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### COST-EFFECTIVENESS OF USING HYDROXYUREA TO TREAT SICKLE CELL ANEMIA IN UGANDA: A MODEL-BASED COMPARISON OF TWO DOSING REGIMENS

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**Background** Recognition of the burden of sickle cell anaemia (SCA) in sub-Saharan African (SSA) countries is increasing, with few therapies available for clinical management. Hydroxyurea is the only disease-modifying therapy that has proven feasible and clinically efficacious in low-income countries in SSA; however, the health economic implications of its use in this region have not been quantified. Thus, we examined the incremental cost-effectiveness of hydroxyurea given as a fixed-dose regimen or at the maximum tolerated dose (MTD).

**Methods** We estimated the cost of outpatient treatment at a specialized sickle cell clinic in Kampala, Uganda, from a provider's perspective. These estimates were used in a discrete-event simulation model to project mean costs (US\$), disability-adjusted life years (DALYs), and consumption of blood products per patient (450 ml units). We calculated cost-effectiveness as the ratio of incremental costs over incremental DALYs averted, discounted at 3% annually.

**Findings** For Ugandan patients under the age of 18, we predicted that hydroxyurea at the MTD would avert an expected 1.38 DALYs and save US\$ 111 per patient compared to standard care, while hydroxyurea at a fixed dose would avert 0.81 DALYs per patient at an incremental cost of US\$ 21. Additionally, we predicted that the fixed-dose alternative would save 9.2 (95% CI 9.0–9.3) units of whole-blood equivalents per patient, while the MTD strategy saved 11.3 (95% CI 11.1–11.4) units of blood per patient.

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### HEALTH CARE INEQUALITY IN UNJUST CIRCUMSTANCE – SRI LANKA EXPERIENCE

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**Objective** Sri Lanka has earned a strong reputation for ensuring universally accessible free health and education, gender equality and opportunity for social mobility since her independence. Nevertheless, during the period of protracted civil war, country encountered many challenges to ensure the viability of the social benefits equally throughout the country.

The main purpose of this study was to evaluate the impact of conflict on inequalities in health services provision and health outcomes between direct conflict-affected area and other areas of the country during the conflicts and early phase of the post-conflict period.

**Method** The main hypothesis of this study was internal conflict negatively affected to the health system in Northern Province and created a health inequality comparing rest of the country. The input process outcome model approach was used for analyzing the inequality in relation to investment to the health, health services provision and health status. Data sources were the Central Bank of Sri Lanka, Department of Census and Statistics, the Ministry of Health, United Nations Development Program and the World Bank.

**Results** There was a substantial shortage of key health care workers in the direct conflict-affected area during the in-conflict period. However, the government hospital beds density remains higher during the conflicts period and has been increased dramatically in early phase of the post conflict period. Low birth weight prevalence was less and there was no significant difference of major communicable diseases prevalence comparing with the national level.

Although Northern Province showed similar reducing trend of Infant Mortality Rate (IMR) with national level from 1997 to 2016, the Maternal Mortality Ratio (MMR) was significantly higher in Northern Province during the same period.

**Conclusion** This study reveals even though conflict related health inequalities are unavoidable, it was remained less in Northern Province in Sri Lanka during armed conflict period.

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### EQUITY, JUSTICE, AND SOCIAL VALUES IN PRIORITY SETTING: A QUALITATIVE STUDY OF RESOURCE ALLOCATION CRITERIA FOR GLOBAL DONOR ORGANIZATIONS WORKING IN LOW-INCOME COUNTRIES

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**Background** There is increasing acceptance of the importance of social values like equity and fairness in health care priority setting (PS). However, equity is difficult to define; it means different things to different people. How equity is understood in theory, may not align with how it is operationalized. There is limited literature on how development assistance partner organizations (DAP) conceptualize and operationalize equity in their health care prioritization decisions for low-income countries (LIC). We explore whether and how equity is a consideration in DAP's PS processes.

**Methods** A qualitative study involving 35 in-depth interviews with DAPs involved in health-system PS for LICs and review of their respective webpages.

**Results** While several PS criteria were identified, direct articulation of equity as an explicit criterion was lacking. However, equity was implied, by some responses, through prioritizing of vulnerable populations. Where mentioned, respondents discussed the difficulties of operationalizing equity, since vulnerability is associated with several, competing factors including gender, age, geography, and income. Some respondents suggested that equity could be operationalized through organizations' lack of support for programs that reinforce pre-existing inequities.

Although several organizations' webpages identify addressing inequities as a guiding principle, they varied in their discussion its operationalization. While intersectionalities in vulnerabilities