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PERSPECTIVES OF STAKEHOLDERS OF THE FREE MATERNITY SERVICES FOR ECONOMICALLY CONSTRAINED MOTHERS IN WESTERN KENYA, LESSONS FOR UNIVERSAL HEALTH COVERAGE

¹Beverly M Ochieng*, ¹Dan Kaseje, ²Monica Magadi. ¹Research and Development; Tropical Institute of Community Health; Kenya; ²University of Hull

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The strategic aim of universal health coverage (UHC) is to ensure that everyone can use health services they need without risk of financial impoverishment. Linda mama (Taking care of the mother) initiative focuses on most vulnerable women, newborns and infants in offering free health services and Financial risk protection that provides overall social protection in the event of pregnancy, childbirth, neonatal and perinatal care for mothers

Purpose of study was to find out the extent of awareness, and involvement among managers, service providers and consumers of 'Linda mama' supported services and benefits of the initiative from the perspectives of consumers, providers and managers

Methods We carried out cross sectional study in four sub counties in western Kenya

Findings From the perspectives of managers, service providers and consumers of the scheme emerge concepts, principles and pathways of successful health interventions. Managers and service providers were well aware of the initiative and were involved in it.

Participation seemed to be more prominent among managers and service providers. Routine household visits by community health volunteers to sensitize mothers and community engagement was core to the initiative. The managers and providers of services displayed profound awareness of how requiring identification cards and telephone numbers had the potential to undermine equity by excluding those in greater need of care such as under-age pregnant adolescents. Maternity and mother child health services improved as a result of the funds received by health facilities. 'Linda Mama' reimbursements helped to purchase drug and reduced workload in the facility by hiring extra hands.

Conclusion The initiative seems to have influenced attitudes on health facility delivery through: Partnership among key stakeholders and highlighting the need for enhanced partnership with the communities. It enhanced the capacity of health facilities to deliver high quality comprehensive, essential care package and easing economic burden.

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AN EPICUREAN CHALLENGE TO DALY'S

Bjørn Hol*. *Philosophy; University of Oslo; Norway*

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The COVID-19 pandemic has increased the necessity of setting priorities in health and beyond. To set such priorities in health, we need meaningful and consistent health measures. The global burden of disease study plays an important role during the pandemic. Disease burden is largely measured through the lens of disability-adjusted life years (DALYs). Since its conception in the early 1990s, the DALY has gained traction and increased popularity. Several revisions of the value

assumptions built into the DALY have followed. Moreover, discussions have been made of the different potential purposes of the DALYs, whether it be monitoring patterns and inequalities in disease burden, aggregating morbidity and mortality, or setting priorities within large health programs. However, much less attention has been on the main assumption of the DALY, that is, that DALYs = YLDs + YLLs. To elaborate, the DALY is the aggregation of years lived with disability (YLDs) and years of life lost (YLLs). However, are YLDs and YLLs entities that can be aggregated? Epicurus famously argued that existence is necessary for anything to matter to you, therefore, death is nothing to you. If Epicurus was right that death (i.e., the incident of death, not the process of dying) is not bad for those who die, then DALY's addition of years lost by death may not give a meaningful result. There are at least three responses to this foundational DALY problem, of which a counterfactual account of harm might be the most viable approach. This counterfactual strategy, however, comes with severe challenges. I argue that Epicurus was correct in claiming that the incident of death is not bad for the dying or the dead. Death, for epicureans, means permanent non-existence, and hence, it remains questionable whether YLD + YLL makes sense.

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SEVERITY AND ILLNESS ADAPTATION

Borgar Jølstad*. *Avdeling for Helseetjenesteforskning (HØKH); Akershus Universitetssykehus; Norway*

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Adaptation to illness, and its relationship with priority setting in health, is a vexing and morally important issue. According to conventional quality-of-life measures and health state valuations, people with various illnesses are not as badly off as others may imagine. This is partly due to adaptation: the process of adjusting to changed circumstances. When we prioritize in accordance with consequentialism, it matters a great deal to get measures of who is worse off right. Whether or not to account for adaptation when deciding who is worse off, and consequentially should be prioritized, has been extensively debated. Arguments against highlight that people sometimes adapt to conditions they should not have to adapt to. This is in line with Amartya Sen's argument against relying on subjective indicators of well-being; people in poverty adapt to their condition, and this will tend to mask injustice if subjective indicators are relied on to the exclusion of objective factors. In our paper, we wish to argue that illnesses that one does not adapt to are, all else equal, more severe than illnesses that one does adapt to. We assume that severity is, at least partly, a measure of health-related worse off-ness. The first part of the argument is that if adaptation is successful, then there is less suffering. Not adapting means more suffering and is, therefore, all else equal, worse than not adapting. Disregarding the relative lack of suffering of those who adapt also means disregarding the suffering of those who do not adapt. We then argue that no plausible theory of well-being relevant for health care can disregard the importance of suffering. Lastly, we argue that not considering adaptation leads to a relative lack of priority for illnesses that are difficult or impossible to adapt to, such as depression.