health gains of the MDG era while tackling the emerging challenges including the COVID-19 pandemic. The past achievements were thanks to Rwanda's universal health coverage (UHC) model, characterized by expansion of health service delivery at all levels, with emphasis on primary health care, f; and more than 85% health insurance coverage through the Community Based Health Insurance (CBHI). The challenge now for Rwanda is to ensure CBHI sustainability and coverage of more services, which requires both more resources mobilization and priority setting systems that maximize health outcomes within available resources. This paper was prepared to document and share the Rwandan experience of priority setting reforms for UHC.

Methods This is a policy analysis case study, describing the context, process, and key actors in the priority setting reforms for CBHI in Rwanda, using a policy analysis triangle by Walt and Gilson. Information was collected through observation and desk review.

Results The priority-setting reforms for UHC were dictated by the increasing pressure on the resource-constrained CBHI to cover more tertiary-level services. In 2019 stakeholders led by the Rwanda's Ministry of Health and Rwanda Social Security Board (managing the CBHI scheme) started discussing how health-economic evidence can contribute to priority setting decisions for CBHI. After several meetings and workshops, the Government decided, through a ministerial instruction published in August 2021, to change the process of defining CBHI benefits packages, and established new criteria and an appraisal committee. In November 2021 a 3-days workshop was organized to develop 1-year implementation roadmap, after learning from other country's experiences.

Discussion The initiation of Rwanda's priority-setting reforms was characterized by Government ownership and stakeholder engagement. The next steps will require strong coordination, and long-term capacity building through learning by doing.

180:oral DESIGNING HEALTH BENEFIT PACKAGES FOR UNIVERSAL HEALTH COVERAGE – SHOULD COUNTRIES FOLLOW A SECTORAL, INCREMENTAL OR HYBRID APPROACH?

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Countries around the world are increasingly rethinking the design of their health benefit package to achieve universal health coverage. Countries can periodically revise their packages by performing sectoral analyses, i.e. by evaluating a broad set of services against a 'doing nothing' scenario using a budget constraint. Alternatively, they can carry out incremental analyses, i.e. to evaluate specific services against current practice using a cost-effectiveness threshold. In addition, countries may employ hybrid approaches. This paper compares these approaches in terms of the nature of allocative inefficiencies, quality of analysis, political feasibility of reallocation decisions, and integrated health system analysis. Sectoral analysis is especially suited in contexts with large allocative inefficiencies in current service provision and can, in theory, realize large efficiency gains. However, it may be challenging to implement a comprehensive redesign of the package in practice. Incremental analysis is especially relevant in contexts where specific new services raise challenges to the allocative efficiency and sustainability of the health system. It may potentially support efficiency improvement, but its focus has typically been on new services while existing inefficiencies remain unchallenged. The use of hybrid approach may be a way forward to address the strengths and weaknesses of sectoral and incremental analysis.

155:oral MONITORING THE IMPACT OF HEALTH SYSTEM STRENGTHENING FOR MATERNAL AND CHILD HEALTH IN GUINEA-BISSAU: FOCUS ON UNIVERSAL HEALTH COVERAGE REMOVES FOCUS FROM STAGNATING PERINATAL MORTALITY

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Objective To investigate coverage of antenatal care (ANC) and facility births and perinatal mortality before and during the stepwise implementation of the 'Integrated Programme for the Reduction of Maternal and Child Mortality' (PIMI), a health system strengthening programme which included free care, health worker training and infrastructure rehabilitation in Guinea-Bissau.

Methods We used data from Bandim Health Project's rural health and demographic surveillance system from three 24-months birth cohorts: pre-PIMI (2011-13), during PIMI's pilot phase (2014-16) and its nation-wide full-scale implementation (2017-19); and two areas: pilot regions (PIMI since 2013) and scale-up regions (PIMI since 2017). Using generalized estimating equations, we compared service coverage (first/fourth ANC consultation (ANC1/4) and facility births) and perinatal mortality over time and across areas. We also assessed associations between perinatal mortality and cluster-level ANC4 and facility birth coverage.

Results Across the three cohorts, 23,828 births were included. Pre-PIMI, approx. 1/3 women obtained ANC4 and facility birth in both areas. ANC4 and facility birth coverage increased to approx. 1/2 in both areas. Relative increases were largest in the scale-up area for ANC4 ($p=0.007$ for same development), and comparable across areas for facility births ($p=0.16$). Perinatal mortality was around 8% pre-PIMI and did not decline over time. Higher cluster-level ANC4 (both areas) and facility birth coverage (pilot area) were associated with a tendency towards lower perinatal mortality pre-PIMI, but this association disappeared over time.

Conclusion While universal access to quality maternal and child health services is considered essential to improve maternal-perinatal survival, increases in ANC and facility birth coverage did not translate into reduced perinatal mortality. Hence, measures of health outcomes cannot be replaced by

measures of service coverage. Rigorous evaluation designs are required to assess the real-life effects of policies aiming to improve survival and identify the potential causes of (absence of) effects.

164:oral FAIR DOMESTIC VACCINE PRIORITISATION

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During the COVID-19 pandemic, many countries have prioritised individuals for vaccination primarily on the basis of (intrinsic) risk factors such as older age and presence of comorbidities. Such a prioritisation strategy ignores risk of exposure to the virus and harm from non-pharmaceutical interventions. In this paper, we develop an account of fair allocation of vaccines. First, we argue fairness requires maximal proportional satisfaction of claims. Second, we argue what grounds people's claim to vaccines is that they are at risk of harm, and fairness requires people are prioritised for vaccination in proportion to the risks they face. Third, we defend an expansive understanding of relevant harms; when allocating vaccines, governments should, in principle, include all pandemic-related risk of harm. Finally, we consider several ways in which different harms could be traded off against each other and defend giving priority to mitigating direct risk of harm from an infectious agent. Our account also provides a principled reason for compensating people who suffer disproportionally from indirect risks of harm (e.g., harms from non-pharmaceutical interventions).

151:poster MENTAL HEALTH INEQUITIES IN THE GLOBAL SOUTH: CREATING SPACES FOR LOCAL VOICES

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This paper explores existing strategies for mental health care in Sub-Sharan Africa and points to the need to underpin the relevant approaches with a local equity framework. Using a case-study, it highlights that the approaches need to reflect local conceptualizations and lived experiences of mental health. The insights are presented against a background of the disproportionately low attention given to mental health care, despite its high burden tying to social, cultural and economic distress among affected persons and their communities. Reviewing the dominant approach to mental health, the articles shows how the underlying epistemic assumptions over shadow local voices while informing approaches that do not appropriately reflect the realities of those experiencing mental health problems, especially given inherent social, cultural and moral nuances that complicate access to services in African contexts. As a way forward, it proffers that an African communitarian equity framework, which reflects the contextual realities of mental health, should guide the relevant approaches towards creating spaces for local values and ethics in mental health reforms.

136:oral OPTIMISING HEALTH BENEFIT PACKAGES IN THE ERA OF COVID-19: A CASE STUDY FROM PAKISTAN

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Objective The health systems costs of COVID-19 are high in many countries, including Pakistan. Without increases in fiscal space, COVID-19 interventions are likely to displace other activities within the health system. We reflect on the inclusion of COVID-19 interventions in Pakistan's Essential Package of Health Services (EPHS) and, from a financial optimisation perspective, propose which interventions should be displaced to ensure the highest possible overall health utility within budgetary constraints.

Methods We estimated the costs of all 88 interventions currently included in the EPHS and collected published data on their cost-effectiveness. We also estimated total costs and cost-effectiveness of COVID-19 vaccination in Pakistan. We ranked all EPHS interventions and COVID-19 vaccination by cost-effectiveness, determining which interventions are comparatively least cost-effective and, in the absence of additional funding, no longer affordable.

Results The EPHS assumes a spending per capita of US $12.96, averting 40.36 million disability-adjusted life years (DALYs). From a financial optimisation perspective, and assuming no additional funds, the introduction of a COVID-19 vaccine (US$3 per dose) should displace 8 interventions out of the EPHS, making the EPHS more cost-effective by averting 40.62 million DALYs. A US$6 dose should displace a further intervention and avert 40.56 million DALYs. A US$10 dose would partially fall out of the package, displacing four additional interventions. If health spending per capita decreased to US$8, a US$3 dose would still be affordable, but not US$6 or US$10 doses.

Discussion Cost-effectiveness is only one criterion considered when deciding which interventions are included in (or removed from) a health benefits package. While displacing certain interventions to create fiscal space for the COVID-19 vaccine may lead to a financially optimal scenario, doing so may be politically unfeasible or socially undesirable. We highlight the difficult trade-offs that health systems face in the era of COVID-19.

169:poster GAPS IN HEALTHCARE SERVICES LEADING TO HIGH EXTRA-PULMONARY TUBERCULOSIS UN-ADDRESSED HIGH ECONOMIC BURDEN OF EXTRA-PULMONARY TUBERCULOSIS PATIENTS

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Background Tuberculosis (TB), annual disease-burden >10.0 million is associated with socioeconomic disparities. Moreover, extrapulmonary tuberculosis (EPTB), despite its high disease-burden, Universal Health Coverage (UHC) implementation remains growing a public health concern.