of stakeholders from sectors other than health (e.g., transportation, finance, trading, international affairs); and seven countries reported detailed information about approaches used to involve stakeholders, as well as different stakeholder groups engaged from academia, medical organizations, religious institutions, or citizen groups.

Discussion In all reviewed plans, stakeholders were dominated by national government and expert representatives from the health sector. Direct involvement of citizens, community or patient groups was recorded in only a few plans. This low level of public participation may be related to the urgency with which plans were developed.

Background The Sustainable Development Goals (SDGs) aim to reduce Neonatal Mortality Rate (NMR) to 12 deaths per 1000 live births by 2030. Although India has made substantial progress in the last few decades in improving child health, achieving NMR targets remains a challenge.

Methods We conducted an overview of Systematic Reviews (SRs) published in the last three years which evaluated health systems (HS) interventions to reduce NMR. We searched two electronic databases and used the Cochrane Effective Practice and Organisation of Care (EPOC) classification to define HS intervention. Two reviewers independently conducted screening, full-text evaluation, data extraction and quality assessment (through AMSTAR-2). Disagreements were resolved by consensus. A narrative synthesis was conducted.

Findings We identified 20 SRs and two overviews of SRs meeting eligibility criteria. About half (n=10) of the SRs appraised were of critically low confidence as per AMSTAR-2 Criteria. Evidence on HS interventions was available for delivery arrangements domain (n=12, 54%), implementation strategies (n=9, 40.9%), one SR on multi-component interventions and none on governance and financial arrangement interventions. Community-based programmes of newborn care (1 SR, 5 studies), home visits by community health workers (1 SR, 9 studies), inter-professional education to healthcare providers (2 SRs, 20 studies), community mobilisation (1 overview, 7 studies), training in emergency obstetric care (1 overview, 5 studies) were found to decrease NMR. Interventions like self-management using home-based records (1 SR, 2 studies), targeted client communication via mobile (1 SR, 4 studies), hospitalisation in single family rooms vs common bay rooms (1 SR, 7 studies), clinical practice guidelines (1 SR, 5 studies), clinical incident reporting (1 SR, 4 studies) were reported to not have any significant impact on NMR.

Conclusion The overview identified HS interventions which might be used to decrease NMR although many SRs were of low quality. There is a need for more high quality updated SRs which can inform policy and practice to achieve the NMR SDG.
Abstracts

Trustworthy Resource Allocation in Health: Promoting Fairness by Mitigating Unjust Use of Power

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Objective During the last decades a vast body of literature has emerged on how to promote fair resource allocation of health resources (1-5). Accordingly, a broadly held view stresses the importance of achieving legitimacy in health prioritization to build trust, including processes based on reasonable values, transparency and inclusion (6). In this piece, we discuss how the reverse also holds, i.e., already established trust in existing institutions promotes conferred legitimacy in health resource allocation. As a consequence, we argue for a shift of perspective on what is required to justify fair priorities; from promoting legitimacy through fair processes to establish trust based on mitigation of unjustly distributed and implemented use of powers.

Method This paper is based on theoretically and empirically informed reflections.

Results Findings from the Comparative Covid Response study, suggest that not only is ‘trust in a nation’s public health system...contingent on the specifics of each country’s institutional arrangements’, but also that ‘(t)rust in official advice correlates with trust in government’(7). These observations support our argument that placing in trust in difficult health priority settings to be fair, depends on the country’s institutions and correlate with existing, supportive trust in government. When such trust is lacking, policymakers can establish it by mitigating unjust use of powers. Based on an analytical approach to power, we suggest a reconceptualization of fair priority-setting that can promote this crucial trust.

Discussion Our conclusion has substantive implications for health priority-settings and health technology assessments: When trust in decision-making authorities and/or institutions is absent, organizing decisions-making processes according to frameworks for achieving legitimacy ‘in isolation’ from how the society is otherwise organized, is not sufficient for decision-making authorities to achieve fair priority settings. Policy-makers must also address and mitigate socially unjust implementation of powers to justify health priorities as ‘fair’.

Equity Impact of a Package of Interventions Addressing Infectious Diseases in Ethiopia (Work in Progress)


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Pandemic-Premium

Horn et al made an interesting analysis of the severity of a pandemic, like covid-19, raising several issues that do not seem to be fully covered by the Norwegian perspective on severity – and I would say generally so. One such issue is the indirect effect a pandemic has even for patients suffering mild disease, in terms of potential spread of disease to patients that will suffer individually severe conditions.

In this talk I will explore whether the assessment of severity should take into account indirect effects in a pandemic and give a ‘pandemic-premium’ even to a mild condition, given the risk of spread and hence potentially severe consequences for other people. By comparing patient-populations where we in both cases effectively can avoid development of severe disease, in one case by treating people with mild disease and in one by treating people with severe disease, I will argue that we have a prima facie reason to either include a pandemic-premium to severity or add a further pandemic factor to consider. I will further explore how such a pandemic-premium should (and should not) be interpreted and explore some pros and cons of such a premium.