

Early stakeholder engagement in economic evaluation in Uganda

Healthcare professionals, public agents, facility users and academics as key actors

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BACKGROUND

Collecting **cost** and **utilization data** from caregivers and healthcare facilities proves challenging. Researchers face the threat of inaccessible or unreliable/inaccurate data.

Economic evaluations hardly seem **relevant** to the practice of physicians and nurses, and **inaccessible** for district health officers and agents who could see use for it.

METHODS

We documented key challenges in collecting these data from caregivers and from public and private healthcare facilities at all levels (hospital to pharmacy).

RESULTS

Four types of stakeholders play key roles (✓) in using and generating reliable data, after overcoming challenges (⊘).

- Healthcare professionals** – physicians, nurses, managers
- ✓ Know about facility operating costs (overhead & medical)
 - ✓ Help identify eligible caregivers
 - ✓ Know when medical procedures differ from guidelines due to stock-outs and variations in practices
 - ⊘ Do not want to get involved in non-care-related work
 - ⊘ See economic evaluations as disguised audits

- Public health authorities** – district health officers, MOH
- ✓ Want to use relevant cost estimates to improve budgets
 - ✓ Know about public procurement costs (medications)
 - ✓ Provide legitimacy and support to the study bringing together healthcare facility professionals
 - ⊘ May have an incentive to audit healthcare facilities
 - ⊘ Have limited influence over private facilities: influence is based on charisma and cooperation, less on authority

- Caregivers**
- ✓ Know what they pay and what they cannot afford
 - ✓ Have essential insights as healthcare facility users
 - ⊘ Do not see the relevance of an economic study for them
 - ⊘ May not remember or feel empowered to answer survey

- Data collection team** – in-country data collectors
- ✓ Know local customs and languages
 - ⊘ Face challenges and fatigue over long-term and complex data collection

NOTA BENE:

This is an **ongoing study**. The results of the cost of illness study will be finalized and published in **open access**. The following results will be updated (Autumn 2019).

STUDY DETAILS

Data collection took place in Gulu, Jinja, Mbarara and Wakiso districts from August 2017 to July 2018.

ENGAGEMENT OUTCOMES

All engagement practices were co-created by the teams at Johns Hopkins and Makerere universities.

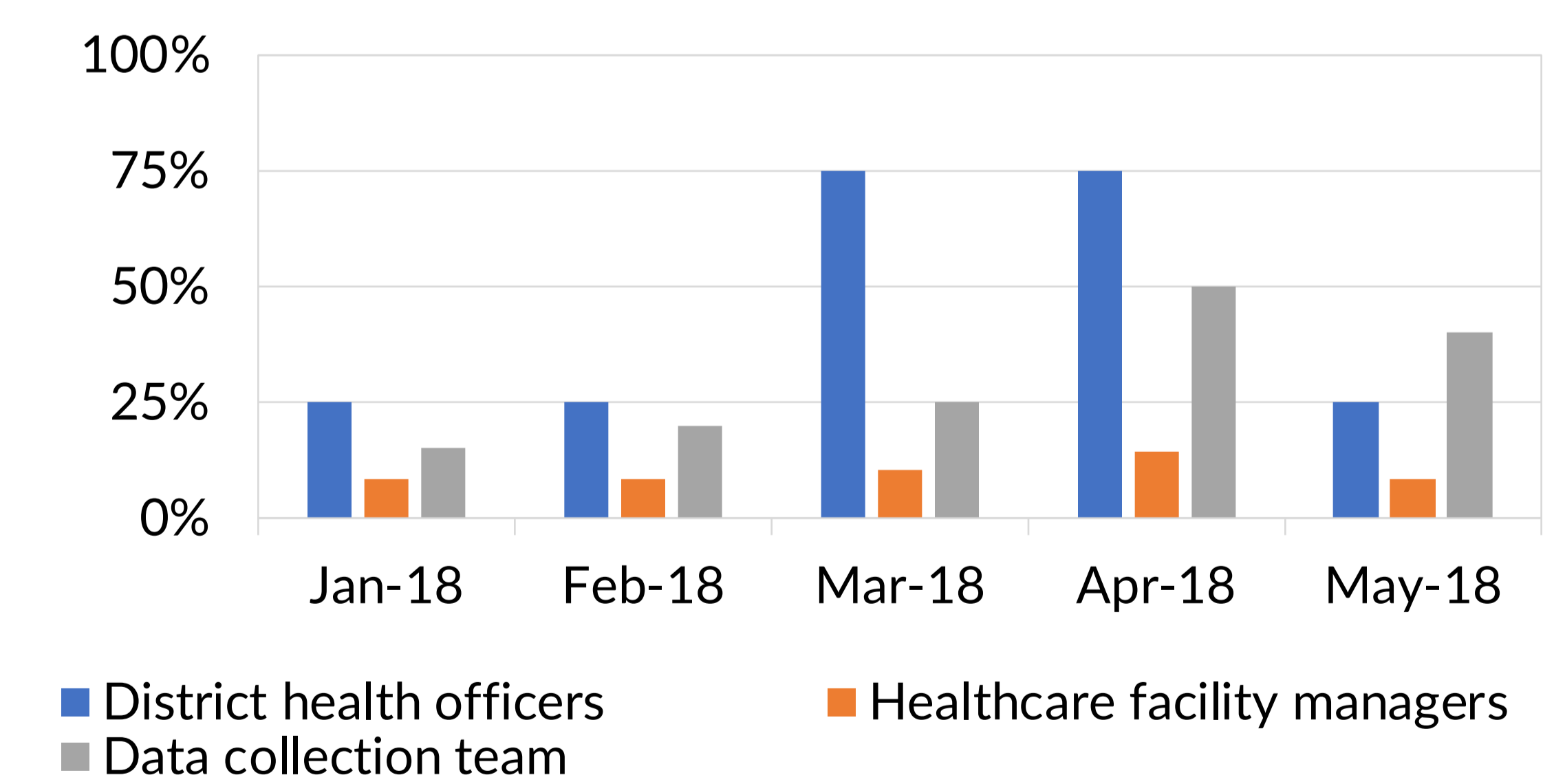
All **surveys** were jointly developed by the two teams and received extensive feedback from (1) data collectors, (2) district health officers and their team and (3) healthcare professionals from two healthcare facilities (in pilot phase). Feedback has allowed to:

- Ensure the surveys were adapted to low-literacy settings
- Reduce potential recall bias for caregivers by optimizing the availability of receipts and supportive documents
- Review linguistic and cultural biases in all four languages of the study (Luganda, Luo, Lusoga and Runyankole)

A **newsletter** (started in Dec 2017) provided study progress updates upon recommendation of healthcare professionals to increase engagement and improve data collection.

- It reached 3 of the 4 district health officers in the study
- It reached some data collectors who then shared with the others (*based on supervisor's feedback*)
- It showed healthcare professionals continuously engaged in this economic evaluation, allowing us to identify potential facilitators

Percentage of stakeholders who read the newsletter

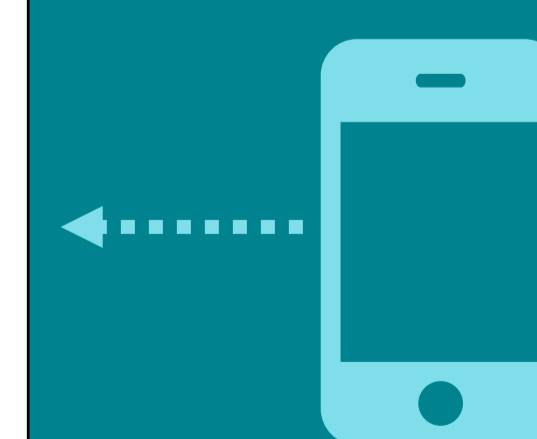


DISSEMINATION

A full **workshop** on cost of illness was prepared during data collection for preliminary (Dec 2018), then full dissemination (expected Autumn 2019). Short courses were published in **open access** through the newsletter.

Planning > Responding

Early stakeholder engagement assures more reliable and meaningful data.



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