

This paper will describe and analyze restrictions on connection and interaction (i.e., social distancing) during the first pandemic in a century. During a pandemic, decision makers are required to make difficult decisions with incomplete information, under high levels of uncertainty, public scrutiny and urgency. Many critical and far-reaching priority setting decisions have occurred outside the health sector, for instance the closing of schools or restrictions on businesses or transportation. These decisions, like decisions about allocating vaccine or hospital care, involve the allocation of some budgetary and human resources. However, more so than in healthcare, they also explicitly involve the allocation of burdens or costs, from both limits on movement and, for instance for service workers, greater exposure to infection. These decisions, like those about allocating healthcare resources, have critical consequences for health. Households suffer job losses and reduced income; children miss school; many, especially those residing in institutions, suffer social isolation—outcomes which have been associated with declines in physical and mental health. These burdens of restrictions on movement and connection and consequent health outcomes may be unevenly distributed and exacerbate existing health inequities. Fair decision making about priorities for connection and interaction is as crucial as fair decision making about allocating intensive care and vaccine. The application of priority setting methods and principles, however, has focused on healthcare and not on other policy actions that can profoundly influence health. This paper presents an analysis of restrictive measures introduced during the COVID-19 pandemic, what we have learned, so far, about the consequences of those restrictions, and makes recommendations for the development and application of priority setting frameworks in this arena to inform future research and practice.

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#### CHRONIC INFLAMMATORY JOINT DISEASE IN ZANZIBAR: A COST EFFECTIVENESS ANALYSIS

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**Introduction** The Zanzibar islands are a semi-autonomous country made up of two sister islands. Population is 1.5 million with the majority living in urban areas. The main referral hospital is based on Unguja island and this is the only hospital with rheumatology care and where disease modifying anti-rheumatic drugs (DMARDs) can be prescribed although there is no rheumatologist on either island. Healthcare is free for the population of Zanzibar. However, DMARD therapy is not included in the essential drugs list and patients incur significant out-of-pocket expenses when accessing care. A cost-effective analysis of DMARD therapy has not been performed. The aim of the project is to assess the efficacy of a basic healthcare package for this disease group to be included in the Zanzibar essential healthcare package.

**Methods** From September 2019 and ongoing, all patients with a clinical diagnosis of rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis were informed of the study and asked to participate. Patients were managed according to an

internationally accepted pre-defined treatment guidelines. Data were collected on disease severity, medication used, quality of life scores using the EuroQol 5 dimensions-5 levels (EQ5D5L) questionnaire as well as income and expenditure for health. Data will be inputted in the Fair Choices tool developed by the Bergen Center for Ethics and Priority Settings (BCEPs) for calculations to determine the cost effectiveness of the package.

**Results** Preliminary results show that increasing combination therapy coverage to 100% for moderate to severe rheumatoid arthritis with low-dose corticosteroids, folic acid supplementation, DMARDs (including methotrexate) was found to have an increased cost of USD 414,381. The incremental cost effectiveness ratio (ICER) per quality adjusted life year was 5.45 suggesting the package to be cost-effective. This would avert 76096 disease adjusted life years (DALYs).

**Discussion** Preliminary analysis shows combined therapy for rheumatoid arthritis to be cost effective. To our knowledge, this is the first study of its kind to be undertaken in Zanzibar. Data collection is ongoing, and we hope to present more robust data from other parameters and a larger sample size at the time of the conference.

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#### GLOBAL HEALTH GOVERNANCE IN PANDEMIC PREPAREDNESS AT WORLD HEALTH ORGANIZATION. TOPICS AND FORTHCOMING DEBATES

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COVID-19 pandemic has shown the flaws in global health governance, regarding pandemic preparedness. Instead of attaining to International Health Regulations (IHR), revised in 2005 at World Health Organization (WHO), every country has instrumented its own rules to control the spread of SARS-CoV2. Nationalistic positions have prevailed, concerning access to medical technologies (such as vaccines, diagnostics or medicines), or quarantines blocking trade and free circulation. The fragmentation in global health governance is very evident. This has been a consequence of the diminished role of WHO, due to its budgetary limits. These constraints have limited the role of WHO to respond in a coordinated way during COVID-19 pandemic.

New pandemics have been forecasted during this century, as a result of changes in the relationship between humans with our environment. Thus, coordination in global health governance is needed. In December 2021, the resolution 74.7 of World Health Assembly (WHA) has ordered the creation of a Commission, which will review international health governance, regarding pandemics preparedness. Through a review of the legal framework, this presentation aims to unfold the possibilities for the new governance -either by amending IHR, creating a new instrument, or a combination of both (for example, the creation of a Framework to respond to subsequent pandemics, such as the one devoted for influenza)-, as well as the topics revisited (i.e. benefit-sharing of pathogens, equitable production and distribution of medical technologies, or the creation of a dispute resolution mechanism). Some themes will be hotly debated between North and South. Additionally, WHO doesn't hold exclusive jurisdiction in some of the topics, as far as they're regulated by other international forums.