exposed to the need to use FP methods (OR=8.09, p<0.001) and an ageing head of household (OR=1.00, p=0.007) were more likely to use FP services. But women who were getting older (OR=0.99, p<0.001), had many children under 5 (OR=0.63, p<0.001) and had desire for more children (OR=0.70, p<0.001) were less likely to use family planning services.

Conclusion

Although exposure to the need for contraception plays a major role in the demand for sexual and reproductive health care, education, access to FP information and the mother's financial autonomy are essential in explaining the use of family planning services. Promoting women's education, by improving their access to formal education, popularising access to information on FP services and promoting women's empowerment are all strategies that can improve the prevalence of use of family planning services in Côte d'Ivoire.

3:45 – 5:15 PM Thursday, March 13, 2025

Trained but unemployed, underemployed and unpaid: empirical research on (and policy options to) incorporate the paradoxical surplus health workers in Africa (organized session)

Pieternella Pieterse

Royal College of Surgeons in Ireland, Freddy Eric Kitutu, Makerere University School of Health Sciences

Description

Background: Just and sustainable health systems rely on a well-trained, effectively distributed workforce. By 2030, Africa may have a shortfall of 6.1 million health workers alongside 700,000 trained but unemployed nurses, doctors, pharmacists. To ensure Universal Health Coverage, health systems must have well-trained employees able to provide high quality, equitably delivered care. Debates about human resources for health are dominated by calls to train more health workers. While important, the fact that thousands of trained staff are not being effectively incorporated into health systems in many African countries is often ignored.

This session: We present research on paradoxically surplus health workers and policy options to incorporate this group into health systems.

This panel puts the paradox of 'surplus health workers' on the health systems agenda and present empirical findings on the dynamics and consequences of un/ under-employment and lack of payment using case studies from Uganda, Sierra Leone, Mali, Chad, Niger and Nigeria.

Our four presentations focus on 1) current knowledge of the scope of the paradoxical trained health worker surplus in Africa (numbers, countries experiencing the problem, cadres) 2) livelihood strategies, hopes and practices of paradoxically un/under employed and unpaid health workers 3) political economy of training health workers that drive this paradoxical surplus 4) governance challenges that arise when otherwise unemployed health workers work informally - in retail medicine markets in Uganda; as 'volunteers' in the formal health system in Nigeria, Mali, Chad, Niger and Sierra Leone, 5) potential solutions, plans and ways forward.

Eleanor Hutchinson's presentation is based on empirical qualitative research that focuses on unemployed nurses working in medicine markets in Uganda.

Olivier Onvlee/Noor Tromp will reflect on the use of district data to show the profiles of health workers in Mali, Chad and Niger. This shows not only a shortage of health workers and their unequal distribution, but also the presence of trained and lay health workers providing care on a volunteer basis.

Charles Orjiakor will draw on empirical research from the public system in Nigeria, where otherwise unemployed health workers are taken on as 'volunteer' staff, with a small negotiable stipend but often take on critical roles.

Pieternella Pieterse describes how in Sierra Leone, 50% of health workers are currently unsalaried awaiting payroll inclusion. With little fiscal space to create new jobs, the increasing numbers of new nursing graduates face unsalaried employment and UHC target ratio of 45 health workers per 10,000 population unattainable.

Surplus health workers and their livelihood strategies: Nurses and midwives working in medicine markets in Uganda

Eleanor Hutchinson *The London School of Hygiene & Tropical Medicine*

Background

To ensure Universal Health Coverage, just and sustainable health systems must have well- trained employees able to provide high quality, equitably delivered care. Debates about human resources for health are dominated by calls to train more health workers but ignore the fact that thousands of trained staff are not being effectively incorporated into health systems in many countries. This presentation raises the issue of 'paradoxically surplus health workers' and show how they become incorporated into informal systems of care.

Methods

We conducted fifteen months of participant observation in Uganda following a dispute and debate about the role that unemployed health workers play in providing care informally in the health system and traced the ways in which midwives and nurses had begun to work as medicine sellers. We followed this with a survey and 30 in-depth interviews with nurses and midwives working as medicine sellers in drug shops in Uganda.

Results

The ethnographic research showed that traditional, untrained, locally embedded drug sellers are slowly being replaced by nurses and midwives who fail to find work in the formal health system and are setting up shops as medicine sellers. These nurses and midwives often spend years applying for formal sector jobs and once they fail look for informal ways to practice their profession. A district-wide survey revealed that 60% of medicine sellers in Luwero are either fully trained nurses or midwives and the majority (82%) are women. These shops offer a meagre living for those working in them, with 61% earning below $100 a month

far below the salary of a health worker. In-depth interviews revealed that these nurses and midwives often have to rely on their families to provide an additional income and in many cases to keep the shop running (by paying rent and/or purchasing stock).

Conclusion

In the past, training to be a nurse or midwife would offer the promise of permanent employment in Uganda. In the last 15 years, health worker unemployment has been growing alongside a lack of trained staff in health facilities. Demand for care means that informal ways of providing a service are often welcomed by members of the community and nurses and midwives are increasingly being found in places that were previously populated by untrained providers.

Unending internships: Without government funding for human resources, Sierra Leone's nursing graduates cannot bring the country closer to achieving UHC

Pieternella Pieterse *Royal College of Surgeons in Ireland, Dublin, Ireland, Ireland*

Background

Sierra Leone's 'skilled health workers-to-population' ratio is 6.4 per 10,000; much lower than the 45 doctors, midwives and nurses per 10,000 deemed essential to achieve Universal Health Coverage (UHC). Achieving UHC is the county's Health and Sanitation Ministry's main policy goal, but without an increase in funding for public health workforce expansion, the country's rapidly growing cohort of young nursing professionals will face unemployment or perpetual unpaid internships. This study highlights the contradicting priorities of key stakeholders who drive health worker production without considering their employment prospects, negating UHC gains.

Methods

Trainee health worker enrolment data (past and projected) was collected for 2019-2026, for all twelve health worker training facilities in Sierra Leone. Interviews were conducted with students and faculty, with key informants and health workers (n= 110) both on the payroll and unsalaried staff.

Results

Since 2020, after the training of two auxiliary nursing cadres was halted due to 'overproduction', the emphasis shifted to training nurses who meet WHO standards (as the auxiliary cadres did not). An increasingly youthful population (over 28% is aged between 15-29) has contributed to the demand for

health worker training. These two factors have led to a significant expansion of public and private sector institutions offering nursing diploma and degree courses, midwifery, lab technician, etc. In four years, enrolment in some training facilities has quadrupled. However, WHO labour market forecasts (2019) predict that only a fraction of graduates will find paid employment. During interviews, training institute proprietors and faculty appeared primarily focus on meeting the demand for training placements, as they were aware of, but unable to influence, students' job prospects. Students were largely overoptimistic about finding paid employment in the public or private sector.

Discussion

The expansion of the health workforce is central to achieving UHC progress. Certain Ministry of Health and training institution leaders emphasised Sierra Leone's focus on training the required number of WHO standard health workers. While laudable, training health workers without expanding financing to hire them, will not lead to UHC expansion. In Sierra Leone, half of the current health workforce works without a salary due to payroll inclusion deferral, and informal charging by health workers is a significant barrier to access to affordable healthcare. Without fiscal space or greater political prioritisation of the health sector, few newly and recently trained nurses and young health professionals will find gainful employment and become UHC champions in Sierra Leone.

The Impact of Volunteer Engagement on Primary Healthcare Systems in Developing Countries: An Ethnographic Study

Tochukwu Charles Orjiakor *Health Policy Research Group, Enugu, Nigeria*

Background

Resource constraints and workforce shortages could lead grassroots actors to seek quick fixes which may prove defective and disruptive in the long run. The current study utilized an ethnographic approach to closely observe primary health centres (PHCs) and health administration offices in Nigeria. The aim is to have a first-hand experience of misdoings and practices undermining efficiency and healthcare access. Specifically, the current study explores the implications of hiring and engaging qualified health workers as volunteers with low wages on the overall functioning of health centres.

Methods

Using ethnographic approaches of participatory observation, four researchers directly observed 6 PHCs and the district administrative offices that oversee them. Observations lasted 8 weeks. To minimize

reactivity, researchers were familiar with the communities and health centres and were introduced as researchers 'observing PHCs for practical solutions. Follow-up interviews to understand underlying motives for specific practices in hiring and engaging volunteers were conducted with key stakeholders, including health facility managers, regular health workers, district administrative officers, and volunteers.

Findings

Following a 10-year employment freeze in the region observed, health worker shortages became rife, forcing facility managers to discretionarily recruit and engage 'volunteers. But 'volunteers' were often qualified trained health workers who were not able to find regular health worker positions. Volunteer pay was discretionary, but often suboptimal, although other benefits of accommodation, access to farmland and experience were occasionally available. However, the presence and commitment of volunteers to provide nearly 24-hour service meant that absenteeism and permissiveness grew amongst regular health workers who became more distant from their work, abandoning roles to volunteers. Supervision lapsed, and volunteers could seek informal payments to support their livelihood. Facility and district administrative managers tolerated the engagement of volunteers provided the doors were open to service users.

Conclusion

Although findings of the current study may be limited to the districts observed, there is evidence that health worker shortages are driving suboptimal volunteer engagement practices. National health policy documents are increasingly recognizing volunteer roles and accommodate the discretion of facility managers in engaging them while providing a proportion of the health budget to cater for their meagre pay. It seems that volunteer engagement is gradually being entrenched as a fix for the systems' inability to have bolster the health workforce.

Use of district data to develop workforce profiles: an opportunity to tailor HRH policies and interventions for primary care providers in Chad, Niger and Mali

Noor Tromp *KIT, Amsterdam, Netherlands, Netherlands*

Background

Remote areas are known for their limited potential to retain healthcare providers. In the context of the Global Fund Strategic Initiative on HRH (2021-2023), we conducted a workforce assessment in Mali, Niger and Chad. Developing a workforce profile, using district data, offers an opportunity to tailor workforce solutions to specific workforce needs.

Methods

We conducted a rapid workforce assessment in a remote district in Niger, Chad, and Mali using local workforce data. A questionnaire was developed to collect data on cadres, qualification status, gender, age, contract type, and experience. Data were collected by a country-level expert and research assistants at each primary care facility in the district. Data were inserted in ODK, and simple descriptive analysis was done.

Results

In the districts of Guelendeng in Chad, Konni in Niger and Kadiolo in Mali, distinct profiles emerged from the data. In these three rural districts a substantial number of the workforce lacked a qualified diploma: 38% in Kadiolo, 29% in Guelendeng, and 61% in Konni. The qualified workforce was mostly young (over 70% are <40 years old), in Mali and Niger (40% in Chad) mainly female and often consisted of registered and auxiliary nurses with different contracts, varying salaries and working conditions and training. The minority was enrolled in the public service (39% in Chad, 33% in Niger, and 17% in Mali). In Niger and Chad, most qualified staff worked less than three years in the district (58% and 80% respectively). A relatively high number of qualified staff worked as volunteers: In Mali 28% and in Niger 38%.

These insights provided district stakeholders information to discuss tailored interventions within their decision space. Examples included preferences to accept volunteers for vacancies and discussing options to align different contractual arrangements.

Discussion

The study shows the importance of actively using locally available data despite the difficulties of obtaining accurate data. The profiles demonstrate the importance of investing in local level data for decision-making, capacity development and tailored interventions. The study showed the need to develop a comprehensive map, including data on volunteers, non-diploma holding staff and contracts and the benefit of an endogenous approach for deploying and retaining health workers in rural areas. The high number of young staff, especially female, shows the importance of coaching and mentoring programmes to offer support by senior staff, potentially digitally and the need for capacity strengthening on gender-sensitive intervention development by district level managers.

Building resilient health systems for emergency preparedness: gender and health workforce intersections (organized session)

Evaline Langat Chipchichir[1], Lisa Avery[2], Sally Muhula[3]

(1) Aga Khan University
(2) University of Manitoba
(3) Mombasa County Government

Background

Readiness for and responsiveness of health care systems to any health crisis depends heavily on a strong health work force of all cadres and levels. Governments are required to strengthen human resources in health with focus on the most at-risk cadres, ensuring that human resource management, organization, capacity building, and support and recovery programmes are inclusive, gender sensitive and transformative and sustainable. Globally, women comprise 70% and up to 90% of the health and social care workforce respectively and are more likely to be providing frontline care. Yet, few research studies evaluate the impact and effects of the COVID pandemic and the public mitigation measures on the female health work force in low- and middle-income countries. Our session will share findings from our research in Kenya on the impact of COVID-19 on female paid and unpaid health care providers.

Conducted between 2022 and 2024 in Kilifi and Mombasa Counties, the study employed mixed methods with paid and unpaid male and female health care providers to understand the relationships between female health care providers experiences and health before, during, and after COVID-19. Through application of a health equity and gender equality lens our session will highlight the varied contextual, cultural and socio-economic factors that differentiate women's experience of COVID-19 and impact health system's abilities to respond to future and existing emergencies and safeguard the women in the health workforce in future health crises.

Understanding the economic implications of COVID-19 on the paid and unpaid health workforce in Kenya

Bilali Yusuf Mazoya *Kilifi County Government, Kilifi, Kilifi County, Kenya*

Background

Health system resilience and responsiveness requires a functional health workforce that can ensure access to universal health care and respond to emergencies. The Kenyan health system response to the COVID pandemic relied heavily on paid and unpaid health care providers (community health volunteers). Yet minimal attention was given to the economic and livelihood challenges faced by these workers during the pandemic.

Objective

To describe the economic and livelihood impact of COVID-19 on paid and unpaid health care providers in Kilifi and Mombasa Country, Kenya and their implications on future pandemic preparedness.

Methods

Participatory mixed methods (qualitative (FGDs, IDIs and KIIs) and quantitative (survey, n = 2526)) framed by health equity, gender-based analysis and human centred design were employed.

Key Findings

Just over half (55.7%) of interviewed care providers were unpaid community health volunteers (44% were paid providers). Compared to paid workers, unpaid providers: relied on other employment as their main income source (63% vs. 3.4%); were divorced (6.2% vs. 0.9%) or widowed (9.2% vs, 2.2%); and were female (81% vs. 70.9%). During COVID unpaid providers faced increased workload (69.3% vs. 55%) and unpaid domestic care burden (53.5% vs. 37.4%). More than three quarters of both cadres had their livelihood affected (80%) with unpaid providers disproportionately affected: over a quarter had complete loss of income (28.4% vs. 5.5%) and 40% described the level of impact on their livelihood as extreme (vs. 6.8% of paid). Most of both cadres did not receive assistance from other sources (61%) despite adverse livelihood impacts. Financial and food support were the most common forms of assistance for those who were recipients of help. Family, friends and NGOs were the most common sources of assistance. Government and employers were of minimal support. Interestingly far less than half of both cadres indicated any involvement in health system or workforce policy development prior to or during times of crises.

Conclusion

Future pandemic preparedness planning must include strategies to mitigate against adverse economic and livelihood consequences for paid and unpaid health care workers. Failure to do so will greatly limit Kenya's health system's ability to withstand future emergencies.

Essential but not equal: the neglected role of gender in health system's emergency preparedness and response

Everlyne Mbuche Mpita *Kilifi County Government, Kilifi, Kilifi County, Kenya*

Background

Globally, seven out of ten health care workers are women. In Kenya, the frontline face of the pandemic health workforce response was predominantly female. Pandemic driven health care system and mitigation measures had unintended health, economic, and societal consequences. Yet the impact of these consequences to the paid and unpaid female health workforce remained neglected.

Objective

To examine pandemic associated gender vulnerabilities among the paid and unpaid health work force and generate strategies to minimize the negative impact of future pandemics on female health providers.

Methods

Quantitative survey (n= 2526) with proportional sampling of female (n = 1932) and male (n = 589) paid and unpaid health care providers in Kilifi and Mombasa Counties, Kenya using gender based and intersectionality analysis.

Key Findings

A greater proportion of the unpaid cadre were women (80% vs.19%). Across both cadres' fewer women were married than men (64.7% vs. 76.5%) but more women underwent separation during COVID than their male counterparts (42.3% vs. 30.4%). Pre and post COVID male monthly income was 1.5 to 2 times greater than that of female providers regardless of cadre. During COVID more women described their livelihood as being extremely affected (28.2% vs. 20.5 %) and experienced complete loss of income (23.7% vs. 15.9%). Women took on average 4 more days of sick leave to care for themselves or others and just under half saw an increase in their unpaid care and domestic work responsibilities compared to a third of men. A similar proportion of male and female providers experienced violence during the pandemic (12.5% vs. 11%), but women were 3.5 times more likely to have home be the setting of violence. Nearly 14 % of female providers were pregnant during the pandemic; the majority (89%) described experiencing pregnancy anxiety because of being a health provider during COVID but only a quarter requested accommodation to a non-frontline role. Despite representing most of the health workforce women were far less likely to have any involvement in health system or workforce policy or guideline development (one third compared to half of men).

Conclusion

The development of gender- sensitive and transformative health systems that can withstand future emergencies need to explicitly address the unique vulnerabilities faced by female paid and unpaid health care providers. Despite being highly dependent on women as providers of care, health systems remain insufficiently responsive to women's specific health workforce needs.

Invisible work: Implications of the unpaid care burden for resilient and gender transformative health systems

Sharlet Anzazi *Kilifi County Government, Kilifi, Kilifi County, Kenya*

Background

Low- and middle-income health systems are highly reliant on a predominantly female, and a community health workforce, often unpaid, to ensure universal access to care and execute pandemic response and preparedness. Historically, little attention has been given to the unpaid care work burden faced by female providers and its consequences for building gender transformative health systems that protects the health and rights of all citizens.

Objective

To document the unpaid care burden faced by female paid and unpaid health care providers in Kilifi and Mombasa, Kenya and propose recommendations for health workforce policies to recognize and address the inequitable burden of unpaid and domestic care.

Methods

Mixed methods were employed: time use survey's (n= 2526) with proportional sampling of female (n = 1932) and male (n = 589) paid and unpaid health care providers; and FGD's, IDI's and KIIs of male and female health care providers, government and key stakeholders.

Key Findings

During COVID unpaid providers experienced an increased volume of work duties compared to paid (69.3% vs 55%). Although both cadres described increases in domestic work distribution, time use and unpaid care, a greater burden was described by unpaid providers (three quarters compared to half of paid). This burden was also gendered. Both men and women described an increase in time use and unpaid labour however this was greater for women (nearly half vs a third of men), especially for domestic work and childcare. Work distribution was also inequitable with responsibilities such as cooking, cleaning and child or ill family member care consistently allocated to women. Qualitative findings revealed the double burden of unpaid care faced by community health volunteers as they absorbed additional unpaid care work on both the domestic and health system sides. Paid health providers were better able to outsource additional unpaid domestic and care work through paid employment of domestic staff. Gender responsive budgeting and policies that recognize and strengthen social protection and rights of paid and unpaid providers were identified as critical gaps by both stakeholders and providers.

Conclusion

The gendered division of unpaid care work remains a key barrier to the development of resilient and gender transformative health systems. Initiatives that recognize, reduce and redistribute the unpaid care burden should be integrated within health system financing and reform. Special consideration is required for community health volunteers who juggle voluntary unpaid health care work, domestic care, and informal sector work for their livelihoods.

Enhancing Decentralized HIV Service Delivery for Improved Coverage and Continuum of Care at Primary health Care Centres: Lessons from Northwest Nigeria

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Keywords

DSD, PHCs, PLHIV, HIV

Background

In 2019, Nigeria adopted the Differentiated Service Delivery (DSD) model to enhance HIV services and care. Despite its implementation across all 36 states and the Federal Capital Territory, Primary Healthcare Centres (PHCs) remain primarily focused on HIV testing and linking patients to higher-level facilities for Antiretroviral Therapy (ART) initiation, even though they are easily accessible to people living with HIV (PLHIV). Additionally, HIV Community outreach has potential of increasing attendance of clients for HIV services at the PHCs. Thus, there is a need to assess the status of PHC service delivery and influence of outreach program towards improved universal healthcare coverage.

Results

There are 35 PHCs with 23 (65.7%) in urban and 12(34.3%) in rural area. About 62.9% of the PHCs have been engaged on community outreach program, 60.0% engaged in client linkages to the 9 secondary hub health facilities in the study states. About 40% screened for tuberculosis and 88.6% provided consultation for clients. All the PHCs provided pre and post-test HIV counselling and laboratory tests but only 2.9% did CD4 count and viral load with 5.7% involved in adherence counselling. Unfortunately, none of the PHCs were involved in ARV initiation, refill and dispensing. Factors influencing community outreach include PHC located in urban area OR=2.9 95%CI 1.7-8.8, staff available for triage OR=3.2 95%CI 1.4-5.9, and availability of TB screening opportunity OR=5.6 95%CI 3.6-10.4.

Conclusion

There is a remarkable gap in the continuum of HIV care at the primary healthcare level in Kebbi, Sokoto, and Zamfara states especially with the initiation of ARV drug. This highlights the need to upscale decentralized HIV service delivery at PHCs. To improve coverage and ensure continuity of care for PLHIV, targeted interventions are recommended to equip PHCs with the necessary resources, training, and support to provide the full spectrum of HIV services, including ART initiation and refill, adherence counselling, and psychosocial support while leveraging on their comparative advantage of community outreach programs to increase demand for HIV services.

Addressing Financing Gaps in Health: New Perspectives for Public-Private Partnerships

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Background

The adverse global economic conditions generated by the aftermath of covid-19 pandemic, and in recent times the Russian-Ukraine war has severely impacted sustained public health financing in resource- constrained settings. To bridge the health systems resource gap, private sector financing has the potential to play critical role that ensures effective delivery of health services. In the case of Nigeria, the consumer base of health services makes up at least 95% of the population. Also, out of pocket expenditure on health services (which reflects the private sector spending on health) has steadily grown from 72.9% in 2000 to 77.5% in 2010, averaging at 75.1% for the 20-years period between 2000-2020.

Objectives

The aim of the study is to provide evidence of comprehensive and comparable analysis of the contribution of the various health funding sources and to establish basis for fruitful collaborations and complementarities for health financing.

Method Used

The study is a comparative analysis of funding for 3 healthcare services: malaria, non-communicable diseases (NCDs) and maternal health services, by funding agents (public, private and external sources). Simple statistical tools of pie-charts and line graphs are employed for the analysis of data obtained from World Health Organization (WHO) database covering 7-years; 2013-2019. Two health financing indicators: % current health expenditure(%CHE) and % government general expenditure(%GGE) are chosen owing to their direct link to the subject of study.

Key Findings

The proportion of private health expenditure remains high for all 3 healthcare services examined in the study in comparison to expenditure from public and external sources both as % CHE and % GGE. Specifically, for %CHE, the proportion of private resources expended on malaria services exceeded the resources expended by both public and external resources (33.7% Vs 4.42% Vs 2.42%,). Similarly, for maternal health services, the proportion of private sector resources expended exceeded that of public and external resources (5.85% Vs 1.85% Vs 0.57%). For the NCDs, private resources spent outweighs public and external resources put together (7.85% Vs 2.514% Vs 0.14%). Similar results were found for general government expenditure (%GGE) where private expenditure on malaria made up larger proportion compared with public and external (9.57% Vs 1.42% Vs. 0.71%) while for NCDs, higher private resources was found to be expended in comparison to public and external resources (2% Vs. 0.85% Vs 0%).

Conclusion

Findings of the study provides sufficient evidence to the effect that private funding for healthcare services is significant. Furthermore, the study lends credence to the need for models that explore collaborative partnership for healthcare funding from all sources to augment capacity gaps for expansion of services that reaches the unmet needs of population.

Clonal dissemination of extended-spectrum β-lactamase-producing Klebsiella pneumoniae isolated from surgical patients, medical devices and hospital environments in the West region, Cameroon

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Background

Hospital-acquired infections (HAI) caused by antibiotic resistant Klebsiella pneumoniae are serious public health concern globally. Extended-spectrum **β**-lactamase-producing Klebsiella pneumoniae (ESBL-K. pneumoniae) are major contributors to life-threatening HAI especially in surgery and intensive care unit wards.

Suboptimal hygiene measures and the non-existence of infection prevention control programs and policies contribute to the easy dissemination of ESBL-K. pneumoniae from the inanimate surfaces, medical devices, healthcare workers to hospitalized patients. This study aimed at determining the prevalence, risk factors, genotypic characteristics and clonal relatedness of ESBL- K. pneumoniae isolated from surgical patients, medical devices and hospital environments at the Annex Regional Hospital of Dschang in the West region in Cameroon.

Methods

A cross-sectional study was conducted over a four-month period from February to May 2022. A total of 91 samples were collected from hospitalized patients (n= 46), medical equipment (n=20) and hospital environments (n=25). Samples were cultured on Eosin Methylene Blue agar. After culture and biochemical identification with API 20E, antibiotic susceptibility testing were carried out using disc diffusion method on Müller Hinton agar. ESBL phenotype was screening using ChromAgarTM ESBL (CHROMagar, Paris, France) coupled with double discs synergy test. In addition, the detection of blaCTX-M, blaSHV, and blaTEM resistance genes was done with Polymerase Chain Reaction (PCR) methods, while the clonal relatedness of isolates was performed using the Enterobacterial Repetitive Intergenic Consensus (ERIC) PCR method.

Result

The overall prevalences of ESBL -K. pneumoniae was 23.9% (11/46). Only two Klebsiella pneumoniae were isolated from medical equipment of which one isolate was ESBL. The result of the hospital environment revealed 28% (07/25) were positive for Klebsiella pneumoniae, with 20% (05/25) being positive for ESBL. High level of resistance (100%) to cefuroxime, amoxicillin-clavulanic acid, cefuroxime, ceftriaxone and cefotaxime were observed. In addition, the resistance rates to gentamicin and meropenem were (89.4%) and (42.1%) respectively. The leading β-lactam resistance gene detected was blaCTX-M (65.6%) followed by blaTEM (43.7%) and blaSHV (25%). The clonal relatedness revealed the likely circulation of ESBL-Klebsiella pneumoniae within and between wards and the hospital environment respectively.

Conclusion

It is therefore imperative, even very urgent, to implement stringent infection prevention and control measures to curb the dissemination of MDR and ESBL-Klebsiella pneumoniae.

Revitalizing Health Service Delivery in Zimbabwe through Innovative Health Financing and the Primary Health Care for Attaining Universal Health Coverage Approach, (PHC4UHC) by 2030.

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Primary health care, (PHC) emerged in the 1970s as a strategy to respond more equitably, appropriately, and effectively to basic health-care needs and address the underlying social, economic, and political causes of poor health. Today there is a more urgent need for LMICs to effectively implement PHC for universal health access, (UHC) for attaining the sustainable development goals, (SDGs, 2030). An integral

part of the country's health system and overall economic and social development, PHC requires coordination on a national basis with all levels of the health system, and other sectors that contribute to a country's total development strategy.

Zimbabwe, at its Independence in 1980, premised its health delivery system on the concept and philosophy of PHC, (WHO, UNICEF, 1978); greatly improving population health status and attaining notable standards. This progress however stalled and regressed following decades of socio-economic and political challenges that impacted negatively on health. Despite progressive increases in budgetary allocations towards the 15% allocation for health, (Abuja, 2001), the fiscal disbursements have been inadequate to keep the system afloat.

Meanwhile, there must be plans for transitioning out of the Global Fund, GAVI and, other major funders by 2030, prompting actions towards domestic resource mobilization and social health insurance.

Aims and Objectives

- To conduct an assessment of the current status of the health delivery system
- To convene a national dialogue for consensus on health financing
- To obtain consensus on the need for a sustainable domestic resource mobilization strategy

Methods

A situation analysis on the status of health delivery and financing situation, mapping health stakeholders, donors and their contributions to health was conducted. A two-day national dialogue on health financing for universal access, was convened, targeting the media, CSOs and parliament with the support of the Global Fund and SADC.

Key Findings

A comprehensive analysis of the situation, status of health financing, progress towards UHC was accomplished and shared. The extent of the system's demise and the urgent need for its revitalization, strengthening through innovative financing and strategy for transitioning out of major financing by 2030 was elucidated. A decision on domestic resource mobilization including advancing the NHI establishment for sustainable health financing and for addressing the vulnerability through improved efficiency of the government's budget was made.

Conclusion

National consensus on sustainable financing for UHC with concrete follow-up actions and a joint

communique by the media, parliament and, the health CSOs has been obtained for revitalizing Zimbabwe's health system.

A Multi-Sectoral Approach to Strengthening Cameroon's Health Emergency and Pandemic Response System: Lessons from COVID-19.

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Background

The COVID-19 pandemic placed an extraordinary strain on economies across the world, affecting health systems, greatly exposing systemic weaknesses and revealing significant gaps in global and national pandemic preparedness. Millions of people were infected and millions of deaths reported. Due to the pandemic, global GDP fell by 3.4%, unemployment soared by 5.77%. Cameroon's GDP fell from 4.03% to -1.2% and unemployment rose from 3.61% in 2018 to 4.12 % in 2020. An attempt to reduce the spread of the infection, prevent deaths and improve immunization rates led to embezzlement of COVID funds to the lack of adequate knowledge on how to treat critical cases among other challenges.

Objectives

The objective of this abstract is to present a multi-sectoral approach to strengthening Cameroon's health emergency and pandemic response system, drawing lessons from Covid-19, by building the capacity of the health work force and communication strategies that build trust through transparency.

Methods

A combination of studies involving qualitative and quantitative study design with primary and secondary data and systematic reviews were used.

Results

A stable health financing and accountability mechanism, building the capacity of the health work force,

investing in infrastructure and a communication strategy that builds trust through transparency will strengthen Cameroon's health emergency and pandemic response system.

Conclusion

To prepare for future pandemics, there is need for an appropriate health financing and accountability mechanism, qualified and diverse personnel, adequate infrastructure and effective communication strategies. The government needs to increase its financial allocation to the health sector from the current 3-5% to 15% of its GDP as recommended by the Alma Atta Declaration.

Keywords

Covid-19 Pandemic, Pandemic response system, Cameroon.

Correlates of Safe birth outcomes: Evidence from the Service Delivery Indicator survey

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Background

The World Health Organization showed that approximately 800 women died from preventable causes related to pregnancy and childbirth every day in 2020. The statistic also showed that Nigeria accounts for over 34% of global maternal deaths. The generality of findings in the extant literature for the drivers of safe births often focus on the demand side. Empirical evidence for supply side drivers is scanty. It is important to address supply side drivers of safe births because aside from access to healthcare, the availability and quality of care provision at the health facility plays a key role in determining health outcomes. This again is important for policy actions on improving population health.

Aims and Objectives

This study examined supply side drivers of safe births in Nigeria using data from the Service Delivery Indicator Survey provided by the World Bank. The study also analyzed the distribution of health infrastructures that drive safe birth across public and private health facilities.

Methods

Findings for the drivers of safe birth are shown using the Poisson regression and the logistic model to capture safe births first as count data using the number of successful deliveries and second as a categorical dependent variable. This is for comparison of findings across models. The distribution of health infrastructure across facility types are shown using measures of central tendency.

Key Findings

Findings showed closely related results for both models. The regression analysis showed significant positive effect of all measures of infrastructure considered in the study on the likelihood of safe birth with stronger effect in terms of magnitude for the availability of a maternity delivery room, having more medical personnel, and the provision of emergency obstetric care. The results showed that private health facilities are better equipped with key infrastructure such as power, protected water source, medical personnel, less unofficial absence of medical staff, having a maternity delivery room, facility ambulance and provision of emergency obstetrics care than public facilities.

Conclusions

The results drive home the need to equip health facilities with key infrastructure that promote maternal health especially in public health facilities and the retainment of health workforce. This again is important with the high patronage of public facilities by the poor who are the majority in the region. Policy actions in this directive is essential in reaching the Sustainable Development Goal (SDG) of reduction in maternal and new-born deaths in Nigeria and by extension the African region.

Vaccine financing in the Democratic Republic of the Congo: five factors that ensured the government pays its vaccines on time and in full

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In 2018, the situation of the vaccination program in the DRC was deplorable: ***2.5 million children under one year old had not received all the vaccines (or 2/3 of the children)***. Similarly, the percentage of children who received the Penta vaccines had decreased over the previous four years, as had the proportion of fully immunized children. . The latter was 35% of children in the 2018 Multiple Indicator Cluster Survey, compared

to 45% in the 2014 Demographic and Health Survey. One of the main reasons for this low coverage was the lack of vaccines. While Gavi had funded up to 94% of the costs of six vaccines under a co-financing agreement with the government (UNICEF, 2023), three vaccines (so-called traditional ones) were supposed to be fully funded by the government. The state was failing. The situation was structurally critical: in the 11 years preceding 2019, the DRC was the country with the most delays in paying its co-financing share globally - in 8 of the 11 years, the country paid after the required deadline. However, since 2019, the government has paid its share for vaccines on time and in full, every year. In 2023, it was the second country in the region to pay for its vaccines - a novelty.

With information from interviews with key informants and analysis of budgetary information, public financial management processes, and the review of vaccine orders, the authors identify the five drivers of this change. These include the establishment of a plan with short deadlines and very few and very clear indicators. It also involves collaborating with other financial partners such as the IMF, which integrated vaccine financing goals into its credit agreement. The government has identified the right person in the right place to be responsible for all internal monitoring, and has established a broad coalition for vaccine financing that goes beyond the government.

Furthermore, the government monitors progress and reviews key indicators every two years. This adaptable and pragmatic process has allowed the DRC government to fully pay for its vital vaccines over the past five years.

Tuberculosis Domestic Financing Strategy as a Driver for Sustainainability: Experience from Kano State, Northern Nigeria.

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Introduction

Nigeria is one of the high TB burden countries worldwide and despite free TB diagnosis and treatment many patients experience catastrophic cost to TB treatment amounting to over 30% of the family's earnings. This affects the socio-economic wellbeing of the populace thereby tilting more people to below poverty line according to the World Bank. To address this and achieve universal health coverage kano state government came up with strategic financing mechanisms to enhance Domestic resource mobilization for TB.

Intervention

Kano State Government endorsed the Abuja declaration of 15% benchmark of annual budgetary allocation to Health sector, including TB. Now to be able to achieve this the state established two new agencies

as financing platforms for health especially the poor and vulnerable people. These agencies are Kano State Contributory Healthcare management agency (KSCHMA) and Kano Health Trust Fund (KHETFUND). While for former provides healthcare services through strategic purchasing in form of premiums for both formal and informal beneficiaries, the latter remits 5% of the state total monthly Internally generated revenue and 1% of the monthly statutory allocation of the 44 Local Government Areas into the agency's account and the accrued amount are used only used for healthcare financing in line with the established operational Guidelines of the agency. And through advocacies TB and Leprosy were included into the financing benefit packages platform for sustainability.

Results

Through these efforts State Government appropriation to TB rose to 300% (from 20 million naira in 2021 to 60 million naira in 2023), coupled with cash backing on yearly basis. Also, there was a special allocation of certain amount to TB and Leprosy (6%) of the total accrued to KHETFUND on regular basis and the financing covers services both in public and private sector and providers.

Conclusion

TB strategic domestic financing is key to financial sustainability and social protection against catastrophic cost resulting from out-of-pocket expenditure due to TB towards attainment of universal coverage.

Electrochemical Treatment for Removing Heavy Metals from Raw Water at Opa Dam: A Technological Approach

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Background

Water scarcity affects over 2 billion people globally, with the UN predicting that by 2025, half the world's population will live in water-stressed areas. Contaminated sources and heavy metals like lead, cadmium, and copper pose severe health risks such as kidney disease, and cancer. Traditional treatment methods often fail, highlighting the need for advanced techniques like electrochemical treatment, which this study optimized by evaluating the effects of key factors by analyzing the effects of various factors, including the water-to-electrolyte ratio, treatment duration, electrode spacing, and applied current.

Methods

Using Scanning Electron Microscopy (SEM), the elemental composition of the electrodes employed in the treatment was examined. Raw water samples from Opa Dam were characterized for turbidity, total

dissolved solids (TDS), chloride, copper, zinc, lead, and cadmium concentrations using standard procedures. Sixteen different working solutions of these samples were subjected to electrochemical treatment under controlled laboratory conditions. An orthogonal array factorial experiment (4x4) was employed to evaluate the performance based on the reduction of selected parameters.

Results

The results indicated that the electrochemical treatment significantly reduced the concentrations of all targeted contaminants. The highest removal efficiencies achieved were 58.35% for turbidity, 88.10% for TDS, 92.31% for chloride, 31.18% for copper, 90.21% for zinc, 56.33% for lead, and 57.71% for cadmium. Optimal treatment conditions varied for each parameter. For instance, the optimal conditions for turbidity removal were a volume ratio of 1.75, a treatment time of 35 minutes, electrode spacing of 1.2 cm, and a current of 1.5 amps. TDS removal was optimized at a volume ratio of 2.0, a treatment time of 30 minutes, electrode spacing of 1.2 cm, and a current of 1.0 amps. Similarly, other contaminants had specific optimal conditions.

Conclusion

In conclusion, this study confirms the effectiveness of electrochemical treatment in removing selected heavy metals from raw water. The optimal treatment parameters identified provide a framework for enhancing water treatment processes using electrochemical methods, thereby contributing to cleaner and safer water resources.

The African Social Economy and the Misguided Responses to COVID 19 in Sub-Saharan African Cities

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Many planners and government officials, who have idealized notions of the modern African city, tend to dismiss the continent's large informal sector as "a chaotic jumble of unproductive activates" that should be removed through punitive policies of forced eviction and repression. The fact is that this sector supports local livelihoods and income, and has helped to alleviate poverty and to provide some degree of social protection; but the poor workers in the sector are vulnerable to numerous occupational hazards and undue harassment by state officials. COVID 19 illustrates how the traditional prejudice against the informal economy was carried over in the top- down containment measures enforced during the pandemic. These measures caused more harm beyond the health threat, and have raised serious human rights concerns.

The initial information about COVID19, and the standard advice about its control were based on data from

high- and middle-income countries. There was panic that the epidemic would spread very fast and take a heavy toll in Africa because of the general health conditions in the continent, and the limited capacity of the health system. Unfortunately, the aggressive measures to contain and manage the pandemic in Africa did not sufficiently take into account the local cultures and social economy of the region, and therefore affected informal sector workers and informal settlements adversely and disproportionately. Most informal sector workers depend for their daily earnings on constant movement and interaction outside the home – be they street or market traders, cart pushers, waste pickers, cab or motorcycle operators and so on. During the pandemic, they were exposed not only to infections but also to constant harassment by state officials who enforced COVID lockdown and other restrictions on movement. Housing conditions in informal settlements are usually overcrowded, with limited access to water, sanitation and social services needed to comply with COVID protocols for social/physical distancing, hand washing, etc; and structural inequalities in most cities excluded informal sector operators from meaningful participation in the design and implementation of COVID-related policies, or due access to the palliatives provided by government and humanitarian organizations.

With hindsight, it now appears that the official response to the pandemic in Africa was misguided in many respects. Africa accounts for only about 2 per cent of global COVID deaths; and many more people died from hunger and damage done by rigid COVID policies. There was widespread distrust among the poor that the top down COVID policies served the interest of the elite oppressors. We argue that for the future government officials and planners, who aspire to international standards of modernity, and adopt the prescriptions of the global community, must learn to strike the right balance between the ideals of international standards, and the reality of local conditions and requirements.

Advancing Vaccine Equity and Primary Healthcare Access in Africa

Adopt-a-Healthcare Facility Project (ADHFP) by the Private Sector Health Alliance of Nigeria (PSHAN): Enhancing Sustainable Primary Healthcare Access through Domestic Resource Mobilization via Nigeria's Organized Private Sector

Offiong Moore, Anne Adah-Ogoh, Rukayyat Sadiq, Tinuola Akinbolagbe, Okechukwu Nnamani, Christopher Samugana and Olamide Popoola

Private Sector Health Alliance of Nigeria

Background

Nigeria currently has approximately 34,076 Primary Health Care (PHC) centres, constituting 85.3% of the country's total health facilities. However, only about 20% of these PHCs are functional, with most lacking the capacity to provide essential healthcare services due to weak health systems, primarily driven by inadequate and unsustainable financing. Strengthening health systems through improved domestic resource mobilization at the PHC level is critical for ensuring equitable access to quality healthcare. The Global Financing Facility has identified the private sector as a potential source for innovative resource mobilization; however, specific contributions from the private sector have yet to be clearly defined.

Aims and Objectives

The ADHFP project, planned for a 10-year duration, explores the role of effective collaboration with the organized private sector in mobilizing funding to revitalize 774 PHC facilities across Nigeria. This initiative aligns with the Nigerian Government's broader effort to revitalize 17,600 PHC facilities nationwide.

Methodology

The project utilizes an adoption model, whereby each PHC facility is supported for five years. Key stakeholders were identified and grouped into three categories: Governance (Federal and sub-national PHC agencies), Financiers/Adopters (private sector entities, individuals, and philanthropists), and Community (health community structures). The project facilitates upgrades in infrastructure and other health system components, including patient management technologies, through funds provided by adopters following the selection and assessment of health facilities. Additionally, facilities are supported in

accessing the Basic Health Care Provision Fund gateway, and community members are linked to health insurance schemes to enhance the sustainability of demand and supply.

Key Findings

The ADHFP has successfully secured over 314 million in disbursed funds from committed amounts totalling 11.7 billion. In the first two years of the project, 210 (28%) of the targeted 774 PHC facilities have been fully adopted. The revitalized facilities have seen significant improvements, including a 200% increase in outpatient department (OPD) attendance, a 230% increase in under-5 immunizations, and a 180% increase in antenatal care (ANC) attendance.

Conclusion

The ADHFP demonstrates the potential of domestic resource mobilization through private sector collaboration in revitalizing primary healthcare in Nigeria. The project's early successes in improving key health indicators underscore the importance of sustainable financing and the vital role of the private sector in achieving broad-based healthcare improvements. Continued engagement and scaling of such initiatives are crucial for sustaining these gains and ensuring long-term health system resilience in Nigeria.

Distribution network optimisation and medical product flow in primary health centres: Insights from healthcare providers in Southeast Nigeria

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Background

The distribution network's impact on medical product flow is crucial for primary health centres in Southeast Nigeria. Despite efforts to improve healthcare delivery, delays are common due to poor distribution network, inadequate infrastructure, and inefficient logistics. A comprehensive study is needed to identify bottlenecks and propose solutions to improve the speed of flow and timely delivery of medical products.

Objectives of the Study

This study is aimed to determine to what extent distribution network optimisation affects speed of flow of medical products of primary healthcare facilities and exploring challenges and potential solutions related to medical product flow in South-East Nigeria

Methodology

The research used a descriptive cross-sectional mixed-methods survey research design. The sample size involved the purposive selection of 155 supply chain managers in the health centres and local government Area (LGA) health authorities. Data was collected through structured questionnaires employing a five-point Likert scale to ranking responses. The study included primary health care workers, medicine supply chain managers at Local Government Areas (LGA), and state managers of medicine supply chain from the Ministry of Health

Findings

With a mean response score of 3.80 ± 1.03, the respondents are of the opinion that electronic procurement enables their health facilities to replenish its out-of-stock-goods quicker. With a mean response score of 3.59 ± 1.14, the respondents are of the opinion that optimizing inventory assets helps to better manage the flow of health commodities. The respondents also believe that deploying electronic data interchange (EDI) which involves sharing of information electronically aids health commodities like medicines to flow quicker from manufacturers to retailers (a mean response score of 3.37 ± 1.10). Furthermore, with a mean response score of 3.77 ± 1.07, the respondents are of the opinion that optimizing transportation network of their supply chain aids goods to get to their consumers quicker. In summary, the regression analysis supports the hypothesis that distribution network optimisation significantly affects the speed of flow of medical products to the health centres. Health centres face challenges in storage, electricity, funding, safety, road conditions, and personnel, affecting healthcare delivery.

Conclusion

A well-designed and managed distribution network is vital for the efficient flow of medical products, directly impacting their availability and reliability, thereby improving the overall service delivery and performance of primary healthcare centres in south east Nigeria. Addressing key issues in medical product flow is crucial for improving healthcare delivery in the State.

Equity of vaccine coverage in the DRC: revealing the multiple facets of inequity.

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Health equity is a priority for the Democratic Republic of the Congo and numerous studies show that average levels of immunization coverage mask important sub-national inequalities, that persist for reasons related to multiple socio-demographic, geographic and supply-side access barriers. Despite these multiple contributory dimensions, most inequality measures only examine disparities by a single dimension, such as wealth or urban/rural status, which may mask persistent disparities correlated to multiple dimensions. Our study uses the Vaccine Economics Research for Sustainability & Equity (VERSE) toolkit to compare measures of wealth-based inequity with a composite multivariate measure of inequity for fully vaccinated status.

The VERSE tool produces a composite equity concentration index (CI) and an absolute equity gap (AEG) based on this index, which in its classification process takes into account several factors affecting equity in immunization coverage, including the level of education of the mother, sex of the child, household wealth, urban/rural environment, residence status and insurance coverage. To focus on inequality rather than inequality, the child's age is used to monitor needs by matching the child's age with the recommendations of the national immunization schedule. The VERSE equity tool is then applied to data from the Demographic and Health Survey (DHS) of 2013-2014 to assess the level of inequity in fully vaccinated status that is captured using only a wealth-based CI versus using composite grading criteria to generate an IC.

Overall, socio-economic status (36%) is the main factor determining whether a child is fully vaccinated against the vaccination schedule. The zero-dose status is explained by the socio-economic status (38.3%) and the mother's level of education (22.5%). Maternal education has a dominant influence on vaccination status in many low- and middle-income countries. However, this influence differed in terms of the extent and outcome of vaccination.

Understanding and quantifying the influence of factors of inequity on immunization coverage is a conducive and necessary element of a concerted effort to mitigate the impact of social status the low level of education of mothers/carers by maintaining regular provision of vaccines and community participation.

Decomposing socio-economic inequality in zero dose vaccination status among children in Somalia: Evidence from Somalia Health and Demographic Survey 2020.

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Introduction

Vaccination is one of the most effective and successful public health interventions, having reduced the burden and averted the deaths of 2-3 million of children every year of vaccine preventable diseases. However, vaccine-preventable diseases still present a significant public health concern due to pockets of children with zero doses, those children who did not receive any of the basic routine vaccines. Studying the distribution, and inequality of zero-dose children is a policy priority that provide insights to achieve universal coverage of immunization as per the SDGs, and Immunization Agenda 2030.

Methods

The study used secondary data from the first Somali Health and Demographic Survey 2020 to examine the distribution, and wealth-related inequality of zero-dose children in Somalia. We used a concentration index, and concentration curve to estimate, and analysis the socio-economic inequalities for zero dose children based on wealth quantiles. Further decomposition analysis of concentration index was also conducted to determine the contribution of various variables to the observed wealth inequality of zero dose children.

Findings

The prevalence of zero dose children, those who did not receive DTP-1 dose, was 77.4%. Zero dose children were from mothers not-attended school (86.9%), and not or partially empowered (71%), and those reported facing challenges in accessing health facilities (65%), did not attend any antenatal care visits during pregnancy (81.5%) and gave birth at home (85.6%). The majority of zero dose children were from remote areas (69.3%), including rural (27.3%) and nomadic (46.7%) areas. Zero dose children were highest in the lowest (28.9%) and second lowest (25.4%) wealth quintiles, and lowest in fourth (16.7%) and highest (11.1%) wealth quintiles.

The concentration curve of zero dose children show curve above the line of equality, demonstrating that zero-dose children are disproportionally more concentrated in households within the lowest and lower wealth quintiles. Consistently, the study found that concentration index of zero dose status children was = -0.23653092 (p-value < 0.0000), CI < 0, indicating that zero-dose children are disproportionately concentrated in poorer households.

Conclusion

The study found a high prevalence of zero-dose children with significant inequalities, and disparities faced by zero-dose children in Somalia. To reach zero dose children, the study suggests multi-faceted pro-poor interventions to enhance maternal education, and empowerment of decision making, improve access and utilization of maternal health services. The study also recommends increasing the access and availability

Willingness to pay for rabies vaccination services and associated factors among communities in Geita District, Tanzania

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Background

Rabies remains a significant public health problem in Tanzania, causing a high economic burden due to medical costs and productive lives lost due to premature deaths. Despite all the effort put into rabies vaccination campaigns, there are still new cases all the time, and vaccination coverage is still low.

Aims and Objectives

To explore the willingness to pay for rabies vaccination services and associated factors among communities in Geita district, Tanzania.

Methods

A cross-sectional study was conducted among 312 respondents in Geita district from August to September 2023. The study deployed a willingness-to-pay (WTP) technique using a bidding game to elicit the maximum values respondents were willing to pay for rabies dog vaccination and human post-exposure prophylaxis. An interviewer-administered questionnaire was used to collect all the necessary data. Linear regression models were used to evaluate the WTP and associated factors.

Key Findings

The results suggest that people are willing to pay slightly more for dog vaccination services ($0.3 above the prevailing price) compared to human post-exposure prophylaxis (PEP), in which the average WTP is the same as the prevailing price. 62% of the respondents were willing to pay above the prevailing price ($1.2) for dog vaccines compared to 32% for PEP ($20). In dog vaccination and human PEP services, men are more willing to pay than women.

Main Conclusions

This study highlights the significance of economic consideration in rabies vaccination decisions. In addition to awareness, availability, and access to vaccines, it is crucial to consider socioeconomic factors and financial values individuals place on the welfare of animals

Implementation of Mass Drug Administration for Lymphatic Filariasis - the progress and the effectiveness and financial savings of integrating into an existing Polio campaign

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(4) 3African Sustainable Development Research Consortium, Nairobi, Kenya

Background

In 2019, Madagascar lost 360 lives to Neglected Tropical Diseases (NTD), which accounted for 0.2% of all deaths (164,161) in the country.

Aims and Objectives

This paper presents (a) the progress made towards achieving the 2023 Lymphatic Filariasis (LF) Mass Drug Administration (MDA) campaign goals; (b) the estimated financial savings resulting from integrating LF MDA into Polio immunization campaigns; and (c) the best practices, challenges, and recommendations.

Methods

In 2023, a total of 21,336,057 people in 83 districts were affected by LF and required Preventive Chemotherapy (PC). This report gives an overview of the LF MDA campaigns conducted by the national Neglected Tropical Diseases Control Programme (NTDCP) in those 83 districts. The LF MDA campaigns had three phases. In the first phase, 24 districts received triple therapy of Ivermectin, Diethylcarbamazine, and Albendazole (IDA), while the remaining 59 districts continued to receive dual therapy of Diethylcarbamazine and Albendazole (DA) as before. The first phase (15 districts) was not integrated, while the second phase (61 districts) was conducted simultaneously with the Polio Supplementary Immunization Activities (SIA) fourth round. The third phase (7 districts) was combined with Periodic Intensification of Routine Immunization (PIRI)

and vitamin A supplementation. PC coverage was calculated by dividing the number of people treated by the total population targeted in the MDA campaign and multiplying by 100. The financial savings were calculated as the difference between the potential expense without integration and the actual expense with integration.

Finding

In Phases 2 and 3, the campaign was able to cover 99.97% of the targeted 12,208 villages, which means that only three villages remained untreated. In contrast, Phase 1 covered all the targeted 2,847 village, attaining 100% geographic coverage. The 68 districts (Phase 2 and 3) that implemented an integrated approach attained an average therapeutic coverage of 76.6% (STDEV=8.3) compared to 73.2% (STDEV=6.7) among the 15 districts (Phase 1) that conducted MDA for LF without integration (p=0.05). The integration of the LF MDA campaign into the Polio SIA and PIRI campaign resulted in an estimated financial saving of US$1,431,203.

Conclusion

This study has shown that incorporating LF MDA into polio immunization campaigns can lead to improved financial efficiency and effectiveness in meeting the objectives of LF programs. It offers valuable lessons and insights to policymakers, which can help in optimizing disease control efforts.

Ward Development Committee A Catalyst for Strengthening Primary Health Care Management: Evidence from Yobe State, Nigeria

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(1) Health Systems Consult Limited (HSCL), FCT, Abuja, Nigeria,
(2) Health Systems Consult Limited, Abuja, Nigeria

Background

Nigeria's PHC system faces challenges including inadequate funding, funds management, and data management. Yobe State located in northeastern Nigeria, faces several health challenges due to limited funding and resources for health, resulting in poor health indices including high infant and maternal mortality rates. Effective PHC management is crucial to address these challenges. Recognizing the need for community involvement in healthcare delivery, the government introduced Ward Development Committees (WDCs) as a strategy to enhance PHC management. The integration of WDCs aims to enhance community participation, accountability checks, optimization of resource allocation, and foster a

more collaborative approach to primary healthcare management, ensuring that healthcare delivery aligns more closely with local needs and priorities.

Aim and Objective

The assessment sought to assess the roles the WDC plays in tracking and management of PHC financing for improved service delivery in Yobe State, Nigeria.

Methods

We conducted a mixed study in 20 purposefully selected PHCs across the 3 senatorial districts in Yobe state, to ensure spread. The study included data abstraction from financial documents, review of meeting reports, validation, and primary data collection through Key Informant Interviews (KIIs) with the health facility Officer in Charge (OiC) and the chairman of the WDC. A quantitative and descriptive analysis was conducted to identify the effectiveness of integrating the WDC into the PHC management structure.

Key Findings

A total of 20 PHCs were assessed, of which 20(100%) maintained a well-documented and up-to-date financial record, conducted monthly bank reconciliations and financial review meetings in the last 3 months, with the WDC chairpersons as co-signatories to PHC facility accounts which has improved transparency and accountability of facility spending. No PHC reported a stockout of essential commodities, because of timely business plan development, submission, and approval for funds, done in collaboration with the WDCs. We also found that in 16(80%) PHCs, the WDC chairman and the OiC were responsible for approving ad-hoc staff payments and reported no delay in payments. 1(5%) reported operational inefficiencies in the past when there was a dispute between the WDC and OiC.

Conclusion

This study shows the effectiveness of the WDC in PHC financial and facility management, resulting in improved quality-of-service delivery and health outcomes in Yobe. However, the WDCs need continuous support from policymakers and health administrators to ensure they bridge the gap that exists between the communities and PHC facilities.

Addressing Maternal and Reproductive Health Challenges Through Financing, Infrastructure, and Outcomes in Africa

3:45 PM–5:15 PM Thursday, 03 March 2025

How much do vulnerable groups count in the Global Financing Facility? Content analysis of stillbirths, and maternal-newborn investments in policy documents for 10 African countries

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(2) Universidad del Cabo Occidental,
(3) Northumbria University,
(4) Research for Health and Development (RESADE), Ouagadougou, Burkina Faso

Background

The Global Financing Facility (GFF) aims to accelerate progress to meet 2030 Sustainable Development Goals for reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAH-N). Our study examines how GFF policy documents address maternal and newborn health plus stillbirths (MNH), given the high burden this group bears relative to investments made.

Methods

We undertook a content analysis of national GFF documents (Investment Cases [IC] and Project Appraisal Documents [PAD]) for 10 African countries: Burkina Faso, Code d'Ivoire, Ethiopia, Kenya, Liberia, Malawi, Nigeria, Senegal, Tanzania, and Uganda. The analysis framework considered progression from mentions of related outcomes (maternal and newborn mortality and stillbirths) and mindset (framing and content), to measures (indicators) and money allocated (investment).

Results

Mentions of maternal and newborn mortality are robust in all country ICs and included as targets or indicators; whereas stillbirth is only included as an indicator in three ICs and mentioned in six ICs. PADs mention MNH outcomes less overall and with variability – maternal mortality mentioned in all but stillbirths not mentioned in four countries and newborn mortality not mentioned in one. The mindset of MNH commonly reflects the continuum of care approach, with more attention to maternal interventions. Some MNH components are rarely mentioned across documents, such as abortion care, respectful maternity or family-centered care, breastfeeding, and small and sick newborn care. Results frameworks in most ICs have standard measures aligned to ENAP/EPMM coverage targets; however, MNH measures reduce in most PADs e.g. newborn health measures not in four countries. Across all countries, PAD investments total USD$1552 million (US$266 million from GFF), and differing approaches to funding descriptions prevent meaningful comparisons of MNH-specific allocations.

Conclusion

While included in GFF country documents, MNH content fades from mentions to mindset, measures and money, despite being a stated priority by the GFF. Major gaps exist, particularly for stillbirths and specific programmatic areas. The GFF is a great opportunity to make a catalytic difference, but it will need to address these gaps to deliver its goals. Disconnects between stated priorities for MNH in ICs and allocated resources in PADs suggest the need for further investigation.

Insurance Status and Utilisation of Maternal and Reproductive Health Services in Kenya

Angela Langat, Tabitha Okech, Jeanette Dawa, Loice Achieng and Thumbi Mwangi

(1) Centre for Epidemiological Modelling and Analysis, Nairobi, Kenya

Background

Health insurance can increase healthcare utilisation by reducing out-of-pocket expenses yet only a quarter of the Kenyan population have any form of health insurance.

Aims and Objectives

To assess the association between health insurance and (i) health expenditure and (ii) use of maternal and reproductive health services (contraception, antenatal care, facility delivery, caesarean section, and postnatal care).

Methods

Data were obtained from the Kenya Demographic and Health Survey. There were 15,556 individuals split equally between insured and uninsured. Health insurance was defined as either being enrolled in the publicly funded National Hospital Insurance Fund, private insurance schemes, or government sponsored programs such as "Linda Mama" which require registration for access. Comparable groups of insured and uninsured were created using Propensity Score Matching (PSM). Subsequently, linear regression was used to estimate the association between health insurance and the outcome variables.

Key Findings

We found that, on average, out-of-pocket expenditure for uninsured individuals was Ksh 497.09 (95% CI = 443.50, 557.95) for outpatient and Ksh 6,505.71 (95% CI = 3532.76, 11,979.80) for inpatient, while insured individuals spent about Ksh 318.73 (95% CI = 242.47, 418.88) for outpatient and Ksh 1356.62 (95% CI = 339.44, 5412.94) for inpatient. Insured individuals spent 31% (95% CI = 22%, 37%) less on outpatient visits and 57% (95% CI = 46%, 61%) less on inpatient services. When insurer payments were included, insured individuals incurred higher expenditures. The insured spent Ksh 632.88 (95% CI = 503.61, 795.27) on outpatient and Ksh 14,269.76 (95% CI = 5804.52, 35,078.49) on inpatient services.

For maternal and reproductive health, insurance was associated with increased hospital delivery by 2.8% (95% CI = 0.9%, 4.6%), caesarean section delivery by 4.5% (95% CI = 0.7%, 8.3%), and postnatal care by 7.4% (95% CI = 3.3%,11.5%), all statistically significant. The association between health insurance and antenatal care and contraceptive usage was insignificant.

Conclusion

We found that health insurance is associated with reduced out-of-pocket expenditure but higher total expenditure which may suggest access to higher-quality or specialised care. Insurance was linked to increased facility delivery and caesarean section but showed no association with free services like antenatal care and contraceptive use. This indicates that health insurance may enhance access to health services which require payment. Universal health coverage could be achieved by improving access to and utilisation of insurance schemes.

Keywords

insurance, spending, out-of-pocket, maternal, reproductive, health care utilization.

Impact of the Quality of Health Facilities Infrastructures on Maternal and Newborn Health: Action Research in 7 Districts of Rwanda

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Introduction

The WHO Standard 8 defines the role of a quality health facility (HF) infrastructure in providing high-quality service care to mothers and children (WHO 2016). An assessment showed that 48 maternity wards and 8 neonatology units needed to be rebuilt or renovated (Access To Health 2021). From 2020 to 2023, the project supported the renovation 34 maternities and 2 neonatology units. The research concerned renovated HFs operating for at least one year.

Methods

We considered customer care, the distance to reach the HF, and the quality of the maternity ward as factors affecting delivery at HF, as well as respect for the procedures, sterilization, and quality of neonatology units for the neonatal infection rate, and assessed their impact through a survey. The quality of maternity wards and neonatology units was assessed on 8 indicators: availability of electricity, natural light, natural ventilation, potable water, privacy, safety access for people with disabilities, respect for patient flow, and respect for restricted areas.

Results

We found that 11 over 16 renovated maternities (68.8%) recorded an increase between 0.2% and 7.9% in the rate of deliveries in health facilities, 1 (6.3%) did not record a change, and 4 (25.0%) recorded a decrease between -0.1% and -2.9% from 2020 to 2023. Besides, the research showed that the proximity of HF to the community contributed to increasing the delivery at HF. Furthermore, customer care encouraged or discouraged the mothers from going to a specific HF. On the other hand, neonatal infections decreased between 32.17% and 51.57%. However, the research showed that HFs that respect operation procedures and those with proven sterilization records have fewer neonatal infections.

Conclusion

Many factors affect the service delivery of mother and newborn health: customer care and the distance encourage or discourage mothers from seeking obstetrical service to specific HF, while the quality of HF always plays a positive role in encouraging mothers to deliver at HF. On the other hand, respect for the procedures and, particularly in the sterilization of materials and the quality of neonatal units, concurs at the same level in reducing neonatal infection.

Prioritisation and resource allocation towards neonatal health in Malawi: exploring the dynamic relationships of health system factors using causal loop diagrams.

Introduction

The WHO Standard 8 defines the role of a quality health facility (HF) infrastructure in providing high-quality service care to mothers and children (WHO 2016). An assessment showed that 48 maternity wards and 8 neonatology units needed to be rebuilt or renovated (Access To Health 2021). From 2020 to 2023, the project supported the renovation 34 maternities and 2 neonatology units. The research concerned renovated HFs operating for at least one year.

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Prioritisation and resource allocation towards neonatal health in Malawi: exploring the dynamic relationships of health system factors using causal loop diagrams.

Monica Patricia Malata[1], Fiammetta Maria Bozzani[2], Jobiba Chinkhumba[3], Charlotte Ward[1], Alinane Linda Nyondo-Mipando[4], Wanangwa Chimwaza[5], Timothy Powell-Jackson[1], Victor Mwapasa[5] and Catherine Goodman[1]

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(3) Health Economics Policy Unit, Blantyre, Malawi,
(4) Kamuzu University of Health Sciences, Blantyre, Malawi,
(5) School of Global and Public Health, Kamuzu University of Health Sciences, Blantyre, Malawi

Background

In LMICs, up to 45% of all under-5 deaths occur during the neonatal period but it is argued that neonatal health is under-prioritised in resource allocation. Priority setting and resource allocation processes are potentially critical governance mechanisms for ensuring that scarce resources are allocated efficiently, equitably, and justly across health needs and populations. However, these processes are extremely challenging in low-resource settings, where the gap between needs and resources is so great. We took a health systems thinking approach to explore how neonatal health is considered in district-level priority setting and resource allocation processes in Malawi.

Methods

We used a qualitative case study approach. Data were collected in February and March 2024 in two districts. Semi-structured interviews were conducted with 19 purposively selected health managers, neonatal health service providers, and community stakeholders. We also observed district healthcare implementation planning meetings, to triangulate observations with interview data. All interviews were audio-recorded and transcribed. Purposive text analysis was used to draw out cause and effect statements that explain neonatal health prioritisation. Causal loop diagrams were developed using the Vensim software to show connectedness and feedback mechanisms amongst various health system factors affecting the prioritisation of neonatal care in resource allocation.

Results

District health teams consider mortality data, intervention costs, and impact as part of the criteria for prioritising resource allocation. However, they work within a context of predefined government budgetary ceilings, development partner priorities, and low government funding. This is exacerbated by central control of a majority of the health budget, and earmarked budget lines for particular services leaving little room for neonatal care. The merging of maternal and neonatal health programs was also reported as a barrier to optimal neonatal health prioritisation, as resource allocation focuses on maternal health care. During resource allocation meetings, maternal health stakeholders eclipse neonatal health stakeholders thereby influencing funding allocation decisions. In some instances, there is a lack of representation from

neonatal-focused stakeholders during the budgeting processes. Also, cultural norms place less weight on neonatal death ("a bearable loss") compared to other deaths, leading to limited advocacy for investment in neonatal care.

Conclusion

Prioritisation of neonatal healthcare in district resource allocation processes is affected by global priorities, national policies and interests, cultural norms, and district factors. The presence of powerful key stakeholders to advocate for neonate health at the global, national, and district levels can improve neonatal health prioritisation.

Modelling the economic and health burden of postpartum haemorrhage due to substandard uterotonics in Ghana, Nigeria, and Senegal

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(2) University of North Carolina Eshelman School of Pharmacy, NC,
(3) MSD for Mothers, Rahway, NJ

Uterotonics are essential in reducing the risk of postpartum haemorrhage (PPH) and saving mothers' lives. However, numerous quality testing studies have found that uterotonics in many low- and middle-income countries (LMICs) are substandard. The objective of this study was to model the economic and health implications of poor quality uterotonics in three West African countries: Ghana, Nigeria, and Senegal. To our knowledge, no studies have estimated the economic burden of poor-quality uterotonics.

We utilised a decision-tree model to estimate country-specific impacts of substandard uterotonics in preventing PPH. Key findings from the three country models demonstrated the financial and health benefits that could come from ensuring that quality uterotonics are used for PPH prevention. Ghana showed the most substantial benefit from improvements in uterotonic quality, with $2 million in savings and 2,200 avoided cases of PPH per 100,000 women giving births. In comparison, annual cost savings were estimated at $1.1 million in Nigeria and $224,000 in Senegal. Both Nigeria and Senegal were projected to see annual reductions of 944 and 875 PPH cases per 100,000 birthing women, respectively.

Modelling the economic impact of poor-quality uterotonics showed that improving the quality of uterotonics could result in significant annual savings at the population level, amounting to $89 million in

Nigeria, $18.8 million in Ghana, and $1.3 million in Senegal. Additionally, these improvements could also lead to a reduction in 100,000 PPH cases annually. The Ghana model has been published and subsequent publications will follow for Nigeria, Senegal, and a comparative analysis.

We advocate, based on the findings, for policy-focused interventions to address the issue of poor-quality uterotonics, which include (but not limited to) procurement and supply chain management, promoting adherence to clinical guidelines and good medicine storage awareness. The results generated will contribute toward evidence to improve uterotonic quality to advance universal health coverage.
The economic impact of poor-quality uterotonics has not been well quantified to date despite growing evidence of uterotonics in LMICs being substandard and/falsified. Poor understanding of the threat of substandard uterotonics risks underinvestment in counter measures to protect patients from acquiring and utilizing poor-quality uterotonics.

Improving the quality of uterotonics has the potential to bring about significant cost savings and maternal health outcome improvements across African countries with a high burden of PPH. The strategies and policies to achieve these economic and health improvements need to be tailored to the specific contexts and needs of each country.

Resource optimization and Priority Setting for Public Health Emergency Preparedness and Response in Africa (organized session)

Elias Asfaw Zegeye *Africa CDC, Division of Health Economics and Financing*

Description

The recent COVID-19 pandemic, the ongoing Ebola and other epidemics in Africa have highlighted challenges that countries on the continent face with optimal resource allocation for effective emergency preparedness and response (EPR). The public health emergency preparedness and response deals with the capability of the public health and health-care systems, communities, and individuals, to protect against, quickly respond to, and recover from health emergencies, particularly those whose scale, timing, or unpredictability threaten to overwhelm routine capabilities.

The Africa Centres for Disease Control and Prevention (Africa CDC) developed a wide range of initiatives supporting Member States to develop and implement comprehensive, regularly tested preparedness and response plans. These strategies include support the development of multi-hazard and multi-sectoral preparedness and response plans for public health emergencies at national, regional and continental levels. However, despite the use of tools to assess and priorities public health risk and vulnerability, non-systematic processes dominate the response to health emergencies in low- and middle-income countries (LMIC), including in Africa when allocating limited resources to identified interventions. Even where prioritisation processes are structured, these typically do not provide explicitly for a consideration of economics and value for money criteria which lead to resource optimization.

With this rationale, and to inform the development of a systematic and evidence-based process for priority setting and resource optimization, the Africa CDC Division of Health Economics and Financing has developed a continental framework for evidence-informed priority setting and resource optimisaiton for public health emergency preparedness and response in Africa. A series of evidence generation, guidance development and case studies were generated to inform the resource optimization in the context of public health emergency preparedness and response in Africa.

This includes:

- A case study on identifying and prioritizing emergency preparedness and response (EPR) interventions across the five countries in Africa.

- A case study on resource mobilization and allocation to emergency preparedness and response interventions across the five countries in Africa
- Guidance for member states on the resource optimization and priority setting for public health emergency preparedness and response.
- A cost-effectiveness analysis of Molnupiravir and Paxlovid in three African countries.

A case study on identifying and prioritizing emergency preparedness and response (EPR) interventions across the five countries in Africa.

Elias Asfaw Zegeye[1], Osondu Ogbuoji[2]

(1) Division of Health Economics and Financing, Addis Ababa, Ethiopia
(2) The Centre for Policy Impact in Global Health, Durham, NC

Research findings suggest that employing structured methods and processes for identifying and prioritizing interventions to implement in the context of EPR leads to more effective, fair, and equitable allocation of resources, resulting in improved health outcomes. Moreover, such approaches could encourage decision-makers to allocate more resources to EPR initiatives and enhance public trust in the decision process Furthermore, incorporating economics criteria in to these processes allows for optimization of limited resources.

African Union Member states have used established tools such as Vulnerability Risk Assessment Mapping (VRAM) and WHO Strategic Tool for Assessing Risks (STAR) to prioritize pathogens of epidemic potential. They have also used established tools such as the International Health Regulations (IHR) Monitoring and Evaluation Framework and World Health Organization (WHO) COVID-19 Strategic preparedness and response plan to identify potential interventions for investment. These tools suggest that countries should consider the need for investment in the areas of emergency preparedness, routine health service delivery, recovery and evaluation, and overall health system strengthening, in addition to reducing further transmission and treating those directly affected by a particular disease. The guidance issued by the WHO for developing and implementing a National Action Plan for Health Security (NAPHS) provides guidance on prioritizing identified activities, both during planning and during implementation. However, there is limited use of formalized, systematic, evidence-based processes for prioritizing between EPR interventions, particularly those which consider criteria such as cost effectiveness, value for money or other economic criteria.

We provide an overview of the approaches employed by some member states to identify and prioritize

EPR interventions. This evidence was generated through desk-based document review, key informant interviews with key stakeholders involved in EPR planning, and country visits in Uganda, Malawi, Nigeria, Burkina Faso and Morocco.

We are planning to have Prof Osondu Ogbuoji from Duke University to be a discussant as well as co-author on the guidance for Member states on resource optimisation and priority setting of emergency preparedness and response

A case study on resource mobilization and allocation to emergency preparedness and response interventions across the five countries in Africa

Dr Josephine Gatua *Africa CDC, Division of Health Economics and Financing, Addis ababa, Ethiopia*

Once countries establish priority interventions for Emergency Preparedness and Response (EPR) (through structured priority-setting or other methods), allocation of resources to these priority interventions and their successful implementation leads to the realization of desired outcomes and impacts. In instances where economic criteria, such as cost-effectiveness, are incorporated for prioritization, the process can contribute to resource optimization.

Variations in the availability of financial resources across settings and emergencies are common and many countries have limited funds to allocate even to prioritized interventions. Presented below are illustrative examples of processes employed by various African Union member states to mobilize financial resources for EPR and allocate them to EPR interventions. These insights stem from desk-based document review and interviews conducted with pertinent stakeholders engaged in EPR planning, including during country visits.

We conduct an overview of the approaches employed by some member states on resource mobilization and allocation of resources to emergency preparedness and response. This evidence was generated through desk-based document review, key informant interviews with key stakeholders involved in EPR planning, and country visits in Uganda, Malawi, Nigeria, Burkina Faso and Morocco.

A guidance for the Member States on Priority Setting and Resource Optimisation of Emergency Preparedness and Response

Richmond Owusu *Department of Health Policy, Planning and Management, School of Public Health, University of Ghana, Legon, Ghana*

The development of systematic processes for priority-setting has been recommended as a strategy to promote the effectiveness and fairness of resource allocation decisions in crisis situations. This is increasingly urgent as health emergencies are becoming more frequent, severe, and unpredictable. Importantly, such processes must be relevant to the African continent and individual African country context. As no suitable guidance on this currently exists, there is a need to develop guidance to support countries with developing and implementing systematic processes for resource optimisation and allocation to interventions in the context of Emergency Preparedness and Response (EPR).

The primary goal of Africa Union (AU) Member States in relation to public health emergencies is to minimize the health, social and economic impact of public health threats. This includes maximising health by preventing or limiting the spread of disease and reducing morbidity and mortality, minimizing social and economic disruptions, as well as promoting early socio-economic recovery and returning to normal.

To maximise population health, decision-makers must allocate resources optimally across the large set of health technologies, healthcare programs, and patient groups, targeted to the right people, in the right locations, at the right time, and in the right ways to achieve the greatest population health gains while also addressing equity. However, the resources at their disposal – finances, staff time, equipment, and facilities – are limited, and all have alternative uses inside and outside the health sector.

The Africa CDC Division of Health Economics and Financing (HEF), has compiled this guidance to support countries, particularly National Public Health Institutes (NPHIs) or equivalent organisations, to strengthen evidence-based resource optimization practices amongst individual AU member states.

A cost-effectiveness analysis of two COVID-19 oral antivirals (COAVs) Paxlovid and Molnupiravir in three African countries

Ijeoma Edoka

University of Witwatersrand, Johannesburg, South Africa

Objective

To assess the cost-effectiveness of two COVID-19 oral antivirals (COAVs) Paxlovid and Molnupiravir compared to the standard of care, in Ghana, Rwanda and Zambia.

Methods

We modelled costs (2022 US$) and health outcomes in the acute phase of the COVID-19 disease from a public payer's perspective in three unvaccinated target populations – (1) patients aged 65 years and above (elderly); (2) adult patients with at least one other underlying risk factors for disease severity; and (3) all adult patients. In addition, we conducted a series of sensitivity and scenario analyses.

Results

In elderly patients, Paxlovid was less costly and more effective (i.e., dominated) than standard of care in all three study countries. Molnupiravir dominated standard of care in Rwanda and Zambia and an incremental cost-effectiveness ratio (ICER) was estimated at US$1023.58 per disability-adjusted life year (DALY) averted in Ghana. In adults with other underlying risk factors, Paxlovid dominated in Rwanda and Zambia while Molnupiravir dominated in Rwanda. Neither Paxlovid nor Molnupriavir were cost-effective in the all-adult group in any country context. Incremental net monetary benefit for Paxlovid was consistently higher than for Molnupiravir. In COVID-19 vaccinated patients, Paxlovid was cost-effective for elderly patients in Zambia and Rwanda but not in Ghana. Key determinants of cost-effectiveness were COAV price, likelihood of early treatment initiation, and hospitalization rates.

Conclusion

In African settings similar to Zambia, Ghana or Rwanda, COAVs could be cost-effective in populations who are unvaccinated, and at high risk of progression to severe COVID-19. More evidence is needed to determine cost-effectiveness for patients that are unvaccinated but have previously been infected with COVID-19 and may have developed some immune protection.

Public financial management: help or hindrance to health facility financial autonomy (organized session)

Tom Hart *ODI*

Description

There is growing consensus that health facility financial autonomy, particularly allowing facilities to receive funds directly, is important for progressing towards universal health coverage. It can enhance efficiency in the flow of funds, strengthen transparency and accountability, improve responsiveness to local needs, and result in better and more equitable health outcomes (Kuwawenaruwa et al. 2018; WHO 2022; Barroy et al. 2019). Yet primary healthcare facilities can retain and manage funds in less than 40 percent of low- and middle-income countries (Hanson et al. 2022).

The public financial management (PFM) system is often viewed as a bottleneck to increasing facility financial autonomy, yet it can be an important enabler of autonomy, supporting greater operational efficiency and accountability.

This session, organized by ODI, ThinkWell and the Collaborative Africa Budget Reform Initiative (CABRI), will bring together research into the status of health facility autonomy across six low- and middle-income countries and explore how PFM systems have interacted, helped or hindered greater autonomy.

The first paper, by ThinkWell and ODI, synthesises research undertaken in Burkina Faso, Indonesia, Kenya, Pakistan, Philippines and Uganda. This documents the arrangement for financing health facilities, and how this interacts with each country's purchasing arrangements, including how resources flow to health facilities, how facilities are captured in PFM systems, and their expenditure management and reporting practices.

The second paper, by Ministry of Health Uganda, ODI and ThinkWell, takes a deeper dive into how PFM systems in Uganda direct resources to local governments and health facilities. Despite providing primary healthcare facilities with grants since 2003, Uganda's experience with facility financing has not been well documented. The paper examines how facilities utilise and manage these funds. It considers the obstacles to greater financial autonomy posed by the PFM system and how reforms in digital PFM could potentially resolve these issues.

The third paper, by CABRI, provides an overview of how PFM systems and rules interact with facility financial autonomy. It also documents how approximately 15 African countries have or intend to increase health facility autonomy and the PFM bottlenecks to this agenda.

Agenda (90 minutes)

Overview (5 minutes)

Synthesis report: Health facility financing in Burkina Faso, Uganda, Philippines, Pakistan, Kenya and Indonesia **(25 minutes)**

Exploring the role of Public Financial Management Arrangements and Financial Autonomy for Direct Facility Funding: A Case Study from Uganda **(25 minutes)**

PFM as Enabler of Health Facility Autonomy in Africa (20 minutes)

Q&A (20 minutes).

Exploring the role of Public Financial Management Arrangements and Financial Autonomy for Direct Facility Funding: A Case Study from Uganda

Antoine Lacroix *ODI, Kampala, Uganda*

Public PHC providers in Uganda have extensive experience with autonomy, with a portion of the PHC grant being disbursed directly to facilities since the mid-2000s, shortly after the abolition of user fees. Despite this experience and the leading roles taken by the Ministry of Health and the Ministry of Finance, Planning, and Economic Development in the reforms, the implementation of Direct Facility Financing in Uganda has received little attention.

This case study documents the PFM arrangements established by the Government of Uganda for implementing direct facility financing and assesses how they support or hinder financial and operational autonomy of PHC facilities. It first outlines the structure of the health system, purchasing arrangements, and the role of local governments in providing PHC services. The study then examines how allocations to public PHC providers are determined and transferred, focusing on the adequacy, reliability, and timing of the payments. In addition, through interviews with facility managers across all types of PHC providers, the study reviews how PFM functions are executed at the facility level.

Leveraging the findings, the study explores how PFM processes could be adjusted to extend provider spending autonomy beyond basic operational costs. It also assesses how stronger data processes and digital solutions could be leveraged to improve provider payments and monitor the allocation and usage of resources by facilities across the country.

Health facility financing in Burkina Faso, Uganda, Philippines, Pakistan, Kenya and Indonesia

Pura Angela Wee Co *Thinkwell, Manila, Philippines*

Purchasing arrangements supporting public health facilities in many LMICs are complex, involving a range of often fragmented financial flows. These facilities often generate revenue from user fees and health insurance reimbursements, while receiving public funds from different revenue sources. The ability of public healthcare providers to receive, spend, and account for these funds varies not only across countries but also within countries by the level of care and subnational unit, as well as by revenue sources. In some countries, such as Kenya and the Philippines, subnational governments have the legal authority to decide how health facilities manage their revenues. In others, like Uganda and Burkina Faso, purchasing is centrally determined, and funds flow through subnational units to facility accounts, with local authorities only responsible for monitoring the use of these funds.

This paper documents the PFM arrangements supporting the implementation of direct facility financing and financial and operational autonomy in six LMICs: Burkina Faso, Indonesia, Kenya, the Philippines, Pakistan, and Uganda. It describes each country's purchasing arrangements and the flow of resources to healthcare providers, and include a detailed analysis of the regulations and processes governing budget preparation, execution, and reporting at facility level. Additionally, it details how facility payments, budgets,

and expenditures are recorded, consolidated, and used for monitoring and planning. The paper also explores how digital PFM can support the implementation of direct facility transfers and address the bottlenecks observed.

PFM as Enabler of Health Facility Autonomy in Africa

Ms. Danielle Serebro

Masters in Development Economics, Collaborative Africa Budget Reform Initiative, Johannesburg, South Africa

Increasing health facility autonomy is dependent on existing PFM rules and systems and the finance ministry's willingness to adjust these where they prove to be a bottleneck. This is well established; however, health stakeholders often lack understanding of the precise ways in which the PFM system may hinder (or help) the success of this reform.

This report aims to dispel some of this mystery and explain what features of the PFM architecture are immovable obstacles to the reform design envisaged by the health ministry, and what can be relaxed with sufficient consultation and justification. It will draw on a conference paper prepared ahead of a CABRI policy dialogue on PFM as enabler of health facility autonomy and contributions from 15 African ministries of health and finance.

Leveraging information from the countries at the policy dialogue and expert inputs, it will consider how facilities are incorporated into budget formulation processes and PFM systems; the PFM implications for how funds flow to facilities through different levels of government; how PFM systems can support output-based provider payment mechanisms; expenditure management processes; reporting and accountability practices; and the use of digital financial management systems.

Community Health Systems and Stakeholder Engagement for UHC and Accountability in Africa

The Use of Community Health Workers (CHWs) in Responding to COVID-19 In the Crisis-Affected Northwest Region of Cameroon May to August 2021

Kongnyu Emmanuel, Ful Morine, Tih Pius and Warri Denis

Cameroon Baptist Convention Health Services, Bamenda, Northwest Region, Cameroon

Background

Cameroon recorded her first case of COVID-19 on March 5, 2020, imported from France and the second was one of his close contacts in Cameroon. The number of cases increased rapidly imported from European countries before community transmission of the disease was confirmed in late April 2020 with Cameroon ranking fifth in sub-Saharan Africa and the first in central Africa in terms of confirmed cases (Arsene et al., 2023).

The Restive Northwest region had a case fatality rate of 10% exceeding the national figure of 2% and the response was challenging in the region due to the ongoing socio-political crisis that has a lot of anti-government sentiments coupled with denial of the existence of COVID-19 by None State Armed Groups (NSAGs). The NSAGs restricted the respect of COVID-19 prevention measures that were put in place by the government including vaccination. As a result, the CBCHS a FBO that had existed in the country since 1936 and is trusted by the population together with UNICEF had to step in to intervene using community-based CHWs.

Objectives

- Conduct community mass sensitization and awareness in 4 of the 5 divisions of the Northwest region with life-saving messages on COVID-19 prevention.
- Distribute critical WASH supplies, hygiene items, and locally made face masks to families to enhance hand washing and mask-wearing.

- Promote hand hygiene practices through the installation of foot-operated hand sanitizer dispensers in public places.

Methodology

Access negotiation was sought to ease the movements of CHWs in the various communities for awareness raising, enumeration, and the distribution of critical WASH supplies such as buckets with taps and soap to promote household hand washing and masks wearing as transmission-based precautions (for contact, droplet and airborne). Foot-operated sanitizer dispensers were installed at public places such as road junctions, motor parks, markets, public offices, and other popular areas. The CHWs in various communities embarked on mass and door-to-door education of households with life-saving messages about COVID-19 prevention.

Results

Within four months, we reached households with critical WASH/hygiene items, and lifesaving messages on COVID-19 prevention and installed foot-operated Hand Sanitizer Dispensers that were easily accessible by thousands.

Conclusion

Access negation, door-to-door approach, the installation of a foot-operated hand dispenser, and household use of buckets with taps for hand washing are essential in reducing the spread of contact, airborne, and droplet-related infectious diseases in resource-constrained areas.

Advancing Health Financing and Accountability: AHBN's Role in Civil Society Participation for Strengthening Nigeria's RMNCAEH+N

Maimuna Abdullahi, Aminu Magashi Garba, Amina Haladu, Khadija Bobboyi and Sadiq Malami

Africa Health Budget Network, Abuja, FCT, Nigeria

Background

Nigeria's RMNCAEH+N Strategy (Reproductive, Maternal, Newborn, Child, Adolescent, and Elderly Health

Health Plus Nutrition) is essential for improving health outcomes, particularly in addressing high maternal mortality rates and ensuring equitable access to quality healthcare services. However, the strategy faces challenges including insufficient engagement from civil society groups - such as NGOs, youth, and media - and weak accountability mechanisms. The Africa Health Budget Network (AHBN), funded by the GFF through PAI, aimed to address these issues by enhancing civil society participation and strengthening accountability frameworks. By fostering broader involvement in the strategy's development and implementation, AHBN sought to create a more inclusive and accountable approach to health financing, with the goal of improving health outcomes across Nigeria.

Aims and Objectives

The project aimed to support the Nigerian Government in finalizing, disseminating, and implementing the RMNCAEH+N Strategy. The key objectives were: (1) to enhance stakeholder participation by NGOs, youth, and media, (2) to develop RMNCAEH+N tracking scorecards for improved financial and non-financial accountability, and (3) to create an enabling environment for active engagement of civil society groups in the strategy's implementation.

Methods

A participatory approach was used to develop the RMNCAEH+N Budget and Accountability Scorecard. The process began with mapping Civil Society stakeholders to identify key participants. A workshop was organized where stakeholders collaboratively developed and validated indicators for the scorecard, focusing on health financing and accountability within the draft RMNCAEH+N Strategy. These indicators were subsequently refined by the AHBN team. A national health budget analysis for 2023-2024 reviewed allocations and progress on key areas such as family planning, immunization, and nutrition, which informed the scorecard. The finalized scorecard was designed for clarity and usability by a graphic designer. Dissemination involved a press conference and targeted advocacy with policymakers, duty bearers, political actors, and legislators.

Key Findings

The scorecard indicates a significant increase in health budget allocations for family planning, immunization procurement, and the Basic Health Care Provision Fund (BHCPF), as well as for nutrition commodities, compared to 2023. However, there is a notable reduction in funding for adolescent and youth-friendly health services in 2024. The scorecard also reveals a lack of detailed budget and expenditure reports, including audited accounts related to RMNCAEH, on the Federal Ministry of Health's website. Additionally, there has been no dissemination of the RMNCAEH+N annual progress report to the public or policymakers. Furthermore, the RMNCAEH strategy has not yet been officially endorsed, launched, or disseminated by the Honourable Minister of Health. Despite these gaps, progress is evident in increased civil society engagement, with more CSOs and youth representatives participating in bi-annual RMNCAEH+N platform meetings and organizing debrief sessions for their constituencies.

Conclusion

The increased and active engagement of civil society has significantly strengthened accountability and transparency, thereby contributing to holding the government more accountable for its health commitments.

Stakeholders' perception of the nature of the relationship between information technology adoption and customer responsiveness: A Study on Health Commodity Supply Chain Management and Performance in Southeast Nigeria

Adaora Uzochukwu[1], Emmanuel Agbaeze[2], and Benjamin Chudi Uzochukwu[3]

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Background

Efficient Health commodity supply chain management can improve healthcare delivery, particularly in regions with limited resources. Information technology (IT) plays a crucial role in optimizing supply chain processes, from procurement to distribution, thereby enhancing customer responsiveness. Understanding the relationship between IT adoption and customer responsiveness is vital for improving healthcare outcomes. By examining this relationship, policymakers and healthcare providers can identify best practices and strategies to enhance supply chain performance, ultimately benefiting patients and communities.

Objectives of The Study

The study aims to examine stakeholders' perception on the impact of IT adoption on health commodity supply chain management in Southeast Nigeria, and its influence on customer responsiveness, identify challenges and opportunities.

Methodology

The study involved 155 Primary Health Care (PHC) workers and Local Government Area (LGA) health authorities in five Southeast Nigerian states, focusing on health commodity supply chain activities. Data was collected on IT adoption and customer responsiveness through a structured questionnaire in 2023, employing a five-point Likert scale to ranking responses. The respondents included officers in-charge of

the health centres, LGA logistic supply chain managers (PHC Coordinators, Immunization Officers, Cold Chain Officers, Store Officers, and LGA Treasurers) all of whom have a direct involvement in health commodity supply chain activities.

Findings

The respondents believe that direct computer-to-computer links with key supply chain partners enable timely meeting of customers' requirements (mean response score of 3.10 ± 1.20), electronic customer information (mean response score of 3.13 ± 1.14), and timely response to customer needs (mean response score of 3.80 ± 1.03). They also believe that mobile computers help respond to customer needs (mean response score of 3.69 ± 1.13). The introduction of internet-based infrastructure improves communication with suppliers, facilitates information flow within departments, and enhances information sharing quality (mean response score of 3.35 ± 1.09). The respondents also believe that their IT system can be seamlessly connected with supply chain partners (mean response score of 3.32 ± 1.03). Healthcare facilities in Southeast Nigeria, on the other hand, face financial constraints and resistance to change in IT. Strategies to overcome these include financial support, capacity building, infrastructure development, stakeholder engagement, clear policies, and leveraging mobile technology to improve access to healthcare services.

Conclusion

IT adoption positively impacts customer responsiveness by improving supply chain visibility, and enhancing communication. By leveraging IT, healthcare providers in Southeast Nigeria can improve supply chain performance and better meet the needs of their patients.

Community engagement for UHC in Africa: A realist synthesis approach

Evaline Langat *Aga Khan University, Nairobi, Kenya*

Background

Nations, people, and communities are unable to participate in and profit from national and global development unless they have access to adequate health. Universal health coverage is the world's number one health agenda under the Sustainable Development Goals, and its concept is strongly based on health as a fundamental right. In Africa, 50 of 54 governments have implemented interventions targeted at reaching UHC. Fifty-three percent of these interventions focused on establishing social or national health insurance, 17% on establishing community-based health insurance (CBHI), and 30% on improving primary health-care delivery. With fewer than ten years into the sustainable development target, less than half of these countries have achieved significant progress towards attainment of 100% UHC coverage.

Aim

Evidence demonstrates that for a country's UHC model to achieve the intended results, dozens of variables from a wide variety of domains must be included. Few studies exist that properly dissect the elements that contribute to the success or failure of the UHC method. Our study sought to give contextual evidence as to which UHC approaches succeed in Africa and why.

Methods

We employed a realist synthesis method, which allows us to look at a large body of literature and uncover patterns in the data to explain what works, for whom, and under what circumstances. We did literature searches on the Cochrane database of systematic reviews, PUBMED, EBSCO, Eldis, SCOPUS, CINHAL, TRIP, and Google Scholar. A total of 9633 citations published between 2005 and 2024 were assessed for eligibility using predetermined inclusion criteria, with an emphasis on UHC adoption, rollout, implementation, challenges, and opportunity in African countries. Primary qualitative, quantitative and mixed-methods evidence was included, as well as original analysis of secondary data.

Findings

A total of 167 papers describing UHC implementation in 18 African countries met the inclusion criteria. Countries who used the primary health care strengthening approach and CBHI were found to be making consistent progress toward UHC. This was due to the fact that these strategies were designed to work within the context of community engagement, which naturally strengthened the community's trust and ownership of the intervention, allowing them to participate fully. They also fostered feelings of mutual association and shared approach, as well as giving the community a voice, increasing the possibility of adopting the UHC intervention.

Conclusion

If Africa is to achieve UHC by 2030 and sustain the gains beyond the SDGs, it is critical to examine the UHC programs and determine where the community engagement character is.

Strengthening the effectiveness of community health system: assessing the factors that enhance or constrain the delivery of health services within communities in Nigeria

Okechukwu Ozor1, Enyi Etiaba1 and Obinna Emmanuel Onwujekwe2

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(2) Health Policy Research Group, University of Nigeria, Enugu, Enugu, Nigeria

Background

Primary Health Care is at the heart of Community health service delivery (CHSD). Sub-optimal (CHSD) has been a challenge constraining the community health system (CHS) globally, especially in developing countries like Nigeria thereby impeding the achievement of Universal Health Coverage (UCH) for the country.

Aims and Objectives

This paper aims to strengthen Primary Health Care service delivery by examining the key factors that either enhance or constrain CHSD in Nigeria at the individual, community/facility and governmental levels while recommending evidence-based solutions for sustaining and improving CHSD within the framework of CHS to achieve UCH for the country.

Methods

Data was collected through a qualitative study undertaken in three States (Anambra, Akwa-Ibom, and Kano) in Nigeria. Respondents
were formal/informal health providers; community leaders and representatives of civil society organizations all purposively sampled. There were 90 in-depth interviews and 12 focus group discussions, which were audio-recorded, transcribed verbatim, and analysed thematically using codes to identify key themes.

Key Findings

Factors constraining CHSD at the individual level were poor health-seeking behaviour, preference for quacks, and male dominance of service delivery. At the community/facility level: superstitious/cultural beliefs and poor attitude of facility workers; at the governmental level were: inadequate financial support, embezzlement of funds, and inadequate social amenities. Conversely, the enabling factors at the individual level were community members' participation and, the compassionate attitude of informal providers. At the community and facility levels, the factors that enhanced CHSD were synergy between formal and informal providers; and support from community-based organizations and structures. At the governmental level, the enhancing factors were the government's support to community-based formal/informal providers and a clear line of communication.

Conclusions

Community health service delivery through a functional community health system can improve overall health systems strengthening and lead to improved community health and ultimately the achievement of

UHC. Policymakers should integrate Community health service delivery in all program implementation and ultimately work with the community health system as a veritable platform for effective community health service delivery.

Equity, Social Determinants, and Health Inequalities in Africa

10:00 AM–11:30 AM Friday, 03 March 2025

Socioeconomic-related Health Inequality in Tanzania: Evidence from the National Household Budget Survey

Francis Donard Ngadaya[1], Peter Binyaruka[1]

Ifakara Health Institute, Dar es salaam, Dar es salaam, Tanzania, United Republic of

Background

Limited knowledge exists regarding the socioeconomic-related health inequalities in Tanzania, particularly on the distribution of illness, disability and multi-morbidity across different socioeconomic groups. Socioeconomic-related health inequalities significantly affect healthcare and health outcomes. Understanding the burden and distribution of illness and disability across different socioeconomic groups is crucial for developing effective health policies to improve health equity.

Objectives

This study examines the socioeconomic-related health inequalities in Tanzania using evidence from the National Household Budget Survey.

Methods

The study used secondary data drawn from the 2017/18 Tanzania National Household Budget Survey (NHBS). The household living standard was measured using household consumption expenditure, which was classified into quintiles. The standardised concentration indices were used to measure the distribution of self-reported illness and disability. Furthermore, we also assessed the distribution of multi-morbidity in illness and disability if an individual has more than one illness (+) and disability (+) across different socioeconomic quintiles.

Results

Out of 45,912 individuals, 18.10% reported being sick or ill from at least one condition in the last two weeks before the survey, with Malaria being the most prevalent illness (7.72%). The prevalence of disabilities is 3.52%, with walking ad remembering being the most prevalent types. Furthermore, the analysis revealed varying degrees of multi-morbidity in illness, with diabetes+ (CI: 0.391), hypertension+ (CI: 0.281) and Urinary Tract Infections+ (CI: 0.416) being concentrated among the wealthiest. Consequently, tuberculosis+ (CI: -0.145), pneumonia+ (CI: -0.107) and diarrhoea+ (CI: -0.024) were more prevalent among the poorest. For the multi-morbidity in disability, hearing+ (CI: -0.090), communicating+ (CI: -0.045), remembering+ (CI: -0.069), and walking+ (CI: -0.049) were more prevalent among the poorest.

Conclusion

The burden of illness and disabilities are unevenly distribution in Tanzania, with the poorest bearing a disproportionate higher burden of multi-morbidity in illness and disability. This calls for the need to design targeted health interventions and policies aimed at reducing inequalities in health which is crucial for achieving equitable health outcomes and improve overall population health.

Study on the Physical and Socio-Economic Environmental Determinants of Health

Thiane Gueye *Dakar, Senegal*

Background

Senegal developed a National Health Financing Strategy in 2017 to move towards Universal Health Coverage (SNFS/CSU), where Strategic Orientation (OS) No. 4 "strengthening high-impact multisectoral health interventions" contains a key measure:

Despite the policies and programs implemented, climate-sensitive, emerging, and re-emerging diseases are experiencing a resurgence, driven by environmental determinants.

Method

The adopted methodology is based on a qualitative survey combined with a literature review to meet our objectives.

The sampling is reasoned and the selection of targets is made based on preliminary knowledge of data availability at various sources.

For health and ecological data, the DHIS2 databases from the MSAS and those from the EMC (Ecological Monitoring Centre) were utilized.

Findings

The analysis of the parameters monitored from 2017 to 2021 shows that environmental factors are the cause of 21% of diseases worldwide.
The evolution of malaria and average annual rainfall shows higher cases of malaria in the rainiest regions of Senegal (Kédougou, Tambacounda, Kolda, and Ziguinchor) with average rainfall around 1000mm.
The distribution of diarrhea problems related to water access shows differences between regions. Saint-Louis and Kolda are among the most affected with more than 10,000 cases (respectively 1,512 and 1,153). Followed by regions where access to a source of drinking water is difficult, ranging from 12.7% to 70.8%, such as Kolda (70.8%), Tambacounda (33.3%), and Saint-Louis (12.6%).

The programs surveyed, the most mentioned are: the PNLP, the PNT, the PEV, ... The majority of the authorities, 70% of those surveyed, assert that there is a framework for consultation.
Providers (64%) believe that morbidity and mortality related to climate-sensitive, emerging, and re-emerging diseases are high.
The majority of the population (67%) has a good understanding of the diseases studied and their determinants. Indeed, they were able to at least mention an example of environmental factors that promote these diseases.

Conclusion

It is a basis of evidence that can help structure the multisectoral management of health issues and facilitate their reconcentration and decentralization.

Keywords

determinants, environment, health programs

Does household size matter in catastrophic health payments for hypertension management and care in Ghana?

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(3) University of Bergen
(4) University of Bergen/University of Oslo

Background

In the era of Non-Communicable Diseases (NCDs) prevalence, catastrophic health expenditure (CHE) relating to managing hypertension has become a national concern in Ghana. Existing evidence suggests inadequate studies on CHE pertaining to hypertension in Ghana.

Aims

This paper aims to evaluate the economic impact of hypertension on individuals and households by measuring catastrophic health expenditures (CHE) related to hypertension care in Ghana.

Methods

We conducted a prospective cross-sectional catastrophic health expenditure survey on the expenditures of managing hypertension among adults' patients at Weija Gbewa Municipal Hospital (WGMH) and Shai Osoduko District Hospital (SODH) in Ghana. The study took a patient perspective, collecting direct and non-direct medical expenditure relating to hypertension care from 382 patients. We estimated the incidence, socioeconomic, and demographic correlates associated with the cost of managing hypertension in Ghana. CHE was defined at thresholds of 10% and 40% of the household's capacity to pay for direct medical and non-direct medical expenditure in the analytical approach.

Findings

Our findings show that direct medical expenditure amounts to 25US$ and direct non-medical expenditure amounts to 4US$ per patient per month. CHE was estimated using household income of 10% and 40% capacity to pay, which reveals that 65% and 58% of the total sample experience catastrophic and impoverished health expenditures. Results from our regression models reveal household size is a significant correlate of catastrophic healthcare payments related to hypertension management and care.

Conclusions

Financial protection for individuals with hypertension in primary health care facilities in Ghana remains limited despite the operations of the National Health Insurance Scheme. The findings suggest a renewed action towards a sustainable health financing mechanism to target individuals with hypertension in Ghana.

Incorporating equity and financial protection criteria into essential benefits package design: a case study of infectious diseases interventions in Ethiopia

Lelisa Fekadu Assebe[1], Boshen Jiao[2], Nathaniel Hendrix[2], Mieraf Taddesse Tolla[3] and Stéphane Verguet[4]

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(2) HU,
(3) ACDC,
(4) Harvard T.H. Chan School of Public Health

Background

Inequalities in health and non-health benefits of public health interventions are key challenges on the path towards universal health coverage, particularly in low- and middle-income countries (LMICs). The design of health benefit package (HBP) creates an opportunity in selecting interventions through established criteria. The aim of this study is to examine the health equity and financial protection impact of selected interventions, along with their costs, at the national level in Ethiopia.

Methods

Data on average health benefits, and program costs were extracted from the latest Ethiopian Essential Health Service Package (EHSP) database. Similarly, population estimates, and disease prevalence were derived from the Global Burden of Diseases (GBD) and, national survey, and published sources. Benefits were distributed across income quintiles using a combined adjusted risk of disease prevalence and coverage, with the latter also used to estimate the programmatic costs. For each of the 30 interventions, we estimated the benefits to health equity and financial protection that would result from an incremental increase in coverage of 10 percentage points for one year.

Results

A total of 390,000 Health Adjusted Life Years (HALYs) would be gained and 64,240 cases of catastrophic health expenditure (CHE) averted by implementing the chosen intervention at 10 percentage point increase in coverage. Overall, the EHSP interventions provide 22% (86,760 HALYs) of the health benefits to the poorest and 20% (77,270 HALYs) to the richest quintile. Similarly, a total of 33% (21,500) cases of CHE were averted in the poorest quintile and 14% (8,740) in the richest quintile.

Conclusion

Despite current coverage gaps, access to certain EHSP interventions had the potential to improve overall health, equity, and financial protection benefits. The potential impact of the selected interventions differs in their impact on population health, health inequality, and financial protections benefit. Examining the trade-offs and weighing each outcome is necessary for prioritization of interventions in the health benefit package.

Keywords

Essential health benefits package; universal health coverage; health disparities; financial risk protection; priority setting; infectious diseases; Ethiopia; sub-Saharan Africa.

The impact of social factors on health outcomes in Africa countries: Evidence from Dynamic panel technique

John K. Njenga *UoN, Nairobi, Kenya*

The aim of this study is to investigate the effect of social factors on health outcomes in Africa countries accounting for Covid-19 pandemic. The study analyses the effects using panel dynamic frame work, utilizing the first general methods of moments (GMM) estimator to estimate the model parameters. The independent variables are income with GDP per capita as proxy variable, urbanization, aging population, labour force and dependency ration. Life expectancy, current health expenditure per capita and less than five years mortality rate are considered as the dependent variables. A total of 44 African countries are considered for analysis using annual data from year 2000 to 2021. An increase in GDP per capita results to a significant increase in current health expenditure per capita. Labor force, urbanization, Covid-19, dependency ratio and population have no significant effect on current health expenditure across Africa countries.

Life expectancy is significantly increased by increase in income, while significant reduced by the occurrence of Covid-19 pandemic. Labor force, aging population, urbanization and dependency ratio have no significant effect on life expectancy. Covid-19 occurrence, increase in GDP per capita, urbanization and labour force result to significant reduction in under five years mortality rate in Africa countries. Africa countries with high GDP per capita experience low under five years mortality, high rate of life expectancy and high current health expenditure per capita. The incident of Covid-19 cases across Africa countries as from year 2020 resulted to decrease in less than five years mortality rate and life expectancy. Urbanization and labour force have a significant effect on under five each mortality rate in most African countries. African government policy makes need to put in measures of enhancing economic development as they will highly impact on health outcomes of the country.

Wealthy households access WASH services: socioeconomic inequities in households' expenditures on water, sanitation and hygiene in urban slums in southeast Nigeria

Uchenna Rita Ezenwaka1, Chinyere Cecelia Okeke2 and Obinna Emmanuel Onwujekwe1

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(2) University of Nigeria, HPRG, Enugu, Enugu, Nigeria

Background

Access to safe water, sanitation, and hygiene (WASH) is essential for human health and well-being, yet many households lack access to these basic services. Household expenditure on WASH is a critical indicator of access, as it reflects the financial burden of securing these essential services. However, limited research has examined household expenditure on WASH at the micro-level, particularly in urban poor settings. Understanding household expenditure on WASH is crucial for developing effective policies and interventions to improve access to these services. This study aims to address the knowledge gap by conducting a micro-level analysis of household expenditure on WASH in slums, in Anambra state, Nigeria.

Methods

A survey of households (n = 421) WASH expenditure was conducted in February in two randomly selected slums in Anambra state, Nigeria. Household expenditures on WASH were collected using a pretested questionnaire. Socioeconomic status (SES) was estimated using household assets ownership. Data was analysed using univariate, bivariate and multiple regression analysis. The concentration index (C.I.) was computed to inform the equity analysis.

Results

Our findings show that the average monthly WASH expenditures per household on WASH were 28,918.05 (approximately USD 19.9). Expenditures on hygiene accounted for 42.2% of total WASH spending while water and sanitation expenditures were significantly lower. Expenditure on WASH varied significantly across income groups, with lower-income households (P=0.00) spending a higher on WASH services compared to higher-income households. There was a significant disparity in WASH expenditures across income quintiles. Households in the lowest income quintile spent more/higher (-0.01) on WASH services compared to the highest quintile (0.025).

Conclusion

Our study highlights the inequities in WASH expenditures among urban poor households, with vulnerable groups shouldering a disproportionate financial burden. We recommend targeted interventions on low-income households by developing effective strategies including subsidies, financing options, and community-led initiatives to ensure equitable access to WASH services to ensure equitable access to essential WASH services.

Healthcare Access and equity (Intersectional Approaches to Healthcare Equity: Addressing Access Disparities and Social Determinants of Health)

Oluwayemisi Soyombo *I care family vision centre, Lagos, Nigeria*

This study explores intersectional approaches to healthcare equity in Ilesa, Osun State, Nigeria, focusing on addressing access disparities and social determinants of health. Ilesa, a semi-urban area in southwestern Nigeria, presents a unique context for examining the complex interplay of factors affecting healthcare access and outcomes. The research adopts an intersectional framework to analyse how multiple social identities and structural factors converge to influence health disparities in Ilesa.

By examining the intersections of socioeconomic status, gender, age, and cultural beliefs, this study aims to provide a nuanced understanding of healthcare inequities in the region. Primary data was collected through a mixed-methods approach, including surveys of 500 Ilesa residents, in-depth interviews with 30 healthcare providers, and focus group discussions with community leaders. Secondary data from local health records and government reports complemented the primary data.

Findings reveal significant disparities in healthcare access across different demographic groups in Ilesa. Low-income residents, particularly women and the elderly, face substantial barriers to accessing quality healthcare services. The study identifies key social determinants of health in the Ilesa context, including poverty, limited education, gender inequality, and inadequate water and sanitation infrastructure. The research highlights the critical role of environmental factors in shaping health outcomes in Ilesa. Limited access to clean water and poor sanitation facilities in certain neighbourhoods correlate strongly with higher rates of waterborne diseases.

Additionally, the study finds that traditional beliefs and practices significantly influence healthcare-seeking behaviours, often intersecting with socioeconomic factors to exacerbate health disparities. Analysis of local healthcare policies reveals gaps in addressing the intersectional nature of health inequities. While some initiatives target specific vulnerable groups, they often fail to account for the compounded disadvantages faced by individuals at the intersection of multiple marginalized identities.

This research contributes to the growing body of literature on intersectional approaches to healthcare equity, providing valuable insights from a semi-urban Nigerian context. By illuminating the complex interplay of factors affecting health outcomes in Ilesa, the study offers a foundation for developing more effective, context-specific strategies to reduce health disparities. The findings underscore the importance of adopting holistic, intersectional approaches to healthcare equity that address both immediate access issues and underlying social determinants of health.

This research has implications for health policy and practice not only in Ilesa and Osun State but also in similar settings across Nigeria and sub-Saharan Africa.

Challenges in Health Workforce Sustainability and Well-Being in Africa

10:00 AM–11:30 AM Friday, 03 March 2025

Sierra Leone's unsalaried health workforce: Its public system still heavily reliant on payroll inclusion deferrals despite 2016 commitments to tackle the issue

Pieternella Pieterse *Royal College of Surgeons in Ireland, Dublin, Ireland, Ireland*

Background

In 2016, the Ministry of Health and Sanitation (MoHS) in Sierra Leone published a report titled the Human Resources for Health (HRH) Country Profile, which provided an in-depth analysis by location, cadre, gender, of the healthcare staff employed at public health facilities country-wide. The report noted that 50% of MoHS workers are trained but 'unsalaried volunteers', who await being added to the payroll. This was identified as a problem and the report's suggestions to address this issue were later adopted in the Ministry's 2017-2021 HRH Policy.

Aims and Objectives

To conduct follow-up research to establish whether the interventions described in the HRH Policy were adopted and successful; to estimate what percentage of trained health workers in the public system is currently 'unsalaried'.

Methods

All 16 District Health Authorities (DHA) were approached, in person, by phone and/or email and asked for the breakdown of their public health facility staff by cadre and on/not on payroll. Non-responsive health authorities were contacted six times. Interviews were conducted with 110 health workers, salaried and unsalaried, and key informants (n=15) such as MoHS staff, DHA officials, donor and NGO representatives. Research ethics approval was obtained from the Sierra Leone MoHS.

Findings

Nine out of sixteen DHAs responded and completed our data collection sheet. The share of trained health workers who are working within the public health sector, waiting to be added to the payroll when funding is available, remains high: 40-50% of primary healthcare facility workers remain unsalaried.

Discussion

Since 2016, additional paid positions have been created but not enough to absorb all sufficiently trained unsalaried workers identified in 2016: Total number of health workers on the payroll has increased from 9,000 in 2016 to between 12,000-14,000 in 2024. In addition, new 'unsalaried volunteers' have been recruited annually. This suggests that 2017-2021 HRH policy options have not been successfully implemented. Neither has the practice of 'recruiting of newly graduated health workers with a payroll inclusion deferral agreement' stopped. Sierra Leone aims to phase out auxiliary cadre health workers but cannot ignore those working unsalaried for years awaiting payroll inclusion. The uptake of new nursing diploma or degree courses is significant, which will increase the supply of nurses. While this is positive regarding the potential for Sierra Leone to improve its nurse/midwife/doctor-to-population ratio, however, without creating additional paid posts for health workers, new nursing graduates will continue to find themselves unsalaried or unemployed.

The Hidden Toll of Colleague Absenteeism: Exploring its Impact on Health Worker Burnout and Emotional Well-being

Onochie Chigozie Eze *Health Policy Research Group, Enugu, Enugu, Nigeria*

Background

Colleague absenteeism among healthcare workers poses significant challenges, impacting patient care, healthcare outcomes, and the overall functioning of healthcare facilities. Previous studies in Nigeria found absenteeism prevalent in Nigeria's Primary Health Centres (PHCs) 77.7% of health workers were absent at least once over a year, while in northern Nigeria another health-sector study reported a figure of about 50%. It is a pervasive issue in healthcare settings, potentially affecting not only workload but also the emotional well-being of remaining staff.

Objective

This study investigates the relationship between colleague absenteeism and health worker burnout, examining the emotional toll on individuals covering absent colleagues.

Methods

The rapid assessment was undertaken in Enugu, southeast, Nigeria. Enugu has a population of 3.3 million with an annual growth rate of 2.8% (National Population Commission, 2010). 5 out of 17 Local Government Areas were purposively selected to represent rural and urban representation and were part of the study

LGAs were known to experience high rates of absenteeism during the first phase of the Anti-Corruption Evidence project. Enugu North, Enugu South and Enugu East are urban locations while Nsukka, Igbo-Etiti are rural.

Participants were purposively selected from 12 PHCs based on their experiences, and knowledge of the issue investigated and will be able to provide the information needed. A total of twelve (12) female health workers were interviewed across the 12 PHCs. Detailed information on the participants is presented in the table below.

Findings

The in-depth interview showed that most of the health workers were unhappy with their colleague's incessant absenteeism, coupled with the fact that they also feel overwhelmed with the workload, which is meant to be shared.

Excerpts from the transcript:

"At times, maybe when the person didn't explain the reason for being absent, it makes me feel bad. When you finish your shifts, maybe you have other things to attend to then you get disappointed by your colleague not being on duty when she's supposed to be I feel bad. Because we are supposed to have the division of labour, but I am taking care of all of them" [CHEW, Female, 49 years, Enugu East]

Conclusion

This study which aimed to shed light on the often-overlooked consequences of colleague absenteeism, has provided insights for healthcare organizations to develop targeted interventions to support the well-being of their workforce.

Human resources in health in Algeria: Emigration of Algerian doctors and intentions of expatriation of resident doctors

Ahcène Zehnati and Christine Peyron *University of Bougogne-Franche Comté, Dijon, France*

Background

Research on the emigration of Algerian doctors is limited and mainly concerns France, where the country is a major supplier of doctors. In addition to the practitioners already expatriated, many young people show a strong inclination to leave. It is therefore relevant to assess their emigration intentions, as their departure could worsen the shortages of healthcare personnel.

Objectives

This article examines the extent of the emigration of Algerian doctors to France, as well as the emigration intentions of resident doctors in their final year of specialization.

Methods

Using various sources, we first estimated the emigration rates, both globally and in specific specialties, for France as a destination country, where data is available. Next, based on a cross-sectional study involving 576 resident doctors in 6 wilayas (regions), we conducted a logistic regression to analyse their emigration intentions.

Findings

If we consider the place of birth, the emigration rate rises to 25.1%, a rate similar to those recorded by some sub-Saharan African countries experiencing an alarming brain drain. Emigration rates vary according to medical specialties. Regarding the emigration intentions of resident doctors, the survey reveals that 74% of them express the desire to go abroad. France remains the preferred destination with 42% interest, followed by Canada, Germany, the Gulf countries, and the United States. Variables related to age, gender, and the region of education have been identified as significant determinants influencing the desire to emigrate.

Conclusions

The results of this study highlight the importance of implementing appropriate policies and measures to meet the aspirations of resident doctors, in order to offer them satisfactory living and practice opportunities in their home country.

Keywords

Keywords: Emigration, doctor, health policy, Algeria.

Health Worker Unemployment among countries with critical health worker shortages

Joseph Nwadiuko1, Ruphin Tanoh Doua2, Lizah Nyawira3

Objectives

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The results of this study highlight the importance of implementing appropriate policies and measures to meet the aspirations of resident doctors, in order to offer them satisfactory living and practice opportunities in their home country.

Keywords

Keywords: Emigration, doctor, health policy, Algeria.

Health Worker Unemployment among countries with critical health worker shortages

Joseph Nwadiuko1, Ruphin Tanoh Doua2, Lizah Nyawira3

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(2) Université FHB de Cocody-Abidjan, Abidjan, Côte d'Ivoire
(3) Amref Health Africa, Nairobi, Kenya

Background

While many LMICs have a shortage of health workforce, there has been rising concern for simultaneous health worker unemployment. However, past reviews of the literature have found little peer-reviewed estimates of unemployment. The Global Code of Practice on the International Recruitment of Health Personnel provides for the identification of 54 "Safeguard Countries" which per the code have the most urgent health workforce needs to be target of support and policy safeguards (including recruitment restrictions). However, it is not known how many of these countries also suffer from unemployment crises.

Methods

A literature review was conducted for estimates of health worker unemployment (either cross-sectional or among graduation cohorts) in safeguard countries. This was supplemented by a search of grey literature for health worker, physician, nurse, and midwife employment in each of the nations in English, French, Spanish and Portuguese. The focus of these searches were numeric estimates of unemployment, but also describe case examples of policy realities surrounding health workforce unemployment.

Data

Of the 54 countries on the safeguard list, we found 69 unemployment estimates for health workers for 31 countries (57.4%), including 27 (72.9%) of countries in the WHO African region. Cross-sectional estimates ranged from 0-60% (median 15%) for physicians, 8.8%-59.4% (median 35.6%) for nurses, 14-98.77% (median 39.4%) for midwives and 6.6%-61.2% (median 28.2%) for combined nurse/midwife estimates. Estimates of unemployment among recent graduates ranged from 2.5-97% (median 48%). There was only one gender-specific estimate for unemployment from Pakistan (where 14.9% of women doctors are unemployed). Policy case studies illuminated the paradox of understaffing co-existing with unemployment (particularly rural or unfunded vacancies), the importance of coordination between educational institutions and ministries of health, the growing prevalence of uncompensated health work (e.g., Sierra Leone), the intersection of unemployment and immigration (with some governments, such as Tanzania, attempting to send unemployed health workers to other countries), and the existence of unemployment throughout the entire public sector, not just in health.

Conclusions

The following study demonstrates that at least half the countries with the highest health workforce shortages simultaneously have health workforce unemployment. This underlines two realities: first, estimated workforce shortages do not currently account for unemployment and may be more

inaccurate than anticipated, particularly for midwives. Secondly there is an urgent need to expand the fiscal space and improve governance over health workforce production as a means of improving health workforce absorption.

Impact of International Cooperation for Health in reducing Medical Brain Drain from Africa: do the main channels matter?

Ruphin Tanoh Doua *Université FHB de Cocody-Abidjan, Abidjan, Côte d'Ivoire*

Background

A growing literature has underlined the role of the inefficiency of health systems, including poor working conditions in the medical brain drain. However, little interest has been paid to evaluating policies aiming to strengthen health systems and to the channels through which these can retain medical workforce at home.

Objective

This study investigates through which channels International Cooperation for Health reduces Medical Brain-Drain (MBD) from Africa.

Data and Methodological framework

We use a new dataset documenting the flows of physicians' and nurses' Brain-Drain from 53 African countries, respectively, to 29 and 21 destination countries, and then, estimate a fixed effect and a standard gravity panel model of international migration of three-year average observations, for the period 1995-2020. Medical Cooperation is approximated by using the Official Health Aid (OHA), the WHO global code of practice (WHO Code), and the Abuja Declaration of Public Health Financing (ACHF), which are three policy instruments implemented to strengthen health systems and improve health outcomes in Africa. As main transmission channels, we focus on health infrastructure (number of hospital bed per 1000 people), HIV prevalence, medical workforce' enrollment, and health workers wages, generally targeted by these instruments of international medical cooperation.

Empirical Results

The research documents three main empirical findings. First, OHA has a direct and an indirect reducing effect on physicians and nurses' brain-drain. Its indirect effect goes through the channels of health infrastructure, and HIV prevalence reducing, with a more pronounced retaining effect on practicing nurses at home. Second, the Abuja Commitment policy instrument reduces physicians and nurses' brain-drain,

directly and indirectly, also through channels such as health infrastructure and HIV prevalence reducing. Third, WHO Code does not reduce the MBD from Africa, even directly and indirectly, but when interacted with OHA and Abuja Commitment policy instrument (Public Health Financing), it plays a key role in their reducing effects on physicians and nurses' brain-drain, with a more pronounced effect on nurses' emigration from home countries.

Policy Recommendation

We recommend close medical cooperation in the implementation of public health policies within the framework of health assistance, the WHO code of practice and the Abuja policy instrument in the African countries most affected by the MBD. By alleviating the challenges of the local health system, through channels such as medical equipment, including health infrastructure, and the fight against HIV AIDS, this close cooperation can reduce the emigration of health workers from home countries in Africa.

Cost-Effectiveness of Surgical, Diagnostic, and Treatment Strategies for Health Conditions in Africa

10:00 AM–11:30 AM Friday, 03 March 2025

Cost-effectiveness analysis of Peritoneal dialysis and Haemodialysis in South Africa: A societal Perspective

Evelyn Thsehla1, Micheal Boachie2

(1) SAMRC/Wits Centre for Health Economics and Decision Science (PRICELESS SA), Johannesburg, South Africa
(2) SAMRC/WITS Centre for Health Economics and Decision Science

Background

More than 800 million people are affected by chronic kidney disease (CKD) worldwide. Haemodialysis (HD), peritoneal dialysis (PD), and kidney transplant are the three main modalities used for managing end stage kidney disease. The cost of these therapies poses a significant burden to health care systems. The aim of this study is to determine the cost-effectiveness of peritoneal dialysis versus haemodialysis, over different time horizon, from the societal perspective in South Africa.

Methods

A Markov model was constructed to estimate the cost-effectiveness of peritoneal dialysis versus haemodialysis. The model was developed in excel and populated with clinical evidence and cost data

synthesized from the literature. The costs and outcomes were estimated over 5, 10 and 15 time-horizon. The outcomes were presented as quality-adjusted life years. Cost effectiveness was estimated using the incremental cost-effectiveness ratio and the incremental net monetary benefit (INMB). Probabilistic sensitivity analysis was also performed to assess the robustness of the results.

Results

The total costs per patient over 5 years were R788 384 for PD versus R1 227 708 for HD. The incremental cost for providing PD was estimated at -R438 875. The net QALYs in delivering PD compared to HD were estimated at -0.09. Cost effectiveness ratio for PD versus PD was R5 096 154/QALY. The INMB was estimated at R328 574 for PD and R322 194 for HD indicating the cost-effectiveness of PD. Probabilistic sensitivity analysis results also showed that PD was cost-effective at a willingness to pay of R38 500. The results were similar over a 10-year and 15-year time horizon.

Conclusions

In South Africa, PD is shown to be cost-effective at a willingness to pay threshold of less than R38 500. While the cost-effectiveness results favour PD over HD, caution must be exercised when choosing between different treatment modalities.

Cost and Cost-effectiveness of Cervical Cancer HPV DNA Self-sampling: A Systematic Review

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(2) University of Glasgow,
(3) Muhimbili University of Health and Allied Sciences

Background

Cervical cancer is ranked the fourth most frequently diagnosed and the fourth leading cause of cancer deaths in women in the world. The incidence and deaths from cervical cancer are higher in developing countries due to a lack of supporting infrastructure in terms of human resources and effective screening technologies.

WHO published a new guideline on using the Human Papillomavirus DNA (HPV DNA) test as primary screening in place of a pap smear and Visual Inspection with Acetic Acid (VIA). HPV DNA tests can be done on both clinician and self-collected samples. Understanding the cost-effectiveness of the self-sampling is important to inform its implementation.

Aim of the Review

The purpose of this review was to collect the current cost and cost-effectiveness evidence of cervical cancer self-sampling globally. Identify the existing strategies, targeted populations, models used and identify existing gaps in the literature.

Methods

We searched for studies on the cost-effectiveness of cervical cancer self-sampling across the globe. These studies were searched from PubMed, Medline (Ovid), Embase (Ovid) and EcoLI databases. The titles, abstracts and full text were screened based on the inclusion and exclusion criteria. The synthesis was based on synthesis without meta-analysis (SWiM) by using a descriptive narrative approach.

Findings

Twenty-nine (29) studies were included in this review. The studies were from 16 countries with one study including three countries. About half of the studies were from developing countries. Studies in developed countries targeted women who were overdue for screening while the population in developing countries was the general population. In developed countries, the self-sampling screening strategies were sending self-sampling kits to women overdue (mail to all) and sending a sampling kit after a woman's request (opt-in), while the costed strategies in the developing countries included a community health campaign and door-to-door. Most of the studies used cost-effectiveness analysis using societal perspectives, and lifetime costing horizons. Four studies also included the budget impact analysis in their findings. In the micro-costing studies, the cost per woman screened ranged from $36.00 in Kenya to $78.34 in Peru. Most cost-effectiveness studies used individual-based Markov models. Studies were heterogeneous, for example on costing perspectives, time horizons, and modelling. Self-sampling appears to be a cost-effective cervical screening strategy.

Conclusion

Cervical cancer self-sampling might be a cost-effective strategy. However, due to the heterogeneity of the studies, country-specific studies are recommended to inform its implementation in a particular country's health system.

Comparing the Cost-Effectiveness of Surgical and Conservative Treatments for Orthopaedic Trauma Fractures in Malawi: A Dynamic Population Model

Pakwanja Twea *PhD Candidate, Norway*

Background and Objectives

While the cost-effectiveness of surgical treatment for orthopaedic fractures is established, some low-income countries still primarily use conservative treatments, which are less efficient. However, the population-level effects of these treatment choices on costs and health outcomes remain inadequately explored. This study aimed to develop a dynamic model to assess the medium-term impact of various treatment options for acute trauma fractures on fracture epidemiology, healthcare costs, health-related quality of life, and mortality. Additionally, the study sought to quantify the opportunity costs associated with different treatment strategies and estimate the potential efficiency gains across multiple fracture types under various treatment scenarios.

Methods

A multi-state Markov model with time-varying transition rates, stratified by age and treatment choice, was used to estimate the burden of femoral shaft, humeral, supracondylar, bimalleolar, proximal ulna, and patellar fractures. The analysis was conducted from the healthcare payer's perspective, focusing on the Malawian population, particularly patients with acute fractures treated in tertiary health facilities. Three treatment strategies were evaluated: no treatment, conservative treatment, and surgical treatment, over a ten-year horizon. Model inputs were derived from expert elicitation, cost data from previous studies, and supplementary literature. Costs and health outcomes were discounted at 3% per year. Scenario modelling compared actual conditions with hypothetical scenarios, such as eliminating inefficiencies and altering treatment choices. Key outcome measures included fracture epidemiology, disability-adjusted life years (DALYs), and fracture-related healthcare costs.

Findings

The study found that the cost-effectiveness of surgery compared to conservative treatment varies by fracture location and is influenced by treatment choices, hospitalization rates and duration, and treatment outcomes. Surgical treatment strictly dominated conservative treatment for femoral and bimalleolar fractures, while it was more effective but more costly for proximal ulna and humeral fractures. These findings highlight the potential to optimize treatment pathways based on cost-effectiveness, enabling healthcare professionals to make more informed decisions and improve patient outcomes.

Conclusions

This study's findings confirm the general cost-effectiveness of surgery over conservative treatment, with variations depending on fracture location and prognosis. The quantification of these differences by fracture type and the emphasis on the impact of treatment choices on chronicity and medium-term health outcomes underscore the importance of understanding the significant influence of fracture location and treatment choices on cost-effectiveness. This understanding is crucial for optimizing orthopaedic care.

Overcoming Barriers to Maternal Health Access and Utilization in Africa

Socio-Cultural Barriers Influencing Access to Maternal Health Care Services In Lafia Local Government Area of Nasarawa State, Nigeria

Usman Ibrahim *Federal University of Lafia, Lafia, Nasarawa, Nigeria*

One of the major problems confronting the advancement of maternal healthcare in Africa is the access to healthcare services and this is due to certain barriers that hinder women from accessing such services. The objective of this study is to find out the socio-cultural barriers influencing access to maternal healthcare services in Lafia Local Government Area, Nasarawa State, Nigeria with particular emphasis on distance, patriarchy and family size. The health belief model was adopted for the purpose of explaining the barriers in accessing maternal healthcare service. Using the Yamane (1967) formula of sample size determination, 400 respondents were selected for the study. Five (5) wards were selected in Lafia LGA for the study through a combination of the lottery method (fishbowl). Generated data were analysed showing frequency, percentages and correlations with the aid of Statistical Package for Social Sciences (SPSS) version 23.0. Findings show that distance, family size and patriarchy act as barriers affecting access to maternal healthcare services in Lafia L.G.A. The study recommends strategic placement of healthcare facilities, construction of feeder road, women empowerment, training and integration of traditional birth attendants on the modern ways to handle emergencies relating to maternal healthcare as ways to curb the barriers affecting access to maternal healthcare services in Lafia L.G.A.

Objectives

family size; patriarchy; access.

Out-of-pocket spending by the pregnant women attending antenatal care/ prevention of mother-to-child HIV transmission services in Ethiopia, and its implication for strengthening health system: applying econometric model

Elias Asfaw Zegeye12, Josue Mbonigaba2, Caroline Kabiru3

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(2). University of KwaZulu Natal, Economics Department, Durban, South Africa
(3). African Population and Health Research Centre (APHRC), Nairobi, Kenya

Background

Universal health coverage (UHC) aims to provide health care access for those in need, including pregnant women attending antenatal care (ANC)/ prevention of mother-to-child HIV transmission (PMTCT) service, without any financial barriers. However, out-of-pocket fees affect ANC/PMTCT service access, coverage and utilization among pregnant women. This paper aims to assess possible explanatory factors for direct medical out-of-pocket spending and their effect on UHC.

Methods

A random sample of 484 pregnant women attending twelve health facilities was interviewed across six regions in Ethiopia. Six health facilities from urban and six health facilities from rural settings were selected from the latest ANC sentinel HIV prevalence report. Ordinary least square econometric model was employed. The dependent variable was the total direct medical out-of-pocket spending by the pregnant women. Direct medical costs consisted of consultation fees, laboratory tests and drug purchase. Normality distribution, linearity and homoscedasticity were tested.

Results

A pregnant woman incurred direct medical costs of Ethiopian birr/ ETB 119 (United States dollar/ USD 6) and ETB 6 (USD < 0.5) in urban and rural settings, respectively ($p < 0.001$). ANC/PMTCT visits and locations were the statistically significant factors related to the dependent variable ($p < 0.05$). Holding other factors constant, a unit increase in ANC visit is related to 33% increase in the direct medical expense (for the care fees, laboratory tests and drug costs) at the public health facilities. A pregnant woman from an urban setting incurred five times higher out-of-pocket spending when compared to her rural counterpart, ceteris paribus.

Conclusion

A pregnant woman from an urban setting experienced higher out-of-pocket spending when compared to a pregnant woman in a rural setting. An increase in ANC/PMTCT visits is directly related to an increase in medical expense, which may have a negative spillover effect on the path towards UHC.

Antenatal Ultrasounds services at health centre level in Rwanda: Monitoring, Evaluation and Learning Results, 2024

Melanie EESP Mukantagara[1], Veronique Zinnen[2], Francois Regisi Cyiza[3], Sharon Umutesi[3], Eliane Nderelimana[2] and Silas Rudasingwa[2]

(1) Enabel, Kigali, Rwanda, Rwanda,
(2) Enabel, Kigali, Rwanda,
(3) Rwanda Biomedical Centre, Kigali, Rwanda

Background

WHO recommends pregnant women receive one ultrasound scan (US) before 24 weeks to estimate gestational age, detect anomalies and improve the pregnancy experience. The strategy adopted in Rwanda in 2018 started in a few districts. Ultrasounds were provided, nurses were trained to use them, monitoring and evaluation system were put in place. This paper summarizes findings from the implementation of this strategy and recommendations to address identified gaps to reach expected outcomes.

Methods

Since July 2021, ultrasounds machines were introduced progressively in health centers, nurses were trained, indicators to measure the benefits selected, data collection by mixed methods (quantitative and qualitative) including quality assessment of ultrasound scan performed was carried out by external experts by the end of 2023 to get feedback from the supply and demand side

Results

Since November 2022, more than 31000 US for antenatal care at HC level of six districts supported by Enabel Project were recorded. The US performed during first trimester (ANC1) increased from 20% (2023) in pilot phase to 52% after scaling up. Of 192 referred cases from HCs to referral hospitals, 126 cases were found with matching diagnosis (66%). Out of 20 participants, 10 had scored 80% or higher on patient on handling US machine. However, some gaps were identified in image recognition. Interview of key informants and FGD with Health managers, care providers and clients confirmed the usefulness of US to reduce unnecessary obstetrical referral cases, satisfaction of users on received services at the nearest place. However, financial accessibility is still an issue as the costs is not yet reimbursed by community health insurance (RSSB).

Conclusion

Although there is evidence of ultrasound improving antenatal care, management of risks and complications as well as satisfaction of both clients and health providers and managers, as a costly

intervention, it is critical to continuously assess the benefits, quality of diagnosis, and case treatment to enhance the strategy ensuring that its objectives are reached. Moreover, addressing identified gaps in competencies and clinical skills, integrating ultrasound module in preservice training of nurses and midwives, consider ultrasounds scan's costs into health insurance are the most critical and urgent decisions for the Ministry of Health and Rwanda Biomedical Center and Rwanda Social Security Board (RSSB).

Keywords

Obstetrical Ultrasounds, Antenatal care, Health center, maternal health

Late prenatal contact in Sahelian countries: does women's level of decision-making power matter?

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(2) Université Cheikh Anta Diop, Dakar, Senegal

Background

The maternal mortality ratio is highest in developing countries, particularly in the Sahel. The average maternal mortality ratio for the five countries (Burkina Faso, Chad, Mali, Mauritania and Niger) in the Sahel is 534 per 100,000 live births, compared with the world average of 223 per 100,000 live births in 2020. Prenatal contact is a means of caring for pregnant women and adolescents in order to reduce this high rate. It includes risk identification, prevention and management of pregnancy-related or concomitant illnesses, as well as health education and health promotion. However, late initiation of antenatal contact can compromise women's health and increase maternal deaths. Delayed initiation of antenatal contact may be due to women's attitudes and behaviours. These attitudes and behaviours may be linked to women's level of decision-making power. This implies that a low level of women's decision-making power may be associated with late prenatal contact. The aim of this study is therefore to test the hypothesis that women's level of decision-making power is negatively correlated with late antenatal contact in Sahelian countries.

Methods

The study uses cross-sectional demographic and health survey data from Sahelian countries. The survey covered women aged 15 to 49 who had given birth in the five years preceding the survey. Compliance with late antenatal contacts among women was assessed by late initiation after the first trimester of pregnancy. This delay was measured according to whether the woman had access to prenatal contact

from the fourth month onwards (late prenatal contact). The association between women's decision-making level and was analysed using a binary probit regression model.

Results

The expected results show that women's low level of decision-making, reflected in their lack of involvement in a decision-making process within the household, leads to late prenatal contact, which does not comply with the WHO's new recommendation that eight prenatal contacts are necessary for women to experience pregnancy as a positive experience.

Conclusions

Women's level of decision-making power reduces the probability of access to late prenatal contact. These results imply that decision-makers in Sahelian countries must, as part of a broad policy, seek to further improve women's decision-making power through concrete actions such as free access to literacy and education for women, easier access to income-generating activities, and home and land ownership.

Innovative Strategies for Workforce and Health System Strengthening in Nigeria and Sub-Saharan Africa

11:30 AM–1:00 PM Friday, 03 March 2025

Developing climate-resilient health systems: a novel approach utilizing artificial intelligence-enabled portable digital radiography for diagnosis of Tuberculosis; the Nigerian experience

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Background/Objectives

Nigeria continues to battle with the triple burden of Tuberculosis (TB), Human Immuno Deficiency Virus (HIV) and Multi-drug-resistant Tuberculosis. Tuberculosis case detection over the years has witnessed significant improvement reaching 59% in 2022. This giant stride achieved despite setbacks posed by the global pandemic of covid-19 is a testament to the resilient health systems built by the country in fighting infectious

We present results showcasing the role of portable digital x-rays (PDX) with artificial intelligence (AI) in improving Tuberculosis case detection across eight states in Nigeria.

Methods

KNCV Nigeria pioneered the use of PDX with AI across eight states with mobile teams deployed to provide TB screening and diagnostic services. Each PDX unit has a backpack containing the x-ray and a solar powered Mobisun power pack. This renewable-energy power source utilizes sunlight to charge the equipment allowing for its use in remote and hard to reach communities. We analysed a one-year cascade data from January to December 2023 across the eight implementing states comparing the results with other TB active case finding interventions that are not using the PDX with AI technology in the same states.

Results

For the PDX with AI across all 8 states, 144, 282 persons were screened, identifying 12,098 presumptives, 99% of these presumptives were evaluated, with 2837 new TB cases diagnosed representing a 24% TB yield, 99% of the diagnosed cases were enrolled on treatment, the number needed to screen (NNS) to get a TB case was just 51 and the number needed to test (NNT) to diagnose a TB case was only 4. Combining all other TB case finding activities in the 8 states shows an average TB yield of about 8%, an average NNS of 203 and an average NNT of 14.

Conclusion

With a very good TB yield of 24% and an NNT of 4, this highly efficient intervention using PDX with AI is significantly improving TB case detection in Nigeria contributing positively towards building sustainable resilient health systems. We recommend scale up of this innovative approach aimed at finding missing TB cases in a sustainable and climate-friendly manner.

The Impact of Official Development Assistance on Health Outcomes: A Rapid Systematic Review of Literature

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Introduction

Each year, low- and middle-income countries (LMICs) rely on more than 35 billion US dollars of official development assistance for health (DAH) to support their health systems. This health financing model has evolved from international efforts to address persistent deficits in domestic health expenditure and the resulting challenges in providing universal access to health services. Although there is a growing body of literature investigating the effectiveness of DAH on health outcomes, there appear to be contested findings and an evidence base characterized by different study samples, data sources, methodologies, and targeted health outcomes.

Methods

To inform health financing and development policies in LMICs, the objective of this rapid systematic review was to comprehensively synthesize evidence on the impact of aid on health outcomes. To evaluate the strength of causal evidence of relevant studies, we modified and applied existing tools for risk-of-bias assessment. We opted for a narrative synthesis to highlight policy-relevant findings, given the heterogeneous evidence base.

Results

Sixty-one studies were included in the synthesis. The most-reported outcomes were maternal and child health-related, and overall, the weight of evidence underlines significant positive effects of aid on health outcomes. The reviewed evidence was drawn from a range of studies employing different econometric methods, with varied methodological rigour, and subsequent quality of studies differed significantly. The reported effects of DAH were generally greater in countries with good governance, including households living closer to aid funded initiatives-the spatial pathway. Additionally, the multiplicity of partners in the health sector, and aid fungibility, although often viewed negatively, did yield some positive benefits on health outcomes. Overall, we find that DAH is an important pathway for enhancing health and better targeting of aid may be crucial to maximising impact.

Conclusion

DAH as a means of improving health is important in LMICs though what is not so apparent are pathways that can maximise the effectiveness of health aid. As a result, more research is needed to explore pathways and health aid allocation mechanisms that more effectively target poorer populations in recipient countries. Policymakers should also consider adapting and contextualising existing health aid delivery channels to enhance the impact of DAH especially among the poor.

Technology-Driven Interventions to Reduce Health Worker Absenteeism in Gombe State

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Background

Absenteeism of health workers has been recognised as a leading form of corruption in the health sector and one of the key obstacles to achieving universal health coverage (UHC) in Nigeria. Gombe State in North-Eastern Nigeria deployed biometric systems at public health facilities, backed by disciplinary measures, to curb health worker absenteeism.

Aim

HSCL conducted a study to review the current state of absenteeism in Gombe State, effects of the intervention and policy implications.

Method

The study was conducted in 20 purposefully selected PHCs across the 3 senatorial districts of the state, to ensure spread. A headcount was conducted in each PHC against the staffing list. Qualitative information was obtained through key informant interview of heads of the PHCs and responsible persons at the State Primary Healthcare Development Agency (SPHCDA), using semi-structured questionnaires.

Key Findings

80% of staff were present on the day of the review across the 20 PHCs. Heads of the PHCs reported that absenteeism have reduced since the introduction of the biometric system. In addition to the biometric system, some PHC managers also use paper-based registers to track absenteeism as the biometric system reports directly to the state level. Facilities with a back-up paper register and disciplinary committees reported lower absenteeism rates than those that used biometric systems only. The SPHCDA conducts spot checks and withholds salaries for those who are absent for 15 days or more. Facilities with disciplinary committees also make staff payback time, by working longer hours and shifts.

Conclusion

The use of biometric systems to track health worker attendance in PHCs has reduced absenteeism in Gombe PHCs. Facilities with better autonomy at managing staff attendance have lower absenteeism than those only using the state administered biometric system. The state should combine the biometric system

The state should combine the biometric system and facility level staff performance management by sharing the attendance data from the biometric system with the PHCs. This will produce better results and increase productivity.

Building a Resilient and Sustainable Healthcare Workforce through Mental Health Support: A Case Study of Kebbi State, Nigeria

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Background

The prevalence of psychosocial stress among healthcare workers in Nigeria is high, with a rate of 61.97%. This stress levels are notably high in high-stakes areas like HIV care, with work overload, poor communication, and resource scarcity as key risk factors. The "Caring for the Carers" intervention by Sanitas Health and Development Foundation (SANHDEF) in Kebbi State aimed to improve mental health awareness and resilience among healthcare workers by empowering frontline workers with tools to support their mental well-being and strengthening their resilience to manage work-related stress.

Methods

A two-days interactive mental health training program was conducted by SANHDEF for 31 participants from 11 secondary health facilities including adherence counsellors, HIV case coordinators, the state Prevention of Mother to Child Transmissions (PMTCT) focal person, Antiretroviral Therapy Nurses and representatives from State Agencies for the Control of AIDS (SACA) and State AIDS and STI Control Programme (SASCAP).

The training incorporated engaging presentations, collaborative group activities, and realistic role plays scenarios. A pre-and post-training assessment was conducted to evaluate changes in participants' knowledge and confidence in managing mental health issues. The Professional Quality of Life Scale (Pro-QOL) tool was used to assess the impact of the training on participants' professional quality of life, focusing on compassion satisfaction and compassion fatigue.

Results

The training resulted in a 25% increase in participants' knowledge of mental health and enhanced their confidence in identifying and responding to patients' mental health needs. Participants also reported an improved awareness of promoting mental health strategies by creating supportive environments for

for patients in their facilities. The ProQOL tool revealed that 54% of participants experienced compassion fatigue and burnout, primarily attributed to high workloads, inadequate infrastructure, and insufficient resources and equipment at the facilities.

Conclusion

The "Caring for the Carers" intervention reveals the urgent need for systemic improvements to alleviate these stressors and support the mental well-being of healthcare workers. The program's design proved effective in addressing the mental health needs of frontline workers and demonstrates potential for similar initiatives to strengthen health workforce capacity and overall healthcare delivery in Nigeria.

The Kaduna PHC Management Strengthening Project: An Action Learning Implementation Approach to Management Capacity Building of Primary Healthcare Facility Managers in Kaduna State, Nigeria

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Background

Due to manpower shortages, service delivery points in Nigeria's primary healthcare system are largely staffed by community healthcare worker cadres whose roles have gradually evolved from community practice to clinical duties in the PHC facilities and additional managerial responsibilities. This paper aims to demonstrate how a state-led action learning approach was successfully deployed and evaluated by the Kaduna Primary Healthcare Management Strengthening Project (KPMSP) in building the management capacity and improving the operational efficiency of PHC Managers in Kaduna State.

Methods

Baseline quantitative data was collected on the management capacity and operational efficiency of PHC Managers in 107 intervention PHC facilities from 10 selected districts in Kaduna State across the thematic areas of Human Resource Management, Financial Management, Inventory Management, Data Management, Planning and Community Relations, Facility Management and Quality Assurance. The

Kirkpatrick model was deployed to collect and evaluate the results of in-class and on-the-job training provided for 214 PHC Managers from the 107 PHCs. An end-line mixed methods assessment was similarly conducted, collecting quantitative and qualitative data on changes over the 8-month course of the intervention, identifying gaps that continue to exist and establishing key drivers of change. Multi-stage cluster sampling was used in selecting 36 end-line PHCs from the 107 assessed at baseline while 19 district and community stakeholders were additionally interviewed.

Results

The assessments showed evidence of improved capacity of PHC Managers and improved operational efficiency across all thematic areas. The percentage of PHCs disseminating facility data to Ward Development Committee members during monthly meetings increased from 21% at baseline to 83% at end-line. From 43% at baseline, 66% of the PHCs properly documented microplanning processes while 94% from 53% had begun to conduct community sensitization. PHC Managers with adequate knowledge of drug quantification rose from 1% to 80% and proper handling expired drugs went from 10% to 100%. From 0%, all PHC Officers-in-Charge had instituted absenteeism reduction processes bringing absenteeism from 92% of facilities to 17%. All the PHCs assessed incurred expenses only within the facility budget.

Conclusion

The combination of in-class management training and on-the-job mentoring resulted in improved management at the intervention PHCs. Mechanisms for long-term institutional mentoring support on management will further improve the efficiency of the PHC system and provide future research opportunities.

Economic Impacts of Non-Communicable Diseases and Health Decision-Making in Africa

11:30 AM–1:00 PM Friday, 03 March 2025t

Impact of COVID-19 on the management of hypertension: a perspective on disease severity, service use patterns and expenditures from Ghana's health insurance claims data

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Background

The fragility of health systems in Africa and its implication on the management of non-communicable diseases like hypertension were exacerbated by the COVID-19 pandemic. Nevertheless, little is known in Ghana about how the pandemic impacted the severity and management of hypertension and the associated expenditures from a government perspective. We posit that providing such evidence may help the government and healthcare providers to improve health system resilience to mitigate the impact of future pandemics on the management and financial cost of hypertension.

Aim

To evaluate and quantify the impact of COVID-19 on the management of hypertension in Ghana by measuring variations in disease severity and management expenditures before and during the pandemic.

Methods

We used cross-sectional data from Ghana's National Health Insurance database comprising 525,021 hypertensive patients. We performed descriptive and inferential statistical analyses to estimate and compare hypertension episode intensity and related claim expenditures before and during the COVID-19 pandemic.

Results

We observed significant changes in health services use for hypertension during the pandemic. While there was a 20% reduction in the number of hypertension claimants in the pandemic year, there was an increase in hypertension severity as measured by the number of hypertension episodes per claimant (a 17.6% increase (95% CI. 17.3% – 18.0%; p<0.001)). There was also an 18.64% or $22.88 (95% CI: $21 – $25, p=0.01042) increase in the mean cost per hypertension claimant in the pandemic year. The increase in episodes per claimant had the largest financial impact on the average cost per claimant.

Conclusion

The findings of this study are relevant for future policymaking and strategy implementation for hypertension control during pandemics in Ghana.

Non-communicable disease multimorbidity in Uganda: Economic effects in binomial response model and endogeneity context.

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Background

Most (at least three-quarters) of global mortality is now attributable to non-communicable diseases (NCDs). This health burden is rising, and it is disproportionately affecting Africa and low-income countries, posing a serious development challenge. The challenge is exacerbated by the emergence and rapid rise in the multimorbidity of NCDs, but this, and the economics of NCD multimorbidity, remain unexplored. It is imperative that economic analyses refocus on investigating the economics of NCD multimorbidity.

Aim and Objective

This paper aimed at examining the economic implications of NCD multimorbidity in an African setting, using evidence from Uganda.

Methods

We use data from the recent National Household Survey of Uganda – the socio-economic and health modules. Economic outcome is based on occurrence of economic catastrophe, computed using a range of catastrophe thresholds that yield binomial-like responses. We employ Maximum Likelihood Estimation (MLE), tested using Special Regressor model for robustness and untangling endogeneity of NCD multimorbidity in a binomial response context.

Key Findings

Overall, NCD multimorbidity escalates both the incidence and intensity of economic catastrophe. Results demonstrate corresponding enormous rise in catastrophe as chronic conditions graduate from no NCD through NCD comorbidity, across the catastrophe thresholds. The Special Regressor model results are consistent with those of MLE. However, the most consistent results that confirm devastating economic effects are detected through the effects of the multimorbidity of major NCDs. Economic catastrophe borne due to multimorbidity is more pronounced when individuals or households are afflicted by the multimorbidity of major NCDs, with marginal effects ranging between 11 and 34 percentage points.

Conclusion

NCD Multimorbidity thus subjects individuals and households to significantly large devastating effects on economic outcomes, but the devastation is larger with the multimorbidity of the major NCDs. Besides adding stock of knowledge on economics of NCD multimorbidity, the evidence underpins NCD

investment case for multimorbidity control – especially multimorbidity of the major NCDs, rather than conservative policy focus on single NCDs. Tailoring policies or investment cases to target the swiftly emerging public health challenge of NCD multimorbidity is crucial for protecting the population against elevated economic catastrophe risks.

Economic Burden and Coping Strategies for Haemodialysis in Dar Es Salaam Region, Tanzania-A Cross-Sectional Study

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Background

Chronic Kidney Disease (CKD) is a major public health problem, not only with increasing morbidity, and mortality but also a high cost to patients and the health care system. This study aims to estimate patient costs and strategies used to cope with cost of haemodialysis in Dar es Salaam region in Tanzania.

Methods

This cross-sectional study included 436 CKD patients on haemodialysis in eight centres in Dar es Salaam between 2022 and 2023. Data was collected by interviewing patients/caretakers using a pre-tested questionnaire. Cost data were collected in Tanzanian shillings (TZS) and converted to 2022 USD (1 USD = 2314 TZS). Data was analysed with Stata 18. The mixed-effects generalized Linear Model (GLM) was used to identify factors associated with haemodialysis treatment. Coping strategies were expressed as proportions.

Results

The average annual cost of haemodialysis was USD 3861.8. Direct medical costs contributed 34.6% (USD 1334.8), direct non-medical costs 17.6% (USD 680.3), and indirect costs 47.8% (USD 1846.8). The economic burden was almost three times higher among patients paying Out-of-Pocket (OOP) compared to those with health insurance, i.e. USD 7902 versus USD 2859. Only 40% of patients reported they were still working; however, they missed about 12 working days every month. The cost of haemodialysis was significantly associated with having an income greate r than USD 43, having health insurance, co-payment , and the

cost of medicines, transportation, meals and the number of lost working days. Strategies commonly used to cope with the costs of haemodialysis included support from family, relatives, and friends (87%), borrowing money (46%), selling assets (22%), skipping treatment (20%), dropping children from schools (18%) and requesting payment waiver (16%).

Conclusion

The economic burden of haemodialysis is high, especially for patients paying OOP compared to the national minimum wage which implies a yearly salary of USD 1556 (formal sector). The government of Tanzania should put in place policies that exempt medical costs for all CKD patients without health insurance, otherwise, they risk being pushed deep into impoverishment and poverty.

Keywords

haemodialysis, economic burden, coping strategies

Use of Health Economic Evidence in Decision Making for Non-Communicable Disease Prevention and Control in Kenya

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Background

Kenya has experienced a significant rise in the burden of non-communicable diseases (NCDs), with cardiovascular diseases (CVDs) and diabetes being among the leading causes of death and disability. Reversing the trend in NCDs requires the implementation and scaleup of prevention and control interventions. Health economic evidence is integral to informing priority setting processes and can compare alternative interventions in terms of their costs and consequences. However, the status of uptake of economic evidence in Kenya is not well documented. This study sought to explore the perspectives of Kenyan stakeholders on the uptake of health economic evidence, challenges faced and recommendations.

Methods

We carried out seventeen comprehensive interviews with stakeholders engaged in cardiovascular disease

(CVD) prevention, management, policy-making, and research in Kenya. The interviewees comprised officials from the Ministry of Health at national and county levels, representatives from civil society organisations, the private sector, as well as health economists and researchers. An inductive thematic approach was used to analyse the data.

Results

The stakeholders found limited use of health economic evidence in decision making for non-communicable diseases in Kenya. The challenges included the non-prioritisation of health economics as a criterion for decision making, the lack of capacity to generate and synthesise the economic evidence, limited and poor data quality for economic modelling, and non-involvement of relevant decision makers in generating the economic evidence. Institutionalisation of health economics decision making, capacity building on the use, relevant stakeholder engagement, simplified communication and dissemination of evidence to decision makers, and improvement of data gaps were identified as integral towards improving the uptake of health economic evidence in decision making for NCDs in Kenya. In addition, improved advocacy of the generation and use of health economic evidence among decision makers to create awareness and improve uptake was considered important.

Conclusion

This study highlights a gap in the uptake of health economic evidence in decision making in Kenya. Concerted efforts are needed to institutionalise the use of economic evidence within the ministry of health. Analysts should involve the relevant stakeholders while designing and generating health economic evidence.

Factors associated with the direct cost of managing strokes at the Ouidah – Kpomassè – Tori Bossito Zone Hospital in 2024

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Background

Cerebrovascular accidents constitute a public health problem due to their high morbidity and mortality rates, as well as their direct care costs. This study aimed to identify the factors associated with direct costs in the OKT health zone in 2024.

Methods

It was a cross-sectional analytical study conducted at the OKT District Hospital. The selection of patients hospitalized for stroke was exhaustive. Data collection was carried out using medical record review forms and cash register software, a questionnaire, and this in accordance with ethical principles. The data were entered using Excel 2022 and analysed using STATA 14. The determination of factors associated with direct costs was made possible through a multiple linear regression model at a 5% threshold.

Findings

The average age of the patients was 60 years ± 13.25. The median direct cost was 216,100 (162,400; 285,299) CFA francs. The associated factors were: the delay in seeking care (p=0.000), the length of hospitalization (p=0.000), ischemic stroke (p=0.000).

Conclusion

The high direct cost of stroke care constitutes a barrier to access for patients, particularly the most disadvantaged. It is important to address the factors that increase this cost and find mechanisms to improve financial accessibility to care.

Keywords

Stroke, Direct Cost, Hospital, Benin

Factors Shaping Enrolment, Equity, and Reimbursement in Health Insurance Across Africa

11:30 AM–1:00 PM Friday, 03 March 2025

What factors shape an individual's probability to be enrolled in a professionally-managed Mutuelle? Results from a cross-sectional case-control study in two districts in Mali

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Introduction

Across West Africa, countries are promoting new models of Community-based health insurance to overcome the challenges faced by existing schemes. We investigated factors associated with an individual's probability to be enrolled in one of two professionally-managed Mutuelles in Mali.

Methods

We carried out a cross-sectional survey adopting a case-control methodology and used multi-stage sampling to select Mutuelle members and non-members. The primary outcome variable was being enrolled or not in the Mutuelle. Three-level mixed-effects logistic regression model was used to estimate the association between individual enrolment and a series of individual, household, and wider community factors.

Results

Of the 1,270 people surveyed 847 and 423 were non-members and members respectively. Respondents with primary education (AOR = 1.6, P = 0,035), secondary education (AOR = 2.31, P = 0,001) or higher school/University (AOR = 5.5, P < 0,001); who were economically active (AOR = 1.52, P = 0,05) and considered themselves wealthy (AOR = 1.94, P < 0,001) were more likely to subscribe to Mutuelles. Those who reported having a good perception of their health (AOR = 0.68, P = 0,038) were less likely to subscribe to Mutuelles.

Conclusion

Albeit substantially higher than what experienced by community-based schemes, membership in these professionally-managed Mutuelles remains low and the determinants of participation do not differ substantially from what reported in the general literature. Targeting the needs of poor vulnerable people and more pervasive communication strategies are urgently needed to enhance enrolment in these new Mutuelles and ensure the way to UHC.

Predictors of NCD Reimbursement; A Case of National Health Insurance Fund (NHIF) towards Universal Health Insurance (UHI) in Tanzania

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Background

Non-communicable diseases (NCDs) have been rising accounting for 74% of global deaths annually. The rise is associated with changes in lifestyle, urbanization, and aging population. In Tanzania, the NCD contributes almost one-third of all deaths (27%). It is estimated hypertension has a prevalence of 26% and hyperglycemic conditions 20%.

The National Health Insurance Fund (NHIF), a social health insurance is an alternative financing mechanism for management of costly chronic diseases to protect individuals from catastrophic health expenditures. There is an increase in claims and reimbursement for NCD services at NHIF, but the factors predicting the reimbursement of major NCDs by the NHIF remain unclear. This study aims to identify the predictors of reimbursement for major NCDs, including cardiovascular diseases, diabetes mellitus, cancers, chronic renal diseases, chronic respiratory diseases, and mental illnesses, at the NHIF.

Objective

To determine the predictors of NCD reimbursement of major NCDs at the NHIF in Tanzania from January 2021 to December 2023.

Method

A cross-sectional study design, applying quantitative methodologies to analyse secondary claims data within the NHIF database. It targeted NHIF beneficiaries with at least one NCDs claim from January 2021 to December 2023, identified through the ICD-10 classification system.

The data was analysed using R Statistical software. A multivariate regression analysis was employed to determine the association between reimbursement predictors and the reimbursement burden of NCDs on the NHIF. Ethical clearance was obtained from the Institutional Review Board (IRB) at MUHAS, similarly, approval from the NHIF was granted.

Findings

The study revealed various NCDs substantially impact reimbursement amounts. Specifically, cancers (0.79 [0.78, 0.80]), chronic renal diseases (0.29 [0.29, 0.30]), and diabetes (0.07 [0.06, 0.07]) were positively associated with an increase in the (logarithmic) reimbursement amount. Additionally, age is a significant predictor of NCD reimbursement, with individuals aged 65+ associated with the highest increase in (logarithmic) NCD reimbursement (0.12[0.12,0.13]). The study also found NCD claims from private facilities associated with higher (logarithmic) reimbursement amounts (0.03 [0.03, 0.03]). Additionally, zonal hospitals

showed a positive association with an increase in the (logarithmic) NCD reimbursement amount (0.02 [0.01, 0.02]). Similarly, NCD claims from city councils (0.14 [0.13, 0.14]) were statistically significant and associated with an increase in reimbursement amount compared to claims from rural areas.

Conclusion

There is a substantial influence of several NCD categories on reimbursement amounts. Age, gender, type of healthcare facility by level and ownership, and urbanity are important factors that determine NCD reimbursements.

Effect of Risk Mitigation of Health Insurance on Healthcare Equity and Universal Coverage in Sub-Saharan Africa

Damianus Okaka[1], Ojah Kalu [2]

(1) KAFU
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The study examined the effect of direct out-of-pocket (OOP) and different prepayment methods for healthcare on health systems' equity in Sub-Saharan Africa (SSA). Equity is measured in terms of health systems' outputs (i.e. life expectancy at birth, under-5 mortality rate, maternal mortality rate and crude death rate). More specifically the study explored the effect of financial pooling and financial risk mitigation on health system's equity to determine a financing approach's appropriateness for universal health coverage (UHC). The moderating effect of carefully selected control variables was also analysed.

The concept of health production based on Grossman's (1972) health capital theory served as the framework for the empirical analysis of this work. The study used panel data from 47 countries over 19 years. The secondary data is pulled from relevant governments and multilateral databases.

The initial investigation used descriptive and bivariate analysis. Multivariate regression was used to assess the strength and direction of the hypothesized relationship between relevant variables of the study. Because our panel has a high-time series and long cross-section, before estimation, we carried out unit root and cointegration tests. To control for omitted variable bias in unobserved heterogeneity which poses interpretational problems in panel data analysis we deployed random and fixed effect estimation techniques. The Hausman test was used to select the right estimation model.

The empirical results reveal that OOP and private health insurance (PHI) financing methods associate adversely with health outcomes. All the other prepayment methods affect health outcomes favorably. However, social health insurance (SHI), a method favoured by WHO and health financing experts for UHC, affects health outcomes insignificantly.

The main conclusion of this study is that any form of private payment either at the point of service (OOP) or through prepayment (PHI) is inequitable. Previous empirical works show that OOP impedes access to needed healthcare, this could be the reason for its negative association with health outcomes. On the other hand, there is no evidence that PHI reduces access to needed healthcare. Proponents of PHI argue that because it is market-based, it allocates healthcare more optimally. We argue that market allocation is dictated by competition, and in healthcare, competition can follow pathways that are welfare-reducing, for example, co-payment, skimming-the-cream, and profit maximization. According to Carrin (2002), financial pooling where households are expected to make regular payments such as SHI are not suited for SSA because of the large informal sector, high income concentration and scattered rural population. These factors increase administration costs and reduce pool sizes which funds available for healthcare and limit risk diversification. Furthermore, SHIs in SSA are exposed to wastage by administrators (Debpuur et al, 2015), in the face of wastage even large pool sizes cannot lead to Pareto improvement. And, according to Atinga et al, (2015), SHIs in SSA are disproportionately exposed to market distortions (through moral hazard and adverse selection) compared to SHIs in other regions. We provide evidence in this work that some of these issues are responsible for the insignificant association between SHI and health outcomes in SSA.

We conclude that the direct payment method causes health systems in SSA to be less equitable. And recommend that to make financial pooling for healthcare effective, and suitable for UHC in SSA policymakers should intervene in the market through guided policies and legislations to increase pool sizes, reduce market distortions, increase the amount of contributions allocated to healthcare, and reduce wastage of funds through corruption and other malpractices. They should also come up with methods of collecting contributions from informal sector employees that are cost-effective. We also recommend policies that would encourage sickness cost risk sharing through private-public partnership.

Factors Influencing Healthcare Insurance Enrolment among Patients at a Public Hospital in Cameroon: A Hospital Based Cross-Sectional Analysis

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Background

Health insurance is believed to attract additional funds for healthcare, enhance operational efficiency, and improve effectiveness within healthcare systems. This study aimed to assess the factors influencing healthcare insurance enrolment among patients at a public hospital in Cameroon.

Methods

We conducted a hospital-based cross-sectional study on 385 Cameroonian public hospital patients from September 2022 to March 2023. Self-reporting measured healthcare insurance enrolment as a binary

outcome. Researchers collected data using a questionnaire and summarised it using frequencies and percentages. We used chi-square and Fisher's exact tests to compare things, and binary logistic regression to find factors that were independently linked to people signing up for health insurance plans. The results were shown as adjusted odds ratios (AORs) with 95% confidence intervals.

Results

Of the 385 participants, 121 (31.4%) were enrolled in health insurance plans. The odds of uptake of healthcare insurance plans were higher among persons aged 46-55 years (AOR: 4.2, 95% CI: 1.2-15, P-value: 0.0025) and those working in the public sector (AOR: 3.5, 95% CI: 1.1-11.2, P-value: 0.0035). Conversely, the odds of uptake of health insurance plans were lower among participants earning less than $86 per month (AOR: 0.1, 95% CI: 0.0-0.3, P-value: 0.0001).

Discussion

The study shows that age, employment sector, and income level affect Cameroon health insurance enrolment. Public sector workers and 46-55-year-olds were more likely to enrol than those earning less than $86 per month. Interventions and policies should target low-income and private sector workers to improve health insurance coverage. To increase enrolment among younger and older adults, age-specific interventions and educational campaigns are needed.

Conclusion

This study highlights critical factors influencing health insurance enrolment among patients in a public hospital in Cameroon. Age, employment sector, and income level significantly impacted enrolment rates, with higher uptake among individuals aged 46-55 years and those working in the public sector. Conversely, lower income levels were associated with reduced enrolment. These findings suggest the need for targeted interventions and policies to improve health insurance coverage, particularly among low-income earners and private sector workers. Additionally, age-specific strategies, including educational campaigns, are necessary to boost enrolment rates among both younger and older populations, ultimately enhancing overall healthcare access and financial protection.

Health insurance dynamics, potential for HIV integration, and implications for the right-to-health and equity in sub-Saharan Africa: Evidence synthesis

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Background

Despite a lack of consensus on optimal health spending for securing the right to health, African countries do not sufficiently finance health. Africa's total healthcare spending has ranged from 5% to 6% of gross domestic product. HIV financing relies heavily on international funding. Notwithstanding the increasing adoption of social health insurance (SHI), integrating HIV into SHI schemes in sub-Saharan Africa (SSA) has been slow.

Objectives

This review assessed the integration of HIV financing into SHI and identified the critical features of the insurance arrangements in Africa needed to realize the right to health when integrating HIV into SHI schemes.

Methods

We reviewed empirical and grey literature on integrating HIV into SHI schemes and its effects on right-to-health in low and middle-income countries (LMICs). Additionally, we reviewed the empirical literature on SHI and its effects on the right to health in SSA. We included articles on all study designs and methods, published in English between 2015 and 2023, describing HIV integration into SHI in LMICs and SHI dynamics in SSA. We explored themes related to funding, pooling, benefits, purchasing, and governance to describe the health and HIV financing mechanisms. We assessed the effect of SHI on right-to-health using a normative framework comprising availability, accessibility, acceptability, quality, and equity.

Results

Funding strategies for SHI-HIV integration include public subsidies, philanthropic contributions, HIV Trust fundraising, debt reliefs, and mandatory air ticket tax. Increasing awareness of health insurance benefits, universal treatment programs regardless of qualifying factors, decriminalizing key populations, deploying sliding scale premiums, transparent administrative procedures, and single national health insurance schemes can enhance enrolment and reduce fragmentation. Benefits work better with a uniform HIV service package, including preventive care, periodic review, explicit referral guidelines and gate-keeping policies, and consumer preferences. Differentiated payment schemes for diverse providers, classifying HIV medicines as chronic care drugs, pooled procurement, drug pricing programs, and using primary care providers are strategic purchasing options. Countries require supportive laws/policies, improved institutional capacity, and coordination to integrate HIV into SHI schemes. SHI schemes improved the availability, accessibility, acceptability, quality, and equity of healthcare in SSA, but evidence of its effect on right-to-health among PLHIV is scarce.

Conclusions

Integrating HIV into SHI needs to improve in Africa. Evidence from this review can inform the design and implementation of HIV-sensitive social health insurance in Africa. The right-to-health framework is a potential tool for monitoring SHI-HIV integration.

Health Financing, Policy Sustainability, and Regulatory Practices in Africa and Beyond

11:30 AM–1:00 PM Friday, 03 March 2025

An assessment of regulatory compliance and best practices in e-pharmacies operating in Kenya and India.

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Background

Poorly regulated e-pharmacies can compromise health system performance through malpractices like dispensing prescription-only medicines (POMs) without a valid prescription, distributing poor-quality medicines and inadequate patient counselling. We assessed compliance of e-pharmacies serving users in Kenya and India to respective local regulatory requirements and global best practices.

Methods

We defined e-pharmacies as business-to-consumer pharmacies selling POMs through websites and identified them on Google® using typical consumer search strings. Two reviewers independently audited the websites using REDCap® (Jan–May 2023). We assessed performance against country requirements and global best practices, stratified by website traffic data from "Similarweb.com" and the declared physical location. Since India lacks 'e-pharmacy-specific' regulations, "proposed requirements" were posited from draft policy documents. We assessed the availability of drug information based on six tracer molecules and analysed data using Stata 18.0.

Results

We identified 26 and 61 e-pharmacies operating in Kenya and India respectively. No e-pharmacy was fully compliant. On average, e-pharmacies serving Kenya met 74% of regulations, compared to 54% for India [range: 50-92% (Kenya); 29-71% (India)]. High traffic e-pharmacies reported comparatively better mean compliance rates [83% vs 72% (Kenya); 62% vs 51% (India)]. Better compliance was comparably observed for e-pharmacies physically located within the two study countries [78% vs 61% (Kenya); 54% vs 40% (India)]. Despite regulatory prohibition, 62% and 34% of e-pharmacies accessible from Kenya and India respectively listed narcotic/controlled drugs for sale. Only 5% of e-pharmacies serving India and 19% serving Kenya displayed registration information. Nearly all (90%) e-pharmacy websites in India and 58% in Kenya provided a facility for prescription upload, implying that e-pharmacies serving clients in India may be more likely to adhere to prescription requirements. Comprehensive drug information was displayed on just 16% of e-pharmacies in India and 42% in Kenya. A telephonic helpline was provided by most websites in both countries, although just one in Kenya and none in India displayed details of supervising pharmacists. Refill reminders were offered by 8 websites in India and only 1 in Kenya. A privacy policy was unavailable on 13% and 35% of e-pharmacies operating in India and Kenya. No single e-pharmacy serving Kenya provided any procedure for grievance redressal.

Conclusion

The regulatory compliance of e-pharmacies varied considerably. This should prompt stricter enforcement in Kenya and prompt the introduction of regulations in India. We recommend risk-based regulation, where regulators recognize compliant e-pharmacies, enhance scrutiny of the partially compliant, and remove the non-compliant.

Direct Facility Financing Mechanism in Tanzania: A Scoping Review of Evidence

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Background

Primary health care (PHC) is vital for universal health coverage in many low- and middle-income countries but is often underfunded. Direct facility financing (DFF) addresses this issue by allocating financial resources directly to health facilities. The primary goals of DFF are to streamline resource allocation, promote fiscal decentralization, and grant autonomy to health facilities to enhance their service readiness,

provision, and responsiveness. Given the growing body of evidence on DFF's impact in Tanzania, we conducted a scoping review of the available published information to synthesize the effects of DFF in PHC facilities.

Methods

We conducted a scoping review through an electronic search of scientific and grey literature published between 2017/18, when DFF was introduced in Tanzania, and June 2024. A total of 15 publications relevant to DFF assessment in Tanzania were retrieved. We extracted, synthesized, and analysed data to provide insights on the effects of DFF.

Findings

Most studies (9) focused on the effect of DFF on quality of care, governance, and accountability. Four (4) studies focused on autonomy in planning and spending, while other studies had cross-cutting themes. Despite some constrained challenges observed, most studies demonstrated a positive effect of DFF in Tanzania on financial management, service utilization, accountability and functioning of facility governing committees, availability of health commodities, strengthening financial management systems, equity in facility financing, and overall health system performance. Other studies assessed the political economy of introducing DFF, implementation progress, and acceptability of the DFF reform in Tanzania. One study compared DFF and performance-based financing in relation to strategic purchasing and financial autonomy.

Conclusion

The scoping review indicates that DFF has positive impact on PHC in Tanzania. DFF has improved financial management, service utilization, governance, and accountability at health facilities. It has also enhanced the availability of health commodities, strengthened financial management systems, and promoted equity in facility financing. However, the implementation of DFF also faces challenges, including the need for continuous capacity building and addressing political and administrative hurdles. Further research and sustained efforts are essential to optimize DFF and ensure its benefits are fully realized across all PHC facilities.

Health Economic Evaluation of an Intervention to Reduce the Impact of Multimorbidity in Malawi and Tanzania

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Background

Multimorbidity, the presence of >2 chronic conditions, presents complex resourcing challenges for health systems in Sub-Saharan Africa, where health systems are vertically orientated toward infectious diseases.

Aim

This study evaluates patient costs, and health-related quality of life (HRQoL) among people living with multimorbidity (PWLMM) with emergency hospital admission in Malawi and Tanzania.

Methods

The study was nested within a prospective cohort study, recruiting participants among acute medical admissions from district and tertiary hospitals in Malawi and Tanzania. Clinical records and point-of-care tests were used to systematically diagnose HIV, hypertension, diabetes, heart failure, ischaemic heart disease, stroke, chronic obstructive pulmonary disease, chronic liver disease and chronic kidney disease. Healthcare costs and EQ-5D-5L data were collected over 90 days to calculate utility scores and HRQoL. Participant costs, catastrophic costs, and health utility scores were analysed and compared for participants with and without multimorbidity.

Results

Total healthcare costs were statistically significantly higher for participants with multimorbidity (Malawi: $56.79 vs $30.93, p = 0.028; Tanzania: $310.28 vs $169.34, p = 0.002). Participants with multimorbidity incurred significantly higher medical costs in Tanzania (Tanzania: $207.33 vs $63.75, p = 0.002) compared to Malawi ($11.73 vs $3.52, p = 0.153). Participants with multimorbidity incurred significantly higher non-medical costs in Malawi ($22.54 vs $14.96, p = 0.030) compared to Tanzania ($9.36 vs $12.36, p = 0.110). There was no significant difference in indirect costs. Pre-hospitalization and inpatient monthly income were higher for those with multimorbidity, but income reduction was not statistically significant.

Catastrophic costs were more prevalent in multimorbidity (without multimorbidity 5.5%, with multimorbidity 7.70%, p = 0.485). Participants with multimorbidity had lower health utility scores at baseline in Tanzania (mean 0.276 vs 0.407, p = 0.05) but not in Malawi (0.417 vs 0.490, p = 0.12). At the end-line (participants final assessment within the study), health utility remained lower for those with multimorbidity (Malawi: 0.832 vs

0.917, p = 0.006; Tanzania: 0.838 vs 0.914, p = 0.094).

Conclusion

The economic burden (patient cost) and health utility impact of multimorbidity are substantial in Malawi and Tanzania, with significant differences in costs and health utility scores observed between individuals with and without multimorbidity. Multimorbidity increases medical costs, particularly in Tanzania, and is associated with lower health utility at admission. Targeted, context-specific strategies are needed to manage multimorbidity and optimise health outcomes, resource use, and financing priorities.

The fiscal sustainability analysis of Burkina Faso's free healthcare policy for maternal and child health

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Background

In April 2016, Burkina Faso implemented a free maternal and child healthcare program. This study investigated the program's fiscal sustainability by examining ways to finance the program's implementation effectively.

Methods

A slightly modified four-dimension definition of fiscal space was used to examine the fiscal sustainability of the free healthcare program. Secondary data from various sources was primarily used in this analysis. The statistical analysis included a desk review, an estimation of the optimal tax rate, an analysis of official donor aid, and a data envelopment analysis to assess the efficiency of the delivery of healthcare services.

Results

Under scenario 1, the free healthcare program will consume 14.60% and 16.00% of the MoH budget in 2018 and 2023, respectively, equalling 0.40% and 0.50% of the overall GDP in those years. The burden of the program will be substantially lower under scenarios 2 and 3, ranging from 11.70% to 14.60% and 9.70% to 14.60% of the MoH's budget, respectively. Furthermore, the estimated optimal tax rate for expanding the

fiscal space was 24.00%, indicating that a slight increase in total tax revenues would be sufficient to finance the program. The findings also reported an average technical efficiency score of 0.73 over 2008 to 2018, suggesting there may be rooms for additional savings.

Conclusion

Together with a firm commitment from the government, increasing domestic resource mobilization, reducing healthcare inefficiencies, and improving the coordination of joint financing arrangements are critical actions to pursue program financing.

Keywords

Maternal, Child, Free healthcare policy, Fiscal, Sustainability, Burkina Faso

Basic Health Care Provision Fund Contribution to Primary Healthcare Financing; A Deep Dive into Two Nigerian States

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Background

Nigeria's health systems like other low-to-middle-income countries, have faced challenges such as underfunding, inequitable resource distribution etc. towards achieving universal health coverage (UHC). In response, the Basic Health Care Provision Fund (BHCPF) was established in 2014 under the National Health Act. The BHCPF is a sustainable model for ensuring equity and financial risk protection of vulnerable populations, by guaranteeing access to a basic minimum package of health services. By providing direct facility financing for primary healthcare (PHCs) facilities, the BHCPF aimed to address the persistent underfunding, which has negatively impacted the quality of service delivered. HSCL conducted a study to assess BHCPF implementation in Gombe and Yobe States.

Aims an Objectives

This study aimed to evaluate the impact of the BHCPF on PHC financing and expenditure patterns at the PHCs.

Method

The study was conducted in 20 purposefully sampled PHCs across the 3 senatorial districts in each state. The study utilized a mixed-method approach comprising qualitative and quantitative data collection methods. This included financial data abstraction for 2022, document review, and key informant interviews to understand the financial management practices and expenditure patterns of PHCs.

Key Findings

In 2022, the monthly average revenue for the PHC was 873,652 and 603,586 in Gombe and Yobe State respectively. The Basic Health Care Provision Fund (BHCPF) emerged as the leading source of revenue for PHCs, contributing approximately 38% and 41% in Gombe and Yobe State, respectively. Other sources include drug revenue user charges, revenues from capitation from the state health insurance scheme, e.tc. The monthly PHC expenditure was 844,235 and N514,882 in Gombe and Yobe State respectively. Analysis of expenditure patterns revealed that drug and medical consumables consumed a significant portion of PHC budgets (50% in Gombe and 39% in Yobe). Additionally, ad-hoc healthcare worker expenses were notable (15% and 26% in Gombe and Yobe, respectively). These average revenues and expenditures also suggest that PHCs have low margins, especially in Gombe states for savings and are susceptible to financial shocks.

Conclusion

The BHCPF has emerged as a critical component of Nigeria's PHC financing landscape. Since its inception in 2019, the fund has demonstrated a substantial contribution to the financial sustainability of PHCs, often serving as a significant revenue source. By augmenting fiscal space, the BHCPF has facilitated increased staffing, improved infrastructure, and enhanced access to essential medicines. However, the sustainability of the BHCPF and its optimal allocation within healthcare facilities warrant further investigation. There is a need for a concerted effort to increase DFF to the PHCs, as only then can we drive closer towards achieving UHC.

Economic Evaluations of Health and Nutrition Interventions in Africa

A Cost-Benefit Analysis of Edible Oil and Wheat Flour Fortification programs in Ethiopia: Return on investment

Elias Asfaw Zegeye *Josue Mbonigaba, Quentin Johnson*

Background and Objective

Micronutrient malnutrition remains a significant public health issue in Ethiopia, affecting most of the population. The purpose is to assess and illustrate the potential positive impacts of fortification on the Ethiopian economy and public health and to measure the investment and its return in economic, health and social sectors.

Methods

A cost-benefit analysis framework is applied. The costs and benefits of the wheat flour and edible fortification were measured in monetary units. A mixed approach consisting of primary and secondary data (including relevant literature review) was used to identify, measure, and value costs and benefits. Additional input validation was done for the list of indicators for CBA modelling.

Results

The estimated annual economic losses due to iron deficiency anaemia, folic acid & vitamin A deficiency in the Ethiopian population amount to $519,100,000 (0.62% of the estimated 2021 GDP). Inadequate vitamin A intake in 2020 accounted for over 2,750 deaths and over $50,000,000 in economic losses. Over 11 million children suffer from vitamin A deficiency. Over the next 10 years, this will result in over 32,000 deaths, almost $600m in losses, and 127 million children with inadequate vitamin A intake.

The weighted average benefit-cost ratio (BCR) is 13.0. In other words, every $1 invested in wheat flour fortification in Ethiopia can return $13.00 to the economy through improved health and higher productivity in the population and workforce. Assuming the estimated 10-year cost of oil fortification, every $1 invested in vegetable oil fortification in Ethiopia has the potential to return $2.75 to the economy of Ethiopia. A combined investment in wheat flour and edible oil fortification programs of $2 will return $15.75 to the national economy.

Conclusion

The positive effects of wheat flour and edible oil fortification on public health are enormous. In Ethiopia, the fortification program for wheat flour and edible oil food vehicles has a positive economic return on the country's macro economy (GDP). Investing in the fortification program will yield a positive return (and benefit) to health and economic development. This could potentially be applied to other low-income resource countries.

Cost Analysis of Enhancing Adolescent Reproductive Health and Nutrition Project in West Harare, Ethiopia

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Background

Scaling up impactful interventions requires a detailed analysis of cost, not just in terms of immediate financial expenditure, but also with a view to long-term sustainability and affordability. To convey effectively, cost analysis should also take into account the "invisible" economic costs. Only by understanding the full spectrum of financial implications can we ensure interventions remain affordable, adaptable, and impactful in the long run.

Objective

The purpose of this cost analysis is to provide information for scaling up the existing interventions, and determine sustainability and affordability of similar projects.

Method

Cost data were analysed using activity-based costing, and total and unit costs were computed for three interventions, Village Saving and Loans Association, Social Analysis and Action and Government level intervention. Two data sets were used for the analysis; actual project expenditure and cost estimation model. In order to compare the actual project expenditure, a cost estimation model was developed that comprises the economic aspect of the project using standard procedure. The time horizon considered in this cost analysis report is from October 2016 to February 2020, a total of 41 months duration.

Results

Unit cost per adolescent girl and per group for Village Saving and Loans Association, based on the cost model, was found to be US$14 and US$317, respectively. However, the actual financial expenditure, per adolescent girl and per group was US$33 and US$ 719. Within individual, the unit cost for Sexual and Reproductive Health & Nutrition, and Life Skill intervention was (SRHN US$276 and Life skill US$292) per group and US$13 per individual, respectively. However, the actual expenditure was US$351 and US$16, respectively, for group and individual.

Estimated unit cost for Social Analysis and Action is found to be US$1,1344 and US$46 per group & per person. On the other hand, the actual expenditure was US$825 and US$28 per group and per person, respectively.

Government level intervention US$ 5,357 and US$ 4,643 per kebele were found in the actual expenditure and estimation model respectively.

Conclusion

The cost of implementing a program is important for future scale up decisions. However, relaying on actual financial data may mislead the implementation cost magnitude as it does not consider non-monitory value of resources. This is one of reason for the difference between cost reports based on actual financial expenditure and cost report based on cost assumption model of this report.

Costs analysis of hypertensives patients' health management in urban Burkina Faso

Rosemonde Maïmouna Guissou *Institute for Health Sciences Research, Ouagadougou, Burkina Faso*

Introduction

Hypertension, in addition to being the most prevalent chronic non-communicable disease (CNCD) in the world, is also a risk factor common to other major CNCDs. In sub-Saharan African countries including Burkina Faso, little is known on households' cost for hypertension management. Illness cost analysis is nevertheless essential for producing evidence for policy makers guidance concerning resource allocation in order to reduce disease burden and improve equity in care access. We analyse hypertensives patients' health management costs in urban Burkina Faso.

Method

A cross-sectional study was conducted in Ouagadougou city from November 2 to December 13, 2023.

Using a cost of illness study's design, 429 hypertensive patients for both public (249) and private (180) health sector of Bogodogo health district, were interviewed using a structured questionnaire. We present median costs and interquartile intervals. Costs were compared between both sectors using Wilcoxon-Mann Whitney test.

Results

Hypertension management monthly costs, which mainly include treatment (modern and/or traditional and/or alternative) and blood pressure measurement, had a median value of 20.95 USD [12.37- 37.11]. Some respondents had faced other types of expenses related to their hypertension during the last 12 months preceding the interview: hospitalizations (for 16.32%) with median cost of 268.35 USD [56.08 - 659.72] and other types of expenses (of which 134/154 were laboratory and/or imaging examinations) for a median cost of 54.84 USD [32.99 - 116.19]. 43.82% of respondents had one or more other CNCDs whose monthly management median costed 3.30 USD [0 - 15.61]. Also, the median total costs of the last doctor's visit were 17.24 USD [8.91 - 44.20].

There were no statistically significant differences between private and public sectors, except for hypertension management other expenses during the last 12 months and for last doctor visit costs which were higher in private sector, and also for other CNCDs monthly management expenses which were higher in public sector.

Conclusion

If the absence of significant difference between the monthly management costs for hypertensives patients in the two sectors reflects a harmonization of the treatments provided to all, questions remain about the weight of these costs on households in a country with a fixed minimum wage of 74.22 USD.
This reinforces the relevance of universal health insurance implementation as desired by the country.

Economic evaluation of caregiver interventions for children with developmental disabilities: a scoping review

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Introduction

African families with children with developmental disabilities (DDs) experience several challenges, including social isolation, stigma, and poverty. Most children with DDs remain unidentified and receive no formal support. Caregiver interventions are education and training models for carers of children with DDs which have been shown to be adaptable and low intensity in implementation. However, economic evaluation evidence on caregiver interventions for DD, which is important for effective resource allocation, is limited. This review aimed to describe the nature of evidence available and methodological aspects of economic evaluations for caregiver interventions for DDs.

Methods

This scoping review employed the Arksey and O'Malley framework and aligned with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR). Seven electronic databases, grey literature and cited references were systematically searched to identify eligible studies on economic evaluations of caregiver interventions for children with DDs published in 1993-2023. We assessed the quality of the included studies using the Drummond checklist. Data were systematically extracted, tabulated, and qualitatively synthesized using inductive thematic analysis.

Results

The searches yielded 7453 articles. Thirty studies met the inclusion criteria which focused on caregiver interventions for conduct disorders (n=8), autism spectrum disorder (n=6), attention-deficit/hyperactivity disorder (n=5), disruptive behaviour (n=5), behaviour problems (n=3), anxiety disorder (n=2), and language delay (n=1). The most used economic evaluation approach was trial based models (n=22), followed by decision analytic models (n=6)). The methods were not explicitly stated in 2 studies. Economic evaluation analyses included cost effectiveness analysis (n=13), costing (n=8), cost utility analysis (n=4), cost benefit analysis (n=1), threshold analysis (n=1) and combined analyses (n=3). Seven studies reported the interventions as cost effective, six studies reported the intervention to be cost saving, and one identified caregiver costs as a cost driver. The main identified methodological challenges were related to costing, outcome measurement in children and the appropriate time horizon for modelling.

Conclusion

Caregiver interventions demonstrate cost-effectiveness, and the available evidence supports the adoption of the interventions evaluated. Additionally, this review identified key methodological challenges and highlighted areas for further research to address these limitations. Caregiver interventions are a promising avenue to strengthen access and reduce costs associated with health services for children with DDs. Prioritizing more economic evaluation studies in this area would inform decision-making on efficient resource allocation, promote inclusivity and equitable access of services for children with DDs within the health system.

Economic costs associated with hearing loss in South Africa

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Background

Congenital hearing loss is a significant public health concern in South Africa and is influenced by various genetic, environmental, and healthcare-related factors. Its prevalence in South Africa is estimated to be 3 to 6 per 1,000 live births, which is higher than in many high-income countries but consistent with rates observed in other parts of Africa. The rising global prevalence of hearing loss is costly both in terms of the health and well-being of those affected in and in financial losses arising from their exclusion from communication, education and employment. Studies to date have addressed the causes, prevalence and the need for or feasibility of potential interventions to address hearing loss in South Africa but no attempt has been made to estimate the economic burden of hearing loss to the country.

Aim

The aim of this study was to estimate the economic costs and disability adjusted life years associated with congenital hearing loss in South Africa.

Objectives

To estimate the lifetime societal costs associated with congenital hearing loss in South Africa

Methods

We constructed a cohort-survival model to estimate the societal lifetime costs of congenital hearing loss. We estimated direct health care costs, education costs and productivity losses. Model inputs were derived from published literature review and consultation with experts. Analyses were implemented in Microsoft Excel, with sensitivity analysis conducted on selected parameters.

Key Findings

Congenital hearing loss is expected to cost society ZAR 1 040 218,06 over the lifetime of an individual. Most of these losses (54%) are due to reduced work productivity and special education special education resources among deaf children contributes 43% to total lifetime costs. Direct healthcare costs associated with hearing loss were approximately ZAR 366 million rand and only made up 3% of total lifetime costs.

Main Conclusion

There are substantial economic costs associated with hearing loss in South Africa. Early childhood interventions such as newborn screening and early identification, assistive devices and speech and language therapy intervention may reduce the particularly high costs associated with prelingual onset of severe to profound hearing impairment and may provide substantial returns on investment.

A costing analysis of a school-based health intervention addressing menstrual health and hygiene management in secondary schools in Uganda: a school-based cluster randomized control trial.

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(3) London School of Hygiene and Tropical Medicine, London, Ghana,
(4) MRC/UVRI and the LSHTM Uganda research unit, Entebbe, Uganda

Introduction

Poor menstrual health (MH) is associated with girls missing school. Evidence on costs and cost-effectiveness of interventions aimed at improving management of menstrual health in low resource settings is limited. The Government of Uganda school guidelines on menstrual health recommend the provision of clean, private toilet facilities, regular supply of water and soap, emergency supplies of pads, painkillers and training of teachers. Despite this, prior studies have shown these guidelines are not well implemented. We assessed the impact of a multi-component school-based intervention (MENISCUS) on education, health and wellbeing outcomes in a cluster randomized controlled trial in sixty secondary schools in Uganda. Thirty schools were randomized to receive the MENISCUS intervention. The MENISCUS intervention includes training of teachers to deliver puberty education, drama skits, provision of menstrual health kits to girls, provision of analgesics, training on pain management techniques and improving basic school water, sanitation and hygiene facilities.

Aims and Objectives

To

- estimate the incremental total cost of setting up and running the MENSICUS intervention;
- estimate the unit cost per student reached; and
- estimate the cost of scaling up the intervention to all schools in Uganda.

Methods

A costing framework was developed to identify cost centres for the MENISCUS intervention and an ingredient-based costing approach was used to collect set-up and implementation costs. Key Informant Interviews were conducted with stakeholders involved in implementing the intervention. Costs were collected from a providers' perspective. Financial and economic costs were identified from project accounts and process evaluation data and valued using an Excel based spreadsheet. All research costs were excluded. Costs were collected in Uganda shillings and converted to 2023 US dollars using the Bank of Uganda exchange rate of 1US$ = 3,662 UGX. Capital costs were annualized using Bank of Uganda discount rate of 11%. Costs were reported using the reporting guidelines in the 2022 Consolidated Health Economics Evaluation Reporting Standards (CHEERS) checklist.

Key Findings

The total incremental cost of setting-up the intervention was US$40,990 and the annual running cost was US$181,503, equivalent to a unit cost of US$6,050 per school, US$44 per student, or US$85 per female student. The cost of scaling up the intervention is US$ 22,140,814.

Conclusion

This study has provided costs estimates for implementing a school based menstrual health interventions in a resource limited setting where previously they didn't exist. Evidence provided from this study will inform programming and budgeting for menstrual health interventions.

Governance and Financing Transitions for Universal Health Coverage in Africa

2:00 PM–3:30 PM Friday, 03 March 2025

An Institutional Analysis of Secondary Hospitals Governance in Nigeria

Ajibola Ogunsola and Karen Grépin *University of Hong Kong, Hong Kong*

Background

The responsibility for secondary care, including functions related to the management of the hospitals providing such care, has been devolved to Nigerian states since at least the 1980s. To govern these secondary hospitals, states themselves have relied on some form of decentralized management structure. Hospital management boards (HMBs), semi-autonomous entities, were established to formulate working rules that serve as guide for decision-making at the level of the hospitals. The outcomes of governance processes in such an arrangement are likely to be determined, inter alia, by three institutional variables: the design of the working rules; the level of congruence in the interpretation/understanding of these rules; and

the degree of compliance with these rules as ensured through monitoring and sanctioning.

Aim

This study seeks to understand secondary hospitals governance processes in Nigeria by examining the presentations of the institutional variables identified above in the study context.

Method

We use Ostrom's Institutional Analysis and Development framework as the study's theoretical framework and adopt a comparative case study design. Cases were selected using a measure of bureaucratic performance to judge the institutional environment, following the assumption that the prevailing environment is likely to be an important influence on the way our institutional factors present. Two polar cases [states] – of good and poor bureaucratic performance – were selected to enable us to identify important and useful contrasts. In both study settings, we conducted in-depth interviews with bureaucrats at the HMB and hospital levels. We focused on individuals involved in routine activities, including drugs procurement, financing, and human resource management.

Key Findings

Preliminary analyses revealed notable between-case differences in the design of rules, especially in the components included in those rules. We found monitoring to be inadequate in both settings but note different strategies adopted by monitors when resources for monitoring were lacking. For example, rationing monitoring visits and leveraging the threat of visits. Analyses also revealed that a common sanctioning instrument in both our settings was staff transfers.

Conclusion

Our analyses add to broader understandings of governance processes in the health system literature. With respect to the study context, we identify areas where institutional reforms may be necessary and offer recommendations on what shape those reforms might take.

Rapid Assessment of Governance & Coordination in Nigeria's Community Health Workforce Programme – the Community Health Influencers, Providers & Services (CHIPS)

Abolade Oyelere, Kimberly Idoko, Yewande Ogundeji

Health Strategy & Delivery Foundation, Abuja, Federal Capital Territory, Nigeria

Background

The Community Health Influencers, Promoters & Services (CHIPS) Programme is Nigeria's flagship community health workforce programme which was launched in February 2018 with the stated aim of bridging the gaps in access to health care, improving the continuum of care, linking households to the healthcare systems, complementing national data systems, improving health outcomes, and strengthening the community component of Primary Health Care (PHC).

Goal

The goal of the assessment was to capture gaps, needs, challenges, and best practices in CHIPS Programme leadership, policies, and supportive supervision with the aim of generating, refining, and aligning on ideas to address gaps and challenges identified.

Methodology

The assessment was qualitative. It involved a desk review of CHIPS programme process and operational documents, guidelines, and tools as well as Key Informant Interviews with senior members of the CHIPS Programme Implementing Unit (PIU) and selected State CHIPS Coordinators on the gaps, needs, challenges, best practices, etc. around the programme's leadership, policies, and supportive supervision.

Key Findings

01 The assessment was qualitative. It involved a desk review of CHIPS programme process and operational documents, guidelines, and tools as well as Key Informant Interviews with senior members of the CHIPS Programme Implementing Unit (PIU) and selected State CHIPS Coordinators on the gaps, needs, challenges, best practices, etc. around the programme's leadership, policies, and supportive supervision.

02 On the policy side, the National PIU has made tremendous efforts to ensure a vibrant policy environment as there are policies, guidelines and tools covering almost every aspect of the CHIPS Programme. Yet, the process of getting end-users to fully internalise and implement these policies and guidelines could be much better than it currently is.

03 Across all levels, and particularly at the lower levels, the exercise of Supportive Supervision faces problems of infrequency and inadequacy. This is for various reasons ranging from insufficient funding to there being a multiplicity of supervisory tools which some of the supervisors have described as complex, competing priorities among supervisors, level of fit/proficiency among the supervisors, etc.

Conclusion

The National PIU requires deliberate steps towards strengthening its mechanisms for communication, regular interaction and visibility with relevant national and sub-national stakeholders and structures. In the future, a CHIPS Programme 2.0 may be considered with the full commitment of the states, supported by evidence clearly demonstrating the cost of not investing in the CHIPS Programme.

Universal health coverage in the context of its epidemiological and financing transition in Ivory Coast

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Background

In line with the global commitment towards universal health coverage (UHC), Ivory Coast is making a push to reduce out-of-pocket (OOP) expenditure and improve the breadth of access and the quality of health services by increasing the population covered, services covered and proportion of costs covered.
Despite considerable efforts, progress towards UHC targets in Ivory Coast has been slow. The low levels of public health financing and high reliance on external support are concerning given the impending donor transitions and reductions in concessional external financing for health. This delayed progress towards UHC is further threatened by a set of four interlinked health transitions: shifts in demography, disease burden, development assistance for health and domestic health finance. Achieving UHC within the context of these highlighted transitions requires intentional efforts and collaborations between multiple stakeholders within the health ecosystem.

Objectives

This study aimed to assess Ivory Coast's preparedness to finance and drive the universal health coverage (UHC) agenda within the context of changing health conditions and resource needs associated with the disease, demographic and funding transitions. Ivory Coast is undergoing transitions in the healthcare system that include a double burden of infectious and non-communicable diseases, and transition from concessional donor assistance towards domestic financing for health. These transitions will affect Ivory Coast's attainment of UHC.

Methods

We conducted a qualitative study, including semi structured interviews with relevant stakeholders at national levels in Ivory Coast. Data from the interviews were analysed using thematic analysis.

Results

Capacity gaps identified by respondents included limited knowledge to implement health insurance schemes at subnational levels, poor information/data management to monitor progress towards UHC and limited communication and interagency collaboration between government agencies and ministries. Furthermore, participants in our study expressed those current policies driving major health reforms like the National Health Act (basic-healthcare-provision-fund) appear adequate to support UHC advancement in theory, but policy implementation is a key challenge due to a lack of policy awareness, low government spending on health and poor evidence generation for information to support decisions.

Conclusion

Our study found major gaps in knowledge and capacity for UHC advancement in the context of Ivory Coast's demographic, epidemiological and financing transitions. These included poor knowledge of demographic transitions, poor capacity for health insurance implementation at subnational levels, low government spending on health, poor policy implementation and poor communication and collaboration among stakeholders. To address these challenges, collaborative efforts are needed to bridge knowledge.

Economic and Behavioral Insights into Malaria and Related Health Burdens in Africa

2:00 PM–3:30 PM Friday, 03 March 2025

The Economic burden and catastrophic health expenditures among children with sickle cell anaemia on households in malaria-endemic areas: insights from Uganda and Malawi

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(5) Training and Research Unit of Excellence, Blantyre, Malawi

Backgrounds

Chronic diseases such as sickle cell anaemia (SCA) frequently result in catastrophic health expenditures, often leading to substantial out-of-pocket expenditures. There is a dearth of evidence about the economic burden of children with SCA, especially in malaria-endemic regions. This study aimed to assess the economic burden of households with sickle cell anaemia and the incidence of catastrophic health expenditures in Uganda and Malawi.

Methods

This prospective cohort study was nested in a clinical trial of malaria chemoprevention alternatives with either weekly dihydroartemisinin-piperaquine or monthly sulphadoxine-pyrimethamine among children with SCA in Uganda and Malawi. The participants were children aged 6 months to 15 years receiving care in selected hospitals. The economic burden of sickle cell anaemia was determined by estimating the cost of illness from a household perspective by valuing and adding direct and indirect costs. We fit quantile regression models to identify factors associated with direct and indirect costs.

Findings

Of the 723 children enrolled with sickle cell anaemia, 437 were from Uganda, and 286 were from Malawi. The average ages were 7.3 years (SD 3.9) and 8.0 years (SD 4.1), respectively. The median annual costs were US$ 2,433 (SD 2,206) in Uganda and US$ 614 (SD 1,042) in Malawi. The main contributors to the economic burden were direct medical costs in Uganda, whereas in Malawi, indirect costs took precedence, as all direct medical costs are paid by the government. There was a significant association between direct costs and the wealth index, showing a negative correlation. Additionally, direct costs exhibited a positive association with malaria episodes. In contrast, indirect costs were positively correlated with hospitalisation rates and wealth index. The concentration index (CI) and concentration curves revealed a pro-rich distribution with values of -0.12 (SE = 0.00, P < 0.00) in Malawi and -0.23 (SE = 0.02, P < 0.000) in Uganda. This suggests that patients from poorer households incur higher direct costs. All households suffered catastrophic health expenditures, with the poorest quartile having the highest incidence at varying thresholds.

Conclusion

Households with children with sickle cell anaemia incur high expenditures that, for a substantial proportion of households, are considered as catastrophic. Malaria incidence, hospitalisation and wealth index were the main predictors of cost variability. There is a need to assuage the high expenditure burden among poorer households, especially in Uganda.

The role of risk perception and social networks in malaria preventive behaviours in Zambezi, Namibia

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Background

Malaria remains a significant public health challenge, particularly in sub-Saharan Africa. In the Zambezi region of Namibia, malaria transmission persists despite targets for elimination. Preventive measures such as bed nets, mosquito avoidance, and indoor residual spraying can mitigate malaria risk, but their effectiveness depends on uptake and compliance. Understanding the factors influencing preventive behaviours is key to optimising malaria control strategies. This study investigates how individual characteristics, risk perception, and the characteristics and preventive behaviours of individuals' social networks contribute to the adoption of malaria preventive measures.

Aims

To examine the impact of risk perception and social networks on the adoption of specific malaria preventive behaviours among individuals in Zambezi, Namibia.

Methods

A household survey was conducted in two regions of Zambezi province, Namibia (Aug 2022-Apr 2023). Respondents (18 years or over; n=1009) were asked about their perceived risk of malaria (scale of 0-10), preventive methods used, and demographics. Two preventive behaviours were examined: the use of bed nets and the use of other physical barriers to avoid mosquitoes (i.e., staying indoors at night or closing/using screens on doors and windows). An individual's social network was defined as individuals living in the same village. Probit and Ordinary Least Squares (OLS) regression models were used to estimate individual preventive behaviours as a function of individual-level risk perception and characteristics, as well as the average group-level preventive behaviours and characteristics of others in the same social network.

Key Findings

The majority of the population reported using bed nets (mean = 0.781, SD = 0.413), while the proportion using other physical barriers was lower (mean = 0.233, SD = 0.423). Findings suggest that the average bed net use within an individual's social network was not predictive of individual bed net use. Conversely, the use of other physical barriers was significantly influenced by the behaviours of the social network. When considering individual-level factors only, individual risk perception was associated with increased use of other physical barriers but not bed net use.

Conclusion

The findings underscore the importance of both individual risk perception and social networks in shaping malaria preventive behaviours. The absence of a relationship between the bed net use of an individual's social network and their own bed net use suggests that other factors, such as net availability, may play a role.

Potential opportunity costs for households of children who will receive a malaria vaccine through EPI in Burkina Faso and Mali

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Introduction

Introduction of a malaria vaccine will have economic implications to both the health systems and the households with children under 5 years of age who are the intended beneficiaries of this vaccine. Assessment of the opportunity costs to the households of utilizing a multi-dose malaria vaccine for their children is important to understanding the full cost/benefit of this life-saving intervention. Here we estimate the household costs associated with pursuing malaria vaccination for young children in Burkina Faso and Mali.

Method

We employed a structured questionnaire for the parents/adult caregivers of children who exited health facilities after receiving other childhood immunization services, the latter serving as a proxy for the malaria vaccine. Data was collected from 104 caregivers at 8 health facilities in Nongre-Masson and Nanoro health districts in Burkina Faso; and from 100 caregivers at 7 health facilities in Bougouni and Diema health districts in Mali. Both direct costs (e.g., transportation, food) and indirect costs (e.g., lost income due to time forfeited for traveling and wait time) to the households were estimated.

Results

Most caregivers travelled to the health facility either on foot or on a bicycle (70.2% in Burkina Faso, and 66% in Mali). None of the respondents reported having made any direct payment for receiving immunization services in Burkina Faso. In Mali, 2.2% of caregivers incurred payments for the visit, specifically for the immunization card and/or gloves. On average, caregivers spent 144 minutes in Burkina Faso and 101 minutes in Mali from their arrival at the health facility to the completion of the visit. The total cost per episode of vaccination to the households was estimated to be US$3.10 in Burkina Faso and US$3.03 in Mali. Lost income was the major driver of the household cost, accounting for more than 85% of the cost in both countries. Transportation costs constituted an average of 8.6% and 12% of the total cost to the household in Burkina Faso and Mali, respectively.

Conclusion

The opportunity cost of time lost for accessing vaccination for children to the household is not small. This highlights the importance of leveraging existing health facility visits for the administration of the malaria vaccine, where possible.

The Financial and Economic Costs of Malaria Treatment at a Public Healthcare Facility in Nigeria: Evidence from a University Medical Centre

Charles C Ezenduka *University of Nigeria Enugu Campus*

Background/Objective

Malaria remains a leading cause of death and disability in Nigeria, constituting huge economic burden on the population. Current evidence on the facility costs of treatment remains essential to enhance the efficiency of resource allocation decisions for improved malaria control and elimination. This study estimated the financial and economic costs of treating uncomplicated malaria through a public healthcare facility in Nigeria.

Methods

A cost of illness study approach was used to estimate the cost of treating uncomplicated malaria in a secondary health facility setting. Prospective and retrospective data were collected within a 3-month period of between September and November 2021. From a prover perspective, hospital costs were estimated from a standard and comprehensive costing procedure. Capital and recurrent items were identified, measured and valued using the ingredient approach, combined with step-down methodology. The costs of capital items were annualized according to their useful life years. Costs attributable to malaria treatment were calculated on the basis of proportion of treated malaria cases to the total outpatient visits. The costs were broadly divided into financial and economic costs. Costs were calculated in local currency [Naira] and converted to US dollars at 2021 foreign exchange rate [US$1=N448].

Results

The total annual cost of N84.548 million (US$188, 723.51) was spent by the facility on the treatment for uncomplicated malaria, at US$32.48 per case, representing about 25% of the hospital's total expenditure in the study year. Personnel accounted for 77% of total expenditure, followed by antimalarial medicines at 8.7%. The financial cost of treatment amounted to US$216,869.50 per annum, at US$37.33 per case. More than 45% of outpatients' visits were treated for uncomplicated malaria. Changes in personnel costs, drug prices and malaria prevalence significantly impacted the study results, underscoring the need for improved efficiency in the use of hospital resources in the management of malaria cases in the facility.

Conclusion

Findings suggest that malaria treatment at the facility consumes a substantial amount of facility resources representing up to a quarter of the hospital budget. The costs were driven mainly by personnel and a high proportion of malaria cases, indicating a scope for enhanced efficiency of resource utilization to prevent wastages and reduce costs to the provider and ultimately the patient. The study findings will contribute information to planning to enhance the efficiency of malaria control and elimination. The high budget implication underscores the need for continued funding support for malaria control in Nigeria.

Economic analysis of two models A and B for community-level malaria management by Community Health Workers (CHWs) in Côte d'Ivoire.

Karna Georges Kone *Muso health, Montréal, QC, Canada*

Background

In Côte d'Ivoire, at the community level, the health system's response to malaria focuses on prevention and community-based care. From a resource rationing perspective, the Global Fund has undertaken a reflection on malaria service delivery models for community health workers to determine the most efficient option to support implementation. In this context, this comparative study of two intervention models for community-level malaria management was conducted.

Methodology

The approach is based on the analysis of secondary data from models A and B, supplemented by interviews with key stakeholders in malaria control and community health in Côte d'Ivoire. It made it possible to inventory the available resources and the resources consumed for the implementation of the community activity package for malaria control. The activities for which the budgets of each funding source were committed have been identified and costs have been associated with them. The analysis of the cost structure made it possible to identify the variables likely to impact the budgets.

Findings

The estimated budget for Model A is 5.925 million euros and for Model B is 4.453 million euros in 2023. Model A has a lower ratio, at 0.41 euros per inhabitant per year compared to 1.20 euros per inhabitant per year for Model B. Model A has a lower overall CHW budget ratio (521.7 Euros per CHW per year compared to 2,158.5 Euros per CHW per year for Model B). The HR budget ratio per CHW per year is 273.8 euros for Model A and 391.8 euros for Model B. The comparative analysis of the budget structures of the two models shows that 1% of Model A's budget is allocated to the health information management system, compared to 44% of Model B's budget.

Conclusion

At the end of this quick evaluation between model A and model B, it appears that model A seems more efficient than model B in terms of case management, while model B seems more efficient than model A in terms of system strengthening.

Digital Health Innovations and Data-Driven Strategies for Health Equity and Access

2:00 PM–3:30 PM Friday, 03 March 2025

How is data and information on health at the community level generated and managed for addressing health issues within community health systems in Nigeria?

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Background

Strengthening Health Management Information Systems (HMIS) at all levels of the health system, including the community level is vital for optimizing healthcare and achieving healthcare goals. However, there is limited knowledge on how health data and information is collected, stored, and used at the community level. It is also not clear how they are linked to the higher levels of the health system such as the primary healthcare (PHC) level.

Aim

This study assessed the types of health data that are collected in communities and the overall data and information system practices within communities, within the construct of community health system, across three states in Nigeria.

Methods

Data was collected qualitatively through 90 in-depth interviews (IDIs) and 12 focus group discussions (FGDs) with purposively selected community members, formal and informal health providers, including community health workers in Kano, Anambra and Akwa-Ibom states, Nigeria. Data analysis was guided by the Expanded Health Systems Building Blocks framework, which gives prominence to communities within health systems. The data from IDIs and FGDs were thematically analysed into three broad themes - types of data collected within the community health system, data transmission and management, and the

challenges of HMIS practices within the community health system.

Results

Various types of data, including patient-specific records and community health activity data, are collected at the community level and transmitted through multiple channels to higher levels of the health system for decision-making. This process involves formal and informal health workers, community-based groups, and organizational intermediaries. However, significant challenges persist, such as the absence of specialized personnel for data collection, limited data input from informal providers, difficulties in reporting data to higher levels, and fragmented data management practices. These issues are compounded by inadequate infrastructure and a lack of centralized storage and coordination, leading to gaps in data quality and effective utilization.

Conclusion

Unstructured health data and information systems exist at the community level, but they are not optimised in both collection and use. There should be investments in collection and use of health data that are generated at the community level, especially those collected from outside primary healthcare facilities. Implementing a unified digital strategy for HMIS can significantly improve data management and healthcare delivery at the community level. This study provides valuable insights for policymakers to enhance the effectiveness of HMIS for evidence-based decision making and overall health system decision strengthening.

Prediction of Retention Rates using Machine Learning: A Case Study of Tanzania's Improved Community Health Insurance Fund (iCHF)

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Introduction

Developing countries like Tanzania rely heavily on out-of-pocket (OOP) payments to finance health. Unfortunately, these OOP payments often expose patients to catastrophic health expenditures (CHE), which hinders progress toward universal health coverage (UHC). Tanzania introduced an improved Community Health Fund (iCHF) in 2017/2018 as a prepayment mechanism to reduce the burden of

healthcare costs on its population. To our knowledge, no study has been conducted in Tanzania to determine the iCHF membership retention rate using secondary data.

Aim

To develop a machine learning model for predicting iCHF membership retention using 2019/2020 and 2020/2021 data.

Methods

This retrospective study targeted 4,020,750 beneficiaries registered in the Tanzania's iCHF health information management system. Claims data was retrieved from iCHF's electronic database covering the period from 2019 to 2021. A logistic regression model was used as the modelling approach. Confusion matrix was used to calculate model performance metrics such as Area Under Receiver Operating Curve (AUC-ROC), accuracy, sensitivity, and specificity.

Results

Annual membership renewal rates in 2019/2020 and 2020/2021 were comparable at 71.5% and 74.8%, respectively. The logistic regression model produced an AUC-ROC of 0.61 indicating a slight better performance than a random classifier with AUC-ROC of 0.5. Using a 0.5 cut-off the model had an accuracy of 71.4%, sensitivity of 99.8% and specificity of 2.6%. The model's performance significantly improved by adjusting the prediction threshold from 0.5 to 0.7, which changed the accuracy to 60%, sensitivity to 62%, and specificity to 53%.

Conclusion

The findings demonstrate the potential of data mining and big data analytics techniques in health insurance data, which is highly underutilised in developing countries. The study has also demonstrated that machine learning models can be trained on iCHF data. Recommendations from this study provide vital considerations in the design of future databases so that they can generate high-quality secondary data.

Leveraging digital technology for health literacy and health equity; the viability of integrating activities of community heath teams with digital interactive engagement of their catchment population; a context analysis of Uganda

Irene Jean Kagogwe *University of Leeds, Leeds, United Kingdom*

Digital health technology has demonstrated effectiveness in streamlining health systems' data management, administration, and health service delivery. The World Health Organization, however, equally emphasizes development of digital health interventions for persons and the wider population. This would enhance demand and strengthen health equity by reducing health illiteracy. Health literacy empowers people to self-manage, seek timely care and proactively participate in building resilient health systems. This warrants innovative response to mitigate the disquieting low levels of health literacy predominantly in sub Saharan Africa.

Aim

The study aimed to establish the practicality of leveraging Village Health Teams' digital systems in Uganda, to integrate interactive engagement by the catchment populace served to enhance health literacy and equity.

Results

The objectives of the study were to; a) find out how the social, economic and governance context of Uganda enable or inhibit exploiting the existing digital system of community health workers to advance health literacy for the wider population and b) analyse the possibility of up-taking digital health tools by the catchment populace.

Methodology

A document review was conducted to extract data from policy papers, guidelines, implementation plans and program evaluation reports to construct a context case for Uganda. Relevant ministry digital archives and online libraries of funders and implementation partners were searched for publicly available documents. Data extraction was aided by RQDA and Excel Spreadsheets plus a modified qualitative data extraction tool of JBI. Two independent coders collaborated to develop codes deductively, and conflict was resolved by consensus. Key observations were gleaned, and a framework approach was adopted for data analysis.

Main Results

the main findings indicated that; a) digital health technologies are socially acceptable and they reduce the gender-driven digital divide b) local implementers can ably adapt, configure and support applications c) there is existing delivery infrastructure like electricity and broadband connectivity, though with inconsistences in supply, d) digital health interventions by community health teams are well streamlined in

Conclusion

Indicated opportunities can be harnessed to create an effective population-wide health digital literacy intervention to accelerate demand for strategic health services like preventive care.

Leveraging Digital Health Innovations to Enhance Prevention of Mother-to-Child Transmission Coverage and Mitigate HIV Transmission in High-Risk Areas: A Case Study from Zamfara State, Nigeria.

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Background

Zamfara state is among the states with the least coverage of Prevention-of-Mother-to-Child Transmission (PMTCT) in Nigeria. The precarious security situation in the region presents formidable obstacles to ensuring consistent healthcare delivery, thus impeding the ambitious target of eradicating the transmission of HIV from mothers to child. Urgent and innovative strategies are imperative to enhance service provision and coverage. These measures aimed to increase PMTCT uptake base on the national guidance on PMTCT intervention.

Descriptions

A robust data visualization dashboard was set up to analyse and classify Local Government Areas (LGAs) according to security levels (segmented as Red, Yellow, and Green). This thorough analysis guided the formulation of targeted approaches to augment PMTCT (Prevention of Mother-to-Child Transmission). The project's digital health strategy entailed the integration of DHIS2, PowerBI, and LAMISPlus (EMR) to enhance data collection, analysis, and visualization. This integration facilitated real-time data monitoring and focused resource allocation. The hub-and-spoke model further expanded PMTCT services from the existing 13 hubs to 89 Primary Health Care (PHC) centres that serve as spokes across all LGAs. Collaboration with local stakeholders played a pivotal role in the efficient implementation of PMTCT services throughout the high security LGAs. In this context, PMTCT coverage denotes the percentage of pregnant women (PW) who received PMTCT services against the established target, whereas the positivity rate signifies the proportion of PW who tested positive for HIV out of those tested.

Results

The analysed data from July 2023 to June 2024 revealed an increase in PMTCT uptake from 78% to 100%. Of the 52,571 new antenatal care (ANC) bookings that were documented and tested for HIV, 70 new cases of HIV-positive individuals were identified and initiated on treatment.

Conclusion

The utilization of automated data visualization tools enhanced data analysis, strategic decision-making, and efficient allocation of resources, resulting in substantial enhancements in PMTCT uptake in all the LGA in Zamfara state. This strategy stands as a paradigm for harnessing digital health solutions to accomplish vital public health goals particularly in regions with high security risks.

Keywords

Digital health, PMTCT, HIV, DHIS2, PowerBI, LAMISPlus.

Assessing the Digital Maturity of Basic Healthcare Provision Fund Gateways at the State Level in Nigeria

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Background

The implementation of the BHCPF across different gateways (State Primary Healthcare Development Agency-SPHCDA and State Health Insurance Agency - SSHIA), has improved healthcare funding, demand and access to quality of care, and capacity building of healthcare workers. However, there is a dearth of comprehensive and accurate data to measure the status of the program, which undermines efforts to adequately monitor and optimize the performance of the BHCPF program.

Aims and Objectives

This study seeks to assess the digital maturity and obtain a comprehensive overview of the current state of the BHCPF monitoring, learning and evaluation (MLE) system across the gateways at the state level.

Methods

The study was conducted in six states (Abia, Edo, Gombe, Ondo, Plateau, and Sokoto) representing the six geopolitical zones of Nigeria. A 37–item structured questionnaire was designed to capture a wide range of digital maturity indicators such as digital infrastructure, processes, and human resource capabilities. Each response was scored on a scale of 1 to 5, with 1 signifying "No maturity " and 5 representing "Advanced maturity " to arrive at a composite score which was categorized into five (5) distinct maturity levels:
No Maturity (0 to 37); Low-Level Maturity (38 to 74); Mid-Level Maturity (75 to 111); High-Level Maturity (112 to 148); and Advanced-Level Maturity (149 to 185).

Key Findings

Findings from the study revealed that all the six (6) states are within the mid and advanced-level maturity score ranges. This indicates significant progress in digital capabilities with none in the no-maturity and low-level maturity score ranges. Across the two gateways (SPHCDA and SSHIA), Plateau (135), Gombe (126), Edo (124), and Sokoto (113) states showed a high-level digital maturity. Only Ondo State (156). In the SSHIA gateway achieved an Advanced digital maturity level, indicating a strong commitment to digital transformation, while Abia state had the lowest digital maturity level (91). The result indicates that the states should focus on improving their current efforts and invest more in innovation to reach higher digital maturity levels.

Conclusion

The assessment of the BHCPF across the six Nigerian states shows significant digital maturity. Generally, all states fall within the mid- to advanced-level maturity range. However, to further optimize data quality, decision-making, and health outcomes, an ICT-driven monitoring, learning, and evaluation system is essential.

Prescription Drug expenditures and utilization - an approach to examining policy, enablers and access factors in the US State Medicaid

Kwesi Eghan *Management Sciences for Health, Arlington, VA*

Background

Prescription drug expenditures and utilization are the fastest growing and most widely varying expenditures within Medicaid programs across US states. The passage of the Affordable Care Act (ACA) in 2010 and the subsequent Medicaid state expansions resulted in substantial health insurance coverage gains among several demographics. It is essential for US policymakers, health plans, including State Medicaid implementers, to recognize the determinants of state-level pharmaceutical expenditures to

influence priority and budget setting, identify effective pharmaceutical expenditure control strategies, and improve the effectiveness of state Medicaid resource allocations.

Aim

To identify the predictors of state-level Medicaid drug expenditures, examine the effects of the interactions between these predictors on Medicaid drug expenditures after the introduction of ACA and estimate a Medicaid pharmaceutical use and expenditure model

Methodology

The study's unit of analysis is the US State Medicaid program. Our study design utilizes a cross-sectional, retrospective study using secondary health insurance claims data and state-level demographic, policy and health service need data. A total of 26,815,541 Medicaid drug claim records equivalent to an average of 76,615 drug claims per state and 2,100 state demographic variables were retrospectively analysed. The dependent variable is the total Drug Expenditure measured as prescription medicines reimbursed per eligible resident per year (Medicaid drug PerCapitaExp). Anderson's behavioural model of health services use was adopted as the conceptual framework to identify and analyse the 53 independent variables. The study employs a state level panel data set covering the period 2009-2015 (n=350) before and after the ACA to examine the importance of demographic, need for health care, economic and policy variables for explaining variations in per capita Medicaid pharmaceutical expenditures all US states (n=350). We performed econometric analysis to estimate parameters for the regression model. Without an a prior knowledge of best fit model estimates for drug expenditures within Medicaid both fixed effect (FE) and random effect (RE) panel regression models were estimated

Results

Estimated coefficients reveal significant influences on drug expenditures from state non-drug Medicaid spending, proportion of males in the population, and provider education programs on generics. The random effects (RE) regression model explains 52.6 % of variation in the dependent variable, a very good fit for panel data. Coefficients for several variables included in the model, (e.g., Per capita prescriptions, proportion of males, and provider generic education were not statistically different from zero. Including an interaction term between ACA Expansion and the percent of state Medicaid expenses reimbursed by the Federal government yielded a negative -significant effect on state level drug expenditures.

Conclusion

The study adds to the conceptual understanding of the determinants of pharmaceutical expenditures within health systems and within third party health payer programs in support of Universal Health coverage.

Community-Based Health Financing and Primary Care Sustainability in Africa

2:00 PM–3:30 PM Friday, 03 March 2025

Assessing the Viability and Impact of Community-Based Health Insurance Scheme (Cbhis) in Nigeria: A Systematic Review

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Background

Achieving universal healthcare coverage (UHC) remains a considerable challenge in developing countries, where out-of-pocket (OOP) expenses for medical services burden a significant portion of the population. In Nigeria, where many healthcare costs are paid directly by individuals, Community-Based Health Insurance Schemes (CBHIS) have emerged as a promising alternative to traditional user fees. These schemes are designed to offer affordable healthcare, particularly to those in informal and rural sectors. Despite their potential benefits, CBHIS in Nigeria are hindered by low enrolment rates, infrastructural challenges, and insufficient funding.

Aim and Objectives of the Research

This study aims to review and assess the viability and impact of CBHIS in Nigeria. It specifically seeks to explore factors affecting enrolment and willingness to pay (WTP) for these schemes, evaluate their impact on health outcomes and service utilization, and examine factors influencing the overall effectiveness of CBHIS within the community.

Methods Used

The research involved a thorough literature search across five electronic databases and grey literature, focusing on English-language publications from 2012 onward. The search strategy utilized relevant keywords and synonyms. The methodological quality of the studies included was evaluated using the STROBE and CASP tools for quantitative and qualitative research, respectively.

Key Findings

The review identified 11 studies from an initial pool of 883 articles that met the inclusion criteria. The findings showed high willingness to enrol (WTE) at 91.1% and willingness to pay (WTP) at 90.2%, with service satisfaction reported at 68.0%. Key determinants of WTE and WTP included educational attainment, household size, marital status, income, occupation, and age. Additionally, factors such as proximity to healthcare facilities, availability of free or subsidized services, and qualified healthcare staff influenced WTE and WTP. The introduction of CBHIS correlated with increased attendance at antenatal clinics and

outpatient services, offering notable benefits like free healthcare for pregnant women and young children, improved access, and more efficient services. However, WTP was significantly higher among urban residents compared to rural ones, reflecting socio-economic disparities. The study highlights a high level of WTE and WTP but indicates moderate service satisfaction, awareness, and knowledge of CBHIS.

Conclusion

CBHIS demonstrate significant potential to improve healthcare access and reduce out-of-pocket costs. However, to fully realize these benefits, there is a need to enhance awareness and education, provide financial support to low-income households, and implement targeted policies to optimize the scheme's effectiveness and contribute to broader healthcare coverage in Nigeria.

Direct financing of primary health facilities in sub-Saharan Africa: Are there lessons for Malawi?

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Background

There has been uneven progress made in improving quality and coverage of health services and ultimately health outcomes in low –and middle-income countries and sub-Saharan Africa (SSA) in particular, where for example, maternal health outcomes remain extremely poor and inequitable. These poor and inequitable health outcomes are linked to low investments in health, and inefficient and inequitable health spending among other causes. To overcome these challenges, several SSA countries, have begun implementing performance-based financing (PBF) and direct financing facility (DFF) in primary health facilities. However, the evidence of their impacts on quantity, quality, and cost-effectiveness of health services among others, remain mixed. We aimed at synthesizing the evidence to date, and examine its implications for primary health facilities financing in the Malawi context.

Methods

We conducted a scoping review of peer reviewed journals in PubMed, BMC, PLOS, Lancet, Hinari and grey literature using key search terms such as: 'performance based financing – PBF', 'pay for performance', 'P4P', 'performance based incentives', 'direct financing facility', 'direct financing facility Kenya, Tanzania etc', 'PBF sub-Saharan Africa, 'PBF Kenya, Tanzania, Nigeria, Zambia, Malawi etc'; The Inclusion criteria was any

article on health financing reforms: PBF and DFF that was published after 1995 (at the commencement of extensive health financing reforms in SSA).

Results

A lack of resources at the facility level is commonly identified as an important constraint in improving primary healthcare. A common response to this is to seek to provide additional resources, increased autonomy and an improved performance focus through PBF and DFF schemes. PBF schemes are widespread across SSA, complex and were even piloted in Malawi (with mixed results), but are rarely nationwide or fully integrated into national systems. In contrast, there are several examples of national DFF schemes in East Africa. Existing cost-effectiveness evidence of both PBF and DFF schemes does not suggest they are cost-effective against the threshold used in the Malawi Essential Health Package (US$61 per capita per annum). However, there may be alternative ways of assessing their value for money.

Conclusion

The design of any direct primary facility financing in Malawi needs to engage with questions around cost-effectiveness, whether it is trying to achieve autonomy or incentives for facilities, trade-offs between simplicity and complexity, and the need to ensure both community involvement and supportive supervision from the national level to the district and the district to the facility.

How can household and community-led activities that address social determinants of health be formally integrated into the primary health care system? - Reflections from three Nigerian states

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Introduction

Contextualized approaches to health promotion and disease prevention, address social determinants of health (SDH), hence the committee on SDH recognizes individuals (households) and communities as the micro and meso levels entry points respectively, for addressing SDH. This paper highlights contextual approaches that have contributed to community health, and how these can be equitably integrated into the formal primary health care (PHC) system.

Methods

A qualitative study was conducted in three contextually different states: Akwa Ibom, Anambra and Kano. A total of 61 in-depth interviews (IDIs) were conducted across the three states, with formal healthcare providers (11), informal healthcare providers (31), traditional and religious community leaders (19) while twelve FGDs were conducted with community members (men and women groups). Manual thematic analysis was conducted, guided by an Expanded Health Systems Framework.

Results

Various community-initiated health related activities were identified across study states, including health awareness programs, distribution of drugs and medical care, nutrition education, environmental sanitation and security initiatives to protect health facilities and providers, usually organized by the community youth groups. Other initiatives ranged from alliance/collaboration with the diaspora associations and indigenous philanthropists to utilizing community structures such as the women's group to organize health talks for community members. Enforcement of environmental sanitation and hygiene was the most common form of community health production, addressing SDH.

Conclusion

Community initiated activities encompass multiple sectors and stakeholders in the community, which are essential factors for addressing social determinants of health and equitable health care delivery. Going a step further, to contextually integrate these activities into the formal primary health care system will enhance health community health service access and delivery, which is key to universal health coverage.

Sustaining the functionality of PHC facilities through user fees and its implications for out-of-pocket expenditure: Findings from a case study on the policy and practice of task-shifting for maternal health services in Nigeria.

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Background

The 1987 Bamako Initiative recommended the establishment of a drug revolving fund (DRF) scheme to ensure the availability of essential drugs in primary healthcare (PHC) facilities. The DRF scheme required primary healthcare facilities to request user charges from clients for essential medicines at a low mark-off

to reduce the cases of 'stock out' in PHC facilities. Many PHC facilities in Nigeria's Federal Capital Territory (FCT) face gaps in manpower, commodities, and infrastructure needed to deliver maternal and other essential healthcare services. Our case study sought to understand the influences and influencers of the policy and practice of task-shifting for maternal healthcare services in Nigeria's FCT.

Methods

Our case study was methodologically grounded in interpretive policy analysis. We engaged policymakers, development partners, regulators, and primary healthcare workers with interviews and focus group discussions. We analysed relevant policy documents and the transcripts of interviews and focus group discussions to understand how task-shifting was viewed and enacted within primary healthcare facilities for maternal health services.

Findings

We found that there were significant gaps in the manpower, infrastructure, and commodities required to deliver maternal health services at PHC facilities. Over half of the PHC facility workforce were 'volunteers', without formal contracts for remuneration but dependent on meagre stipends funded by facility-generated revenue. We also found that user fees were frequently paid for maternal health services such as childbirth and family planning. PHC facility managers were guided by the principles of the drug revolving fund to request user fees from clients. However, the user fees requested were not required to cover the costs of essential drugs only. Rather, user fees were also collected to raise resources to cover volunteer stipends and to provide essential commodities and basic infrastructure - a transformation of the 'drug revolving fund' to a 'facility sustenance fund'. We deduced that higher than expected user fees would have been requested to cover facility needs to address the gaps in manpower, infrastructure and commodities. This could potentially cause significant increases in out-of-pocket expenditure for clients at PHC facilities.

Conclusion

The delivery of maternal health services in FCT primary healthcare facilities is affected by gaps in manpower, commodities, and infrastructure. To address these gaps, higher user fees (above the expected user fees for the drug revolving fund) are paid by clients. This has implications for out-of-pocket expenditure for maternal healthcare services in PHC facilities and could impede progress toward universal health coverage.

Primary Health Care Financing within Health Budgets: A Case Study of Three Nigerian States

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Background

Primary Health Care (PHC) is crucial for achieving Universal Health Coverage (UHC) in Nigeria, yet it remains critically underfunded. Despite the Abuja Declaration's target of allocating 15% of the national budget to health, only 5.75% of the 2023 budget was allocated, with an even smaller proportion directed to PHC. This study examines the allocation and utilization of funds for PHC facilities within the broader context of state health budgets, focusing on three states: Gombe, Kaduna, and Yobe.

Aims and Objectives

The study aims to assess the proportion of state health budgets allocated to PHC in Gombe, Kaduna, and Yobe states and the trend in State Primary Health Care Development Agencies (SPHCDAs) budgetary releases, evaluating how these allocations align with the broader goal of UHC.

Methods

A comparative analysis was conducted using budgetary data from the SPHCDAs of the three states. The study assessed the total health budget versus the proportion allocated to PHC, as well as the actual releases from 2020 to 2023. Key informant interviews with state health officials and PHC providers were conducted to gather qualitative insights into the challenges and successes of PHC financing.

Key Findings

The findings reveal that PHC allocations constituted a small fraction of the total state health budgets in 2022: 12% in Kaduna, 5% in Gombe, and 7% in Yobe. In addition, fund releases were inconsistent, with only 60-70% of allocated funds released annually on average. Out-of-pocket payments constitute 61% of PHC facility inflows in Gombe State and 25% in Yobe State, highlighting the financial burden on individuals. The introduction of the Basic Health Care Provision Fund (BHCPF) has not fully addressed the persistent gaps in funding and resource allocation, which continue to hinder service delivery and infrastructure improvements at PHC facilities. Systemic challenges, such as budget release delays of 6-9 months, were identified, further disrupting service delivery and increasing reliance on out-of-pocket payments.

Conclusion

While efforts to meet the Abuja Declaration target continue, there is a critical need for more strategic and

targeted allocations within state health budgets to prioritize PHC. A deliberate focus on enhancing PHC financing, through both state budgets and mechanisms like the BHCPF, is essential to strengthen service delivery and achieve UHC in Nigeria.

Promoting financial sustainability of public health facilities and financial protection of the population under Community Based Health Insurance (CBHI): lessons from Rwanda

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Background

In reforms to achieve Universal Health Coverage, financial sustainability of public health facilities is often not sufficiently prioritized, even though public health facilities are critical for ensuring access to basic healthcare services. Rwanda's CBHI is its largest health insurance scheme and covers healthcare services mainly through public facilities for more than 90% of the population. CBHI members are subject to a 10% copayment at the point of care. However, the incidence and magnitude of social cases (CBHI-enrolled patients unable to afford co-payments and non-members who cannot pay the full cost of care received) has not been systematically investigated, although is considered to have an increasingly negative effect the financial sustainability of some public health facilities. Auditor General Report of 2022 showed that receivables owed, due to social cases amounted to Frw 1.29 billion (≈ USD 1.2 million) in 22 hospitals. Facilities with many social cases may struggle to generate enough funds to procure necessary quality medical inputs in a timely manner, resulting in poorer quality of service delivery. Further, a high incidence of social cases can indicate a gap in financial protection; an issue which should be understood better, to aid Rwanda in achieving universal health coverage.

Objective

This study provides a better understanding of the extent and nature of the financial effect of social cases on the sustainability of public health facilities. This includes identification of the main causes of social cases and any systematic patterns in occurrence of social cases in Rwanda.

Methods

The study employs a mixed method approach that entails quantitative analysis of facilities' financial

information, key informant interviews and focus group discussions to understand the perspective of both the representatives of public health facilities as well as MOH/central government representatives. The sampling of facilities is purposive to ensure representation across all levels of public health facilities.

Results

Preliminary findings indicate that financial losses due to social cases are greater in higher level facilities (hospitals) and have a significant adverse effect on their operations. In addition, the cost of social cases to hospital is estimated to have increased by 111% from 2019 to 2022. This rise in social cases indicates a growing gap in the population's financial protection that requires urgent attention. Key policy recommendations from this study suggest the adoption of additional financial mechanisms for covering the cost of social cases, especially at higher level hospitals and a review of the co-payment policy for CBHI.

Mental Health

2:00 PM–3:30 PM Friday, 03 March 2025

Determinants of Subjective and Psychological Wellbeing for Adolescents and Young Adults in Sub-Saharan Africa: A Systematic Review and Case Study

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Background

Adolescents and young people make up the greatest proportion of the population of Sub-Saharan Africa (SSA). Understanding and improving their wellbeing should be considered a priority as it is associated with improved individual and societal wellbeing. Research on the determinants of wellbeing in adolescents and young people has been concentrated in the global north. Interventions designed for this context are unlikely to work in SSA due to the unique challenges faced in SSA.

Aims and Objective

The aim of this study was to systematically review the literature on the determinants of subjective and psychological wellbeing in adolescents and young people in SSA and organise these factors according to Bronfenbrenner's socio-ecological model.

Methods

This paper is a combination of a systematic review and a case study. The case study was included to triangulate the systematic review results, aiming to identify differences in the wellbeing of adolescents and young people between upper-middle-income and low-to-middle-income countries in SSA. The review was based on the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) statement guidelines. A systematic search of the following databases was conducted: EBSCOhost, PubMed, Scopus, Google Scholar, and the National Bureau of Economic Research (NBER). The search strategy was guided by literature. For the case study, wave 5 data from the National Income Dynamic Study, which is a nationally representative longitudinal study conducted in South Africa was used. A Probit regression with wellbeing as the predictor variable was used in the analysis.

Key Findings

7701 results were returned from the search. Of these, 19 were eligible for inclusion in the review. The review highlighted the importance of individual, interpersonal and community factors as determinants of wellbeing in the target population. The sample size for the case study was 6987, and age was restricted to 15 and 24 years. The mean age was 19.31 (SD=2.84). 53% were females, and 65% rated their wellbeing as average and above, while 17% were depressed, according to the CES-D-10 scale. Religion, aspirations, household income, socioeconomic status, trust in relatives and age were statistically significant predictors of wellbeing.

Main conclusion(s)

This is the first study to systematically review and organise the determinants of wellbeing for adolescents and young adults in SSA. There is a need for multi-sectoral policies to aid in improving adolescent wellbeing. More research studies that use longitudinal data collected exclusively from adolescents and young people need to be conducted in SSA.

Economic Evaluation of Mental Health Interventions for Depression, Bipolar Disorder, and Anxiety Disorders in Nigeria

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Depression, anxiety disorders, and bipolar disorder are chronic and highly disabling conditions that begin early in life and often persist, leading to substantial economic and health losses. This study underscores the

necessity for increased investments in mental health to mitigate the impacts of these conditions in Nigeria. Utilizing the mental health module of the OneHealth tool, we calculated treatment costs and health impacts from 2022 to 2042, assuming a linear increase in treatment coverage. We incorporated a 5% improvement in both work ability and productivity due to treatment, mapping these improvements to current labour participation rates and GDP per capita. The net present value of investments required from 2022-2042 to significantly enhance effective treatment coverage for depression, anxiety disorders, and bipolar disorder is estimated at US$ 6.3 billion and US$ 10.7 billion for moderate and aggressive scenarios, respectively. Our analysis highlights the profound economic burden of mental health conditions on Nigeria and illustrates the substantial health and economic benefits from investing in evidence-based interventions for these disorders. To diminish the adverse effects of mental health conditions and enhance life expectancy and quality of life while reducing productivity losses, Nigeria should: strengthen mental health governance and legislation; enhance mental health financing; prioritize mental health interventions; and invest in the evidence-based models demonstrated in this study. These actions align with the overarching theme of fostering resilient and strong African health systems through informed health economics and policy strategies.

Addressing Disparities in Psychological First Aid Awareness, Training and Practice Among First Responders in Nigeria

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Objectives

The aim of this study was to examine if and how first responders in Nigeria provide Psychological First Aid to emergency victims. Key objectives include assessing first responder awareness of Psychological First Aid, determining their level of PFA training and level of PFA utilisation with emergency treatment

Methodology

A descriptive cross-sectional survey that adopted a mixed-method approach was utilised. This study was carried out among first responders living in Lagos State, Nigeria. The quantitative aspect of the study consisted of 386 respondents, while for the qualitative study, 17 participants were selected using snowball sampling across various strata of first responders based on their diverse roles and experience in emergency response.

Results

Findings from this study deduced that 59.6% of respondents were aware of, 27.2% were trained and 38.3% practised PFA. However, findings noted a significant difference in awareness based on education as persons with tertiary education were 4.21 times more likely to be aware compared to those without (OR=1.73-10.23). Qualitative findings revealed that respondents lacked access to opportunities to practice PFA due to the absence of protocols in their learning and practice environments.

Results

In conclusion, this study highlights varying levels of awareness and training in Psychological First Aid (PFA) among respondents, indicating both opportunities and challenges in preparedness for emergency response. Strategies that promote PFA awareness among older age groups should be developed and entry-level first responders should also receive PFA training.

Keywords

Psychological First Aid, First Responders, Emergency Victims, Nigeria.

Understanding the economic burden of Common Mental Disorders (depression and anxiety) among young people in Ghana: Qualitative Study

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Background

Evidence from high-income countries suggests that common mental disorders (CMD) among young people are associated with substantial economic burden. In Ghana, there is little evidence about the economic burden of CMD among young people. This study seeks to understand the financial and productivity losses of CMD in young people in Ghana, and the coping mechanisms used by affected households.

Methods

Twenty-five (25) participants were interviewed between February and June 2024 using a structured topic

guide. Participants were purposively sampled, including 6 young persons with CMD (aged 15-29) identified through formal and informal services, 3 caregivers (for participants under 18), 5 mental health providers, 8 key informants from district, regional and national levels with experience of mental health policy/legislation/service implementation, and 2 traditional and 1 faith-based healer (who provide alternative mental health support). The primary study sites were Kassena Nankana Municipality and West District (Upper East Region of Ghana). All interviews were audio recorded, transcribed, and translated from Twi/Kassim to English. Both inductive and deductive approaches were used to develop codes and sub-codes using QDA Miner Lite version 3.2. Codes were grouped into themes and analysed thematically.

Results

The findings indicate that most young people with CMD receive no treatment, since mild-moderate CMD is rarely reported or misdiagnosed. However, the minority who seek formal or alternative care for severe CMD experience significant economic burden. This arises from high cost of medication due to frequent shortages of free medicines in public facilities, cost of prayer rituals and spiritual sacrifices through alternative care, transport costs for follow-up reviews and accessing medications, and reduced income for caregivers. Economically active young people and caregivers reported job losses and reduced working hours. Those in education reported absenteeism and poor academic performance, limiting access to higher education.

The financial burden of CMD was exacerbated by poverty, preference for seeking care outside the immediate community due to stigma (contributing to high travel costs), medication shortages, misdiagnosis, negative experiences of services, and delaying care-seeking until crisis point due to poor recognition of milder CMD symptoms.

Family support, faith groups, and community associations were the main coping mechanisms. Additional support included NGOs donating medicines for those in financial need, and health care providers paying for clients' food and bills.

Conclusion

The finding from this study can inform measures to address the unmet needs of young people with CMD. Future studies should estimate the economic impact of CMD quantitatively and evaluate the cost-effectiveness of promising models of care such as school-based programmes.