Economic and Financial Evaluation of Interventions Improving Women's, Children's, and Adolescents' Health in Low-and-Middle-Income Countries: Scoping Review and Evidence and Gap Map

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Acronyms and abbreviations

AHWB	Adolescent health and well-being
BCR	Benefit-cost ratio
CBA	Cost-benefit analysis
CEA	Cost-effectiveness analysis
COI	Cost of inaction
CSE	Comprehensive sexuality education
CUA	Cost-utility analysis
DALY	Disability-adjusted life years
DCEA	Distributional cost-effectiveness analysis
ECEA	Extended cost-effectiveness analysis
EGM	Evidence and gap maps
HIV	Human Immunodeficiency virus
ICER	Incremental Cost-Effectiveness Ratio
LMICs	Low- and middle-income countries
MNCH	Maternal, newborn and child health
PICOS	Population, intervention, comparisons, outcomes and study
QALYs	Quality-adjusted life years
SDGs	Sustainable Development Goals
SRHR	Sexual and reproductive health and rights
SROI	Social return on investment
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WCAH	Women's, children's and adolescents' health

Chapter 1: Executive summary

1.1 Background

Every year, 4.9 million stillbirths, maternal and newborn deaths are caused by complications during pregnancy, childbirth or shortly after childbirth, referred to as maternal or newborn deaths (WHO, 2023). Almost 800 women still die from preventable causes related to pregnancy and childbirth each day with 95% of those occurring in low and middle-income countries (LMICs) (WHO, 2023). Globally, there were 2.3 million neonatal deaths worldwide in 2022: approximately 6300 deaths per day (UNICEF, 2024).

In addition, over 2.1 million children, adolescents and youth aged between 5 to 24 died in 2022 (WHO and UNICEF, 2024). Approximately one in seven of adolescents aged between 10 and 19 worldwide suffer from a mental disorder, which accounts for 13% of all disease burden in this age group (UNICEF, 2024).

Furthermore, substantial inequities in women's, children's, and adolescents' health (WCAH) remain within and across countries and regions. To achieve the ambitious goals set out in the Sustainable Development Goals (SDGs) and the United Nations (UN) Global Strategy for WCAH 2016-2023, substantial improvements in resource allocation are likely to be required to promote interventions that improve outcomes at a reasonable cost in specific contexts. This evidence and gap map aimed to provide a comprehensive overview of the evidence and to answer the research question:

What is the nature and extent of the evidence base on economic and financial evaluations of interventions targeted at improving WCAH in LMICs?

1.2 Methods

Due to a large number of economic and financial evaluations identified (n=732), a narrative synthesis of the main findings was limited to equity-informative economic and financial evaluations. However, characteristics of all included studies are added in the annexe (Arksey and O'Malley, 2005), supplemented by an evidence and gap map (EGM) that help visualize the evidence.

Eligible interventions included those providing sexual and reproductive health and rights (SRHR), for example, the promotion of modern contraception; maternal, newborn and child health

(MNCH), for example, antenatal care; adolescent health and well-being (AHWB), for example, mental health; and nutrition support. Eligible studies were full economic and financial evaluations, including cost-benefit analyses (CBA), cost-effectiveness analyses (CEA)—both distributional CEAs (DCEA) and extended CEAs (ECEA)—cost-utility analyses (CUA) and other designs like investment cases and social return on investment (SROI) analyses.

A comprehensive search strategy was employed for academic databases, including economic and financial evaluation repositories such as Tufts and Disease Control Priorities 3 and 28 additional grey literature sources. Studies published from 2010 onwards were included. Studies were coded and assessed using a pre-validated data extraction form and critical appraisal tool and presented using an EGM approach, which highlighted the areas of evidence concentration and any gaps (White et al., 2020). A narrative synthesis of the main findings was conducted using equity-informative economic and financial evaluations.

1.3 Results

The review included 732 studies from 46 564 citations retrieved from academic databases and grey literature sources.

1.3.1 Areas of robust evidence

Nearly 50% of the economic and financial evaluations were conducted in sub-Saharan Africa (n=349), 25.4% in South Asia (n=187) and 16.3% in East Asia and the Pacific (n=120). The highest concentration of studies was in four countries: South Africa (n=64), China (n=63), India (n=62) and Uganda (n=58). 16% (n=113) of studies identified focussed on Latin America and the Caribbean, with the greatest density in Brazil (n=32). Francophone Africa was most represented by Burkina Faso (n=18), the Democratic Republic of Congo (n=13), Mali (n=12), Senegal (n=12) and Rwanda (n=11). Approximately 57% (n=420) of the studies focussed on children aged under-five (0-59 months), followed by 44% (n=322) which focussed on all women, including pregnant and lactating mothers and women of reproductive age.

By far the greatest number of studies concerned MNCH with 81% (n=595). Immunization at 38% (n=224) was the most frequently reported intervention followed by interventions to combat infectious diseases with 32% (n=196) and antenatal care at 11% (n=83). SRHR accounted for 23% (n=171) of the studies, with prevention, detection and treatment of reproductive cancers,

especially cervical cancer, accounting for 47% (n=82) of the studies, followed by HIV and other sexually transmitted infections (STIs) at 37% (n=57). AHWB accounted for 12% (n=93) of studies.

In 48% of studies (n=349), CUA was used and in 39% (n=284), CEA was used. Most of the evidence (82%) was rated as moderate (n=386; 52%) to low risk of bias and, therefore of moderate- to high-quality (n=217; 29%).

In most studies, the research questions were clearly defined and appropriate, the benefits were measured appropriately by QALYs or DALYs and sensitivity analyses were conducted to account for uncertainty in parameter values to demonstrate the long-term cost-effectiveness using a lifetime horizon or a time horizon appropriate to the disease evaluations.

1.3.2 Gaps in Evidence

Relative gaps in evidence from Europe and Central Asia (n=35; 5%) and the Middle East and North Africa (n=59; 8%) are identified. Less than 5% studies each were reporting on children aged 5-9 years (n=34), adolescents aged 15-19 years (n=23), adolescent boys (n=21), preterm/low birth weight (LBW) infants (n=18), stillbirth and bereaved parents (n=4).

There are striking gaps in evidence with less than five studies on injuries and trauma (n=3) and mental health and psychosocial support for mothers and young children (n=3). Critical gaps exist with less than 5% of studies conducted on safe abortion services and treatment of complications of unsafe abortion (n=8), and the prevention, detection and immediate services and referrals for cases of sexual and gender-based violence (GBV) (n=7), and information, counselling and services for sexual health and well-being (n=1). No studies on comprehensive sexuality education (CSE) were identified. Only 2% of the included studies focussed on learning, competence, education, skills and employability. No studies were identified on the other domains of the AHWB component. There are gaps in evidence on multisectoral interventions such as water, sanitation and hygiene (WASH), child protection and education. Preparedness and response were also under-studied.

1.4 Conclusions

The findings indicate robust evidence on key interventions focusing on: MNCH, including immunization services, infectious disease prevention and treatment, antenatal care and routine newborn care; SRHR, including the prevention, detection, and treatment of reproductive cancers (especially cervical cancer), prevention and treatment of HIV and STIs, and counselling for

modern contraceptives; and for AHWB, including physical health and capacities, mental health and optimal nutritional status. The majority of studies were conducted in Brazil, China, India, South Africa and Uganda. Children aged under-five, pregnant women, and women of reproductive age predominated. This evidence base thus provides robust and up-to-date data to support policy decisions and investments in essential interventions for WCAH in LMICs.

Evidence from economic and financial evaluations that emphasize equity suggests that the intervention is strongly pro-poor. These evaluations focused on regions with insufficient healthcare facilities or areas characterized by high poverty levels and limited resources. The findings indicate a positive impact on individuals and communities with lower socioeconomic status.

1.5 Implications

A critical component of global efforts to improve WCAH is developing sound evidence on cost-effective strategies that could inform national and global action plans and identifying areas where evidence can be better utilized to inform policies and investments.

Based on the findings of the review, several areas of evidence concentration are identified such as the prevention, detection and treatment of reproductive cancers (especially cervical cancer), counselling for modern contraceptives and improving physical health and mental health capacities. A key recommendation is to utilize existing, robust evidence on economic and financial evaluations at the country level to facilitate decision-making through a knowledge translation approach. This approach involves utilizing available sound and high-confidence evidence about cost-effective strategies to inform national and global action plans.

The online interactive EGM provides a searchable, navigable resource for policy-makers to assess what evidence exists to inform policies and programmes as well as identify areas where evidence can be better utilized to inform policies and investments. It is critical to note that cost-effectiveness alone should not dictate decision-making priorities. Instead, interventions must be contextualized within the in-country burden of disease and consider the budget impact and implications on financial risk protection alongside fairness, equity, acceptability and patient satisfaction, thereby holistically addressing the actual health needs of communities (WHO, 2021).

Chapter 2: Background

2.1 Problem statement

Recent decades have significantly improved the health and well-being of mothers, newborns and children. However, substantial inequities persist in health outcomes, access to services and financing, which are critical determinants of the observed variations in maternal, newborn and child health across and within countries. Despite a global reduction in maternal deaths between 2000 and 2015, progress stalled from 2016 to 2020, with 54 countries, predominantly in sub-Saharan Africa, off-track to meet under-five mortality targets by 2030 (WHO, 2023). As a result of complications during pregnancy, childbirth or after birth, 4.5 million women and newborns die each year-94 per cent of all maternal and newborn deaths occur in low and-middle-income countries (LMICs) (WHO and UNICEF, 2023). Globally, there were 2.3 million neonatal deaths worldwide in 2022, equating to approximately 6300 deaths per day (UNICEF, 2023).

Looking at the stillbirth rates across income groups, it is evident that pregnant women in LMICs, with a stillbirth rate of 21.6 per 1,000 total births, are at an eight-fold greater risk compared to their counterparts in high-income countries, where the rate was 2.8 per 1,000 total births in 2021. (UNICEF, 2024). Over 1.5 million adolescents and young adults aged 10–24 died in 2021, equating to 4100 daily (WHO, 2023). Girls younger than 19 years have an increased risk of stillbirths, neonatal deaths and preterm and low birth weight (LBW) infants (WHO, 2023). Several sexual and reproductive health and rights (SRHR) needs remain unmet among adolescents, primarily because of a lack of knowledge, social stigma, laws and policies prohibiting the provision of contraception and abortions to adolescents (Prata and Weidert, 2020).

COVID-19 further disrupted health and social services, especially in low-resource settings. In 2022, an estimated 45 million children under 5 (6.8 per cent) were affected by wasting, of which 13.6 million (2.1 per cent) were suffering from severe wasting. More than three-quarters of all children with severe wasting live in Asia and another 22 per cent live in Africa. (UNICEF, 2024). Additionally, the global burden of mental illness among those aged between 10 and 19 accounts for 13 per cent of health conditions with suicide being the fourth leading cause of death among those aged between 15 and 19 (WHO, 2021). In 2023, there were an estimated 1.9

million adolescent girls and young women (aged 15–24 years) living with HIV, compared with 1.2 million adolescent boys and young men (aged 15–24 years) (UNAIDS, 2023). A growing trend towards unhealthy diets, inactive lifestyles, alcohol and tobacco abuse and environmental hazards, such as air pollution, are other significant problems facing adolescents (Ati et al., 2021).

Women's, Children's, and Adolescents' Health (WCAH) is pivotal not only from a human rights perspective but also for sustainable development and economic stability. Investments in WCAH are linked to broader economic growth and enhanced social security (WHO, 2017; WHO, 2023). The Sustainable Development Goals (SDGs) as delineated by the UN in 2020 (SDG 3, 4, 5, and 6) and the Global Strategy for WCAH by Kuruvilla,et al. (2016) underscore these commitments. The latter, a directive of the World Health Organization, builds on Every Woman, Every Child initiative, aiming to end preventable deaths, enhance health and well-being through comprehensive nutritional and mental health strategies, and ensure universal access to reproductive and sexual health services. Furthermore, it seeks to transform societal structures by addressing key social determinants of health, including education, gender equality, and economic empowerment, through legislative and policy reforms alongside sustainable financing measures. The health outcomes of WCAH are worse when demographics are marginalized or excluded from society, discriminated against or live in underserved communities, especially the lowest-income and least educated (Torche et al., 2024).

Furthermore, resources for health are often insufficient or fragmented and accountability for policy implementation is lacking in many LMICs (Raga, 2024). A lack of equity between countries, within and across borders, further hinders efforts to prevent the deaths of women, children and adolescents and to improve their well-being (Akseer et al., 2020). There is still a huge inequity in the mortality and morbidity risk between ethnic groups, socioeconomic classes and locations, even in countries with low overall death and disability rates (Akseer et al., 2020; WHO, 2023).

In addition, economic conditions continue to put significant pressure on domestic and external finance with many countries still experiencing fragmentation in planning, financing and monitoring of aid for WCAH (Hanson et al., 2022). Enhancing collaboration within the multilateral system is more crucial than ever for accelerating progress toward the SDGs on WCAH and ensuring that health resources are used efficiently and effectively alongside other approaches, such as data and delivery for impact and innovation in products, services and financing.

2.2 Rationale

While investment in women's, children's, and adolescents' health (WCAH) is supported globally by evidence, linking it to economic and social benefits (WHO, 2022), access to robust economic and financial evaluations does not directly address lags in achieving targets. However, it remains essential for enabling evidence-informed decision-making, including knowledge synthesis products, to address the bottlenecks in achieving Sustainable Development Goals (SDGs) targets related to sexual, reproductive, maternal, newborn, and child health. Investing in WCAH is projected to generate significant returns by 2030, including the prevention of deaths and substantial demographic dividends from early childhood and adolescent health investments (Kuruvilla et al., 2016; Sheehan et al., 2023; WHO, 2022).

To enhance health outcomes for WCAH, it is crucial to mobilize investments that increase equity and align with national priorities as part of the PMNCH 2021-2025 strategy. While interventions in WCAH have proven beneficial, acceptable, and feasible, economic and financial evaluations are necessary to ensure they are also cost-effective and affordable (Vogel et al., 2019; Lie et al., 2015). These evaluations aid in prioritizing interventions effectively (Drummond et al., 2015).

Addressing these challenges requires improved resource allocation supported by comprehensive economic and financial assessments. This EGM aim to map the evidence on economic and financial evaluations of WCAH interventions in LMICs and identify evidence gaps, thereby highlighting areas where more research is needed. This would enable future evaluations to focus on filling these gaps, guiding researchers and funding bodies in prioritizing areas for future research.

2.3 Objectives

The overall aim of the EGM was to map the available evidence on economic and financial evaluations of interventions targeted at improving WCAH, to assess the risk of bias in these evaluations, to identify gaps and to provide the evidence base for advocacy material on investing in WCAH in LMICs.

This review aims to answer the following research question:

What is the nature and extent of the evidence base on economic and financial evaluations of interventions targeted at improving WCAH in LMICs?

2.4 Eligibility criteria

Only full economic and financial evaluations were considered for inclusion (Box 1). Studies with cost-effectiveness data within or alongside randomized controlled effectiveness trials were eligible. Systematic reviews of economic and financial evaluations were not included, however, the reference list of these was checked for any primary studies that could be included.

A description of the eligibility criteria for studies included in this EGM is provided under the conventional populations, interventions, outcomes, and study methods framework (PICOS):

- Population: target population and World Bank regions.
- Interventions: services and health system enablers.
- Comparators: routine care, treatment as usual, another similar intervention, and no intervention.
- Outcomes: valuation measures; and
- Study methods: economic and financial evaluations.

These are described in more detail in this section.

2.4.1 Population

This review is focused on interventions improving WCAH in LMICs (World Bank Classification, 2022).

Consequently, the populations of interest are listed in Tables 1 and 2. Table 1 lists the population groups and subgroups by main WCAH categories. The population categories are mutually exclusive; individual studies may be classified under multiple categories. For instance, if a study examines the impacts on multiple target groups, that study is coded for each population category studied.

Table 1 Population group and sub-groups by WCAH

Population group	Population subgroups
Children aged under-five (0-59 months)	Pre-term and/or LBW
	Newborns (0-28 days)
	Stillbirth and bereaved parents
	Children (1 month-9 years)
School age children (5-9 years)	Children (5-9 years)

	Children (age not specified)
Adolescent (10-19 years)	Adolescent (10-14 years)
	Adolescent (15-19 years)
	Adolescent girls
	Adolescent boys
All women	Women of reproductive age group
	Pregnant and lactating women

Table 2 lists the other population groups, such as vulnerable populations, and studies targeted at the health workforce or mixed populations.

Table 2 Other population subgroups

Population group	Population subgroups
Vulnerable populations	People with disabilities
	Internally displaced people
	Refugees
	Members of the lesbian, gay, bisexual, transgender, intersex or queer community
	Indigenous Peoples or other ethnic minority groups
Others	The health workforce, mixed populations or unclear population sub-groups

2.4.2 Interventions

Intervention categories are divided into two sub-categories:

- services comprising the three broad categories of interventions SRHR, MNCH and AHWB (PMNCH 2021-2025; Ross et al., 2020); and
- health system enablers for implementing the services, such as essential public health functions, health system building blocks, multisectoral interventions and preparedness and response.

2.4.3 Services

The list of service intervention categories and subcategories is given in Table 3. This review focussed on the health sub-domains of the AHWB framework only.

Table 3 List of intervention categories: services

Intervention categories	Intervention subcategories
SRHR	Counselling and services for a range of modern contraceptives with a defined minimum number and types of methods
	Safe abortion services and treatment of complications of unsafe abortion
	Prevention, detection and management of reproductive cancers, especially cervical cancer
	Information, counselling and services for subfertility and infertility
	CSE
	Antenatal, childbirth and postnatal care including emergency obstetric and newborn care
	Information, counselling and services for sexual health and wellbeing
	Prevention and treatment HIV and other STIs
	Prevention, detection, immediate services and referrals for cases of sexual and GBV
MNCH	Antenatal care
	Intrapartum care
	Postnatal care
	Newborn care

Intervention categories	Intervention subcategories
	Breastfeeding
	Immunization
	Infectious disease
	Mental health and psychosocial support
	Child development
	Injury and trauma
	Young child feeding
AHWB	Adolescent physical health and capacities
	Mental health and capacities
	Optimal nutritional status and diets
	Not defined/all

2.4.4 Health System Enablers

The list of health system enablers for implementing services is given in Table 4.

Table 4 List of intervention categories: health system enablers

Intervention categories	Intervention subcategories
Essential public health function	Health promotion and disease prevention
	Management of sick individual
Health system building blocks	Leadership and governance
	Service delivery
	Health system financing
	Health workforce

	Medical products, vaccines and technologies
	Health information systems
Multisectoral	WASH
	Financing
	Education
	Shelter
	Food security and livelihoods
	Nutrition
	Social protection
	Child protection
Preparedness and response	Community engagement
	Advocacy
	Accountability
	Quality of care
	COVID-19
	Emergency preparedness and response

Comparators

Eligible comparators included:

- routine care.
- treatment as usual.
- another similar intervention; and
- no intervention.

2.4.5 Outcomes

Health outcomes were measured, estimated, or evaluated as changes in clinical indicators, numbers of health-related events, for example, cases of diseases or deaths, disability-adjusted life-years (DALYs), or other measures of effect (Table 5).

Table 5 Summary measures. or valuation of outcomes

Summary measures or valuation of outcomes
Quality-adjusted-life-years (QALYs)
Incremental cost-effectiveness ratio (ICER)
Disability-adjusted-life-years (DALYs)
Willingness-to-pay (WTP)
Cost-of-illness
Years of life-lost
Years-lived-with-disability (YLD)
Healthy-life-years-lived (HLYL)
Value of statistical life years (VSL)
Economic burden
Return on investment (ROI)
Net present value (NPV)
Benefit-cost-ratio (BCR)
Cost-of-inaction (COI)
Net benefits
Opportunity cost
Deaths averted

Infections averted
Other condition specific outcome measures

2.4.7 Study types: Economic and financial evaluations

For this EGM, only full economic and financial evaluations— including cost-benefit analyses (CBA), CEAs, cost-utility analyses and other designs—were considered to be eligible (Box 1). We defined full economic and financial evaluations as those that explicitly compare the costs and consequences of an intervention in question to an alternative course of action known as the comparator (Turner et al., 2021). Studies with economic and financial evaluation data within or alongside randomized controlled trials were also eligible. Economic and financial evaluations that reported only costing data were excluded. Systematic reviews of economic and financial evaluations were not included. However, the reference list and included studies for these were screened to identify relevant primary studies, as indicated below.

Box 1 Definitions of types of economic and financial evaluations used for this review

Cost-benefit analysis (CBA): An economic evaluation comparing the cost and benefits of an intervention where both are expressed in monetary units, for example in US dollars.

Cost-effectiveness analysis (CEA): An economic evaluations in which the cost of the intervention is related to a single clinical or natural measure of effectiveness, such as years of life, deaths and cases.

Cost-utility analysis (CUA): An economic evaluation in which the cost of the intervention is related to a multidimensional measure of effectiveness which considers not only the outcome but the valuation of benefits, such as QALYs or DALYs.

Distributional cost-effectiveness analysis (DCEA): A type of CEA that provides information about equity in the distribution of costs, effects and efficiency in terms of aggregate costs and effects. DCEAs provide distributional breakdowns of who gains the most and who bears the most significant burdens (opportunity costs) by equity-relevant social variables—such as socioeconomic status, ethnicity, location—and disease categories, including severity of illness, rarity and disability.

Extended cost-effectiveness analysis (ECEA): An expansion of a CEA in which the relative costs and gains in health outcomes of interventions are compared in the form of years of life saved, premature deaths averted, QALYs or DALYs gained or averted. An ECEA also includes non-health benefits such as financial risk protection (usually shown by cases of poverty averted) and distributional consequences such as equity in the economic evaluation of health policies (usually shown indirectly by stratification of outcomes by population covariates).

Social return on investments (SROI): A type of CBA that uses a full-income approach incorporating the value of life years. Outputs of interest will include lost productivity in the workforce, lost human capital acquisition, impacts going beyond the individual such as intergenerational impacts, shorter life expectancy, premature mortality, days of healthy life gained due to the intervention, costs of averting the effects of inaction and costs of seeking care or of treatment, such as out-of-pocket payments.

Investment case: The term has been used in several senses. As per WHO, attention is concentrated on investment cases reporting an ROI statistic. For example, for vaccine-preventable diseases, investment cases typically describe the immunization resources needed to achieve and support high levels of population immunity, ideally at a level high enough to prevent transmission (Thompson et al., 2012).

Budget impact analysis: A budget impact analysis is an economic assessment that estimates the financial consequences of adopting a new intervention and evaluates whether the high-value intervention is affordable.

Cost-of-illness (COI): This measures medical and other costs resulting from a specific disease or condition. This helps to understand the magnitude of the impact of a disease or condition and to assess the economic burden compared to other diseases and conditions.

Adapted from: Lauer, J. A., Morton, A., Culyer, A. J., & Chalkidou, K. (2020). What counts in economic evaluations of health? Benefit-cost analysis compared to other forms of economic evaluations.

Chapter 3: Methods

Due to a large number of economic and financial evaluations identified (n=732), the narrative summary of the main findings was limited to equity-informative economic and financial evaluations. However, the characteristics of all included studies were included in Annex 3 (Levac et al., 2020; Arksey and O'Malley, 2005). This was supplemented with an EGM that presented the areas of evidence concentration and gaps (White et al., 2020). Mapping the evidence in an existing area is an approach that has been used since the early 2000s (Saran and White, 2018). EGMs are "evidence collections" (Snilstveit et al., 2013) that provide a visual overview of the availability of evidence for a particular sector; in this case, WCAH.

3.1 Search strategy

Specialist health economics databases, general medical and health databases and grey literature sources (PubMed, Embase, CINAHL and PsycINFO) published between January 2010 and December 2022 were searched. The following databases were searched in the second phase: Centre for Agriculture and Biosciences International (CABI) abstract, Web of Science Core Collection and Ovid-MEDLINE. Economic and financial evaluation repositories, such as Tufts and DCP3, and 28 additional grey literature sources were searched. Furthermore, outreach was targeted to the PMNCH, World Bank, WHO, the Global Financing Facility (GFF), UN International Children's Emergency Fund (UNICEF), UN Population Fund, UN Women, Gavi, The Vaccine Alliance and the United Kingdom's Foreign Commonwealth Development Office, to identify relevant reports, studies and analyses that should be included in the mapping.

Systematic reviews of economic and financial evaluations were not included, however, the reference list and included studies of these were screened to identify relevant primary studies, as indicated below. Literature in English, French and Spanish was included, as were studies published from 2010-2022. Language-specific databases were not searched so some economic and financial evaluations published in French and Spanish may have been missed. The authors of this report note this as a limitation. The search strategy is added in Annex 1.

3.2 Study screening and selection

Titles and abstracts of all identified citations were deduplicated and imported into the EPPI reviewer 4 for screening. Individual authors assessed the unique citations against the

eligibility criteria using a pre-validated screening tool. Potentially relevant articles were included for full-text screening and assessed for eligibility. Articles were eligible for inclusion if they provided comprehensive economic and financial evaluations alongside effectiveness studies. Specifically, we considered studies that assessed both the health impact (effectiveness) and the economic implications (costs, benefits) of interventions related to women, children, and adolescent health. Articles were included if; they were full economic and financial evaluations of effectiveness studies; the interventions included SRHR, MNCH and AHWB; they targeted WCAH populations in LMICs; and they were published between 2010 and 2022. Tutorial or methods papers, systematic or narrative reviews and papers that only reported costing information and studies that targeted only men above the age of 19 years were excluded. For uncertainties or disagreements on specific articles, the authors discussed until a consensus was reached. Reference lists of included and excluded articles for studies that may have been missed in the original search were manually searched for. Unique titles identified from this step were assessed for eligibility based on the same inclusion criteria.

3.3 Data extraction and analysis

Studies were coded and assessed using a pre-validated data extraction form and critical appraisal tool drawing on the Drummond Checklist (Drummond et al., 2015) and Consolidated Health Economic Evaluation Reporting Standards 2022 (CHEERS) (Husereau et al., 2022), and presented using an EGM approach (Annex 2).

Characteristics of the studies in each economic evaluation were extracted. These included: the regions or countries they focussed on; the date range of publication; the review's aim; the study method (economic and financial evaluation design type); the target population; the time period it spanned; the WCAH intervention assessed (for example, antenatal care, child immunization); the comparator description; the category of intervention (for example, SRHR, AHWB); the outcome measures,; the perspective considered; the cost year; the currency; the data sources used; the equity; and the distributional criterion (Annex 3).

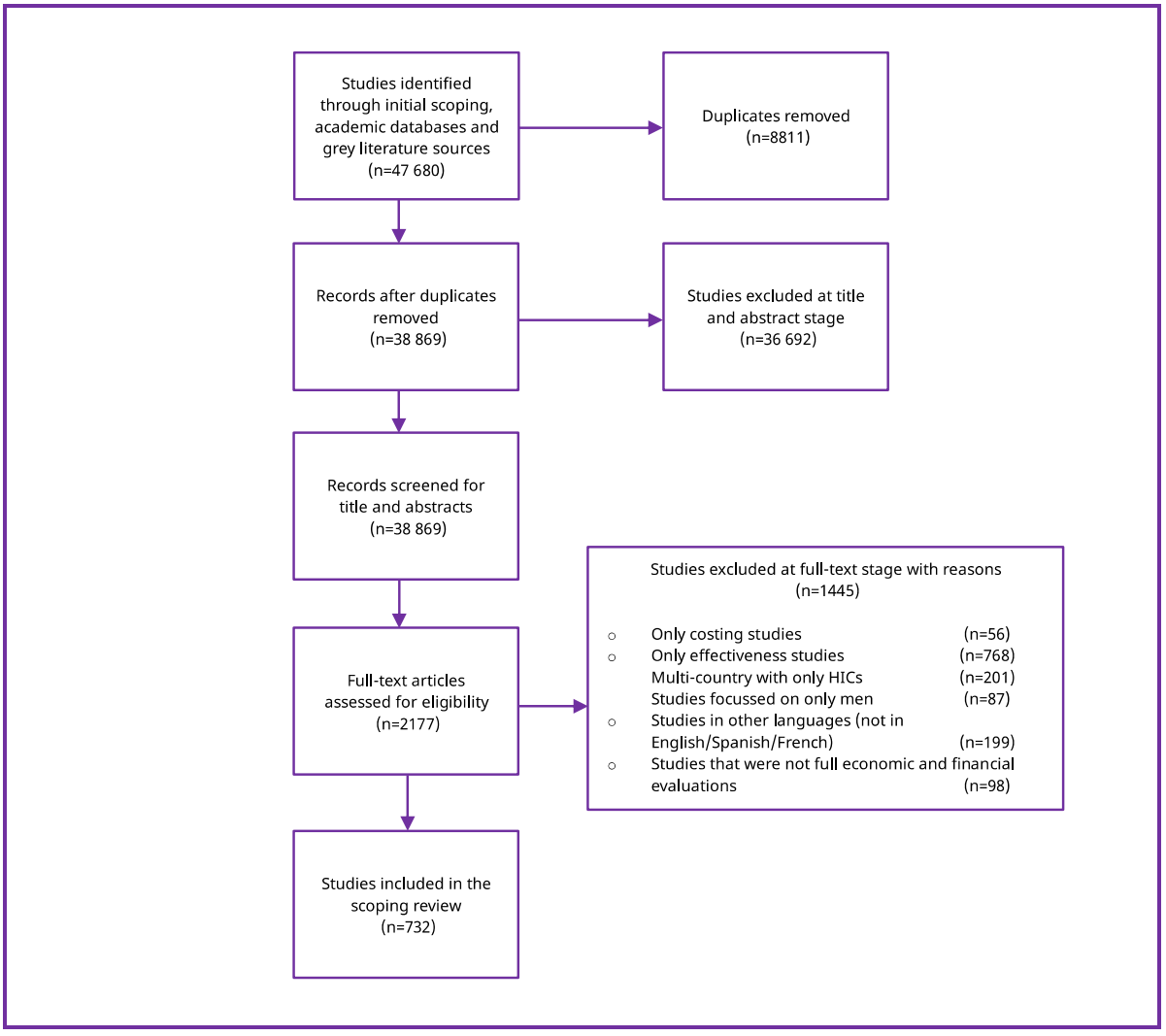
3.4 Methods for mapping

The EGM was developed using the EPPI-Mapping tool (Digital Solution Foundry and EPPI_Centre, 2020).

Chapter 4: Results

From the initial scoping exercise of academic databases and 28 grey literature sources, 47,680 studies were retrieved, of which 8811 were removed as duplicates. Some 36 692 studies were excluded after the screening of titles and abstracts revealed that they did not meet the inclusion criteria, leaving 2177 studies for full-text retrieval. Assessing for their eligibility excluded a further 1445 studies for various reasons, such as studies reporting only costing data, studies including only male populations and studies reporting only effectiveness data, as detailed in the PRISMA chart (Fig. 1). As a result, the search yielded 732 studies for inclusion in this EGM.

Figure 1 PRISMA flow diagram of study inclusion

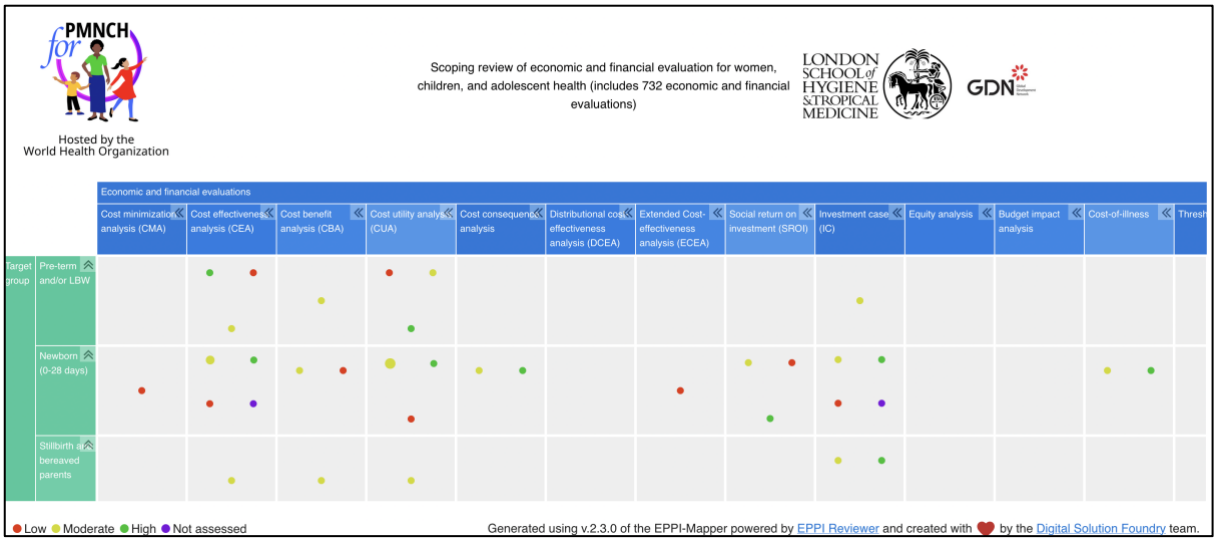


4.1 Visualization of EGM

Evidence & Gap Maps (EGM) are a useful tool for development decision-makers looking to see what evidence exists to inform policies and programmes. For funders and researchers, these maps show where more investments are needed or where they can avoid duplicating existing research. The EGM adopts a framework designed to systematically capture different interventions and outcomes associated with each of the three domains of WCAH (Kuruvilla et al., 2016). It looks at the evidence by each of the strategies (for example, MNCH and AHWB) and also looks at economic and financial evaluation by regions they have been conducted in or the types of valuation measures, and target population (Fig. 2). This is an exciting way to advocate for what a country needs to focus on as the WCAH community moves towards implementation and improved adaptation and scale-up.

The interactive file allows users to select one or more filters to see the corresponding studies along the matrix. For example, if interested in finding economic and financial evaluations targeted at children aged under-five and conducted in South Asia, the studies with these characteristics may be retrieved by selecting the required filters, such as South Asia as the region and children aged under-five as the target intervention group. The map allows users to see the bibliographic information and links to studies, mostly via URLs or digital object identifier (DOIs).

Figure 2 Snapshot of an aggregate map by target group and types of economic and financial evaluations

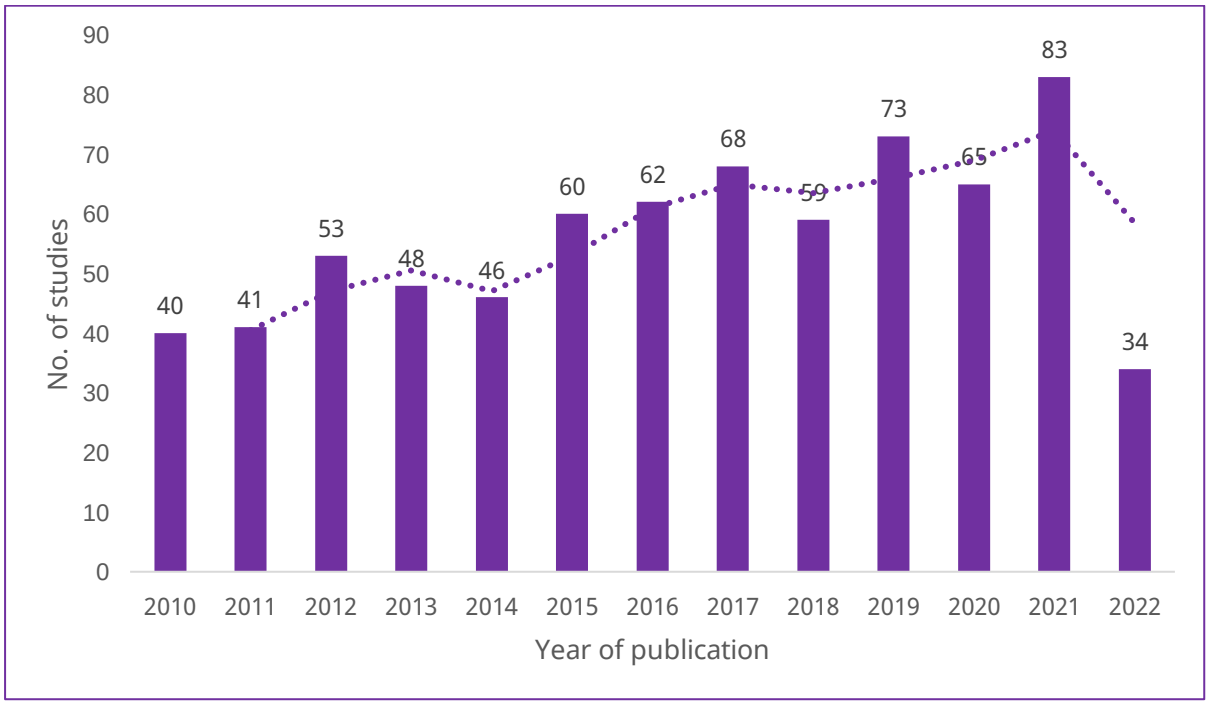


4.2 Key findings: Areas of robust evidence and gaps in evidence

4.2.1 Trends in the publication of economic and financial evaluations

The included studies have increased steadily since 2010 (Fig. 3). An increase in 2021 could also be seen, highlighting the importance of interventions for WCAH following the global COVID-19 pandemic. Close to 40% of the economic and financial evaluations included in the review were published before 2015 and indicate the need to update the evidence base.

Figure 3 Trend of economic and financial evaluations over the publication years

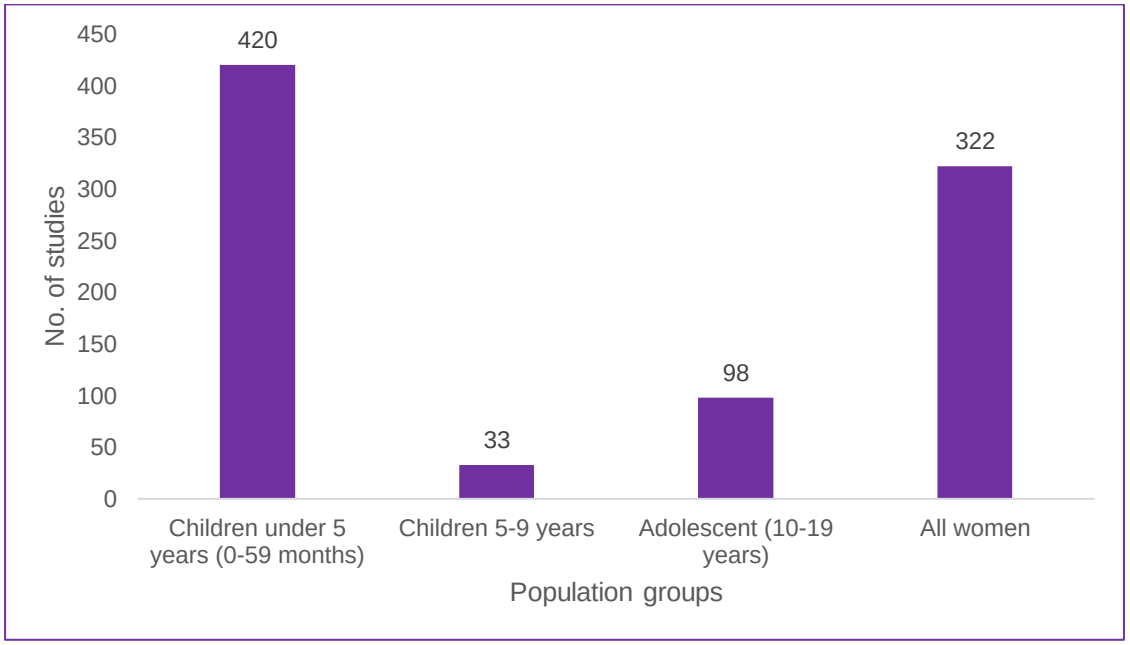


4.2.2 Characteristics of included economic and financial evaluations

Population

Approximately 57% (n=420) of the studies focused on children under-five, followed by 44% (n=322) on all women, including pregnant and lactating mothers and women of reproductive age. Approximately 13% (n=96) of the studies were focused on adolescents. School-age children (5-9 years) were under-represented with only 6% (n=50) of studies focussed on this demographic (Fig. 4).

Figure 4 Number of economic and financial evaluations by population groups



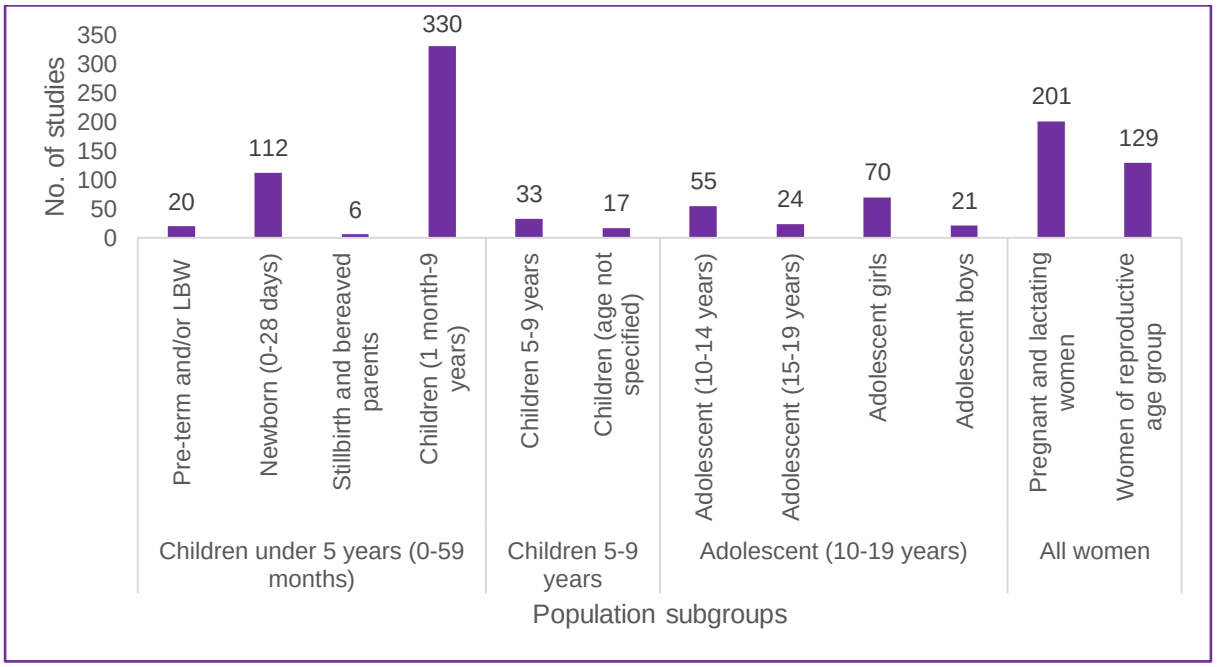
Note: The number of studies shown in each figure refers to the total number of studies under each category presented. Individual studies may be classified under multiple categories. For instance, if a study examines the impacts of multiple interventions or multiple target groups, that study would be counted within each intervention or population category studied. The sum of studies for each figure may therefore be greater or lesser than the number of unique studies associated with that figure.

Figure 5 unpacks the different population subgroups, such as adolescents, into those aged 10-14, those aged 15-19 years, adolescent girls and adolescent boys. Children aged under-five are subdivided into pre-term and/or LBW, newborns (0-28 days), children under-five, stillbirth and bereaved parents, school-age children (5-9 years) and child age not-specified.

Approximately 45% of the studies focused on children under-five (n=330), followed by 27% on pregnant and lactating women (n=201), 17% on women of reproductive age (n=128) and 15%

(n=112) on newborns. Furthermore, 10% of the studies specifically addressed adolescent girls (n=70) and 7% focused on adolescents aged 10-14 as a whole (n=55) (Fig. 5).

Figure 5 Number of economic and financial evaluations by population subgroups



Note: The number of studies in sub-group categories may not equate to the main population category as some studies target multiple population sub-groups and the same study may be coded under multiple categories. Therefore, the sum of studies for each figure may be greater or lesser than the number of unique studies associated with that figure.

Less than 5% of the studies reported on children aged 5-9 (n=33), adolescents aged 15 to 19 years old (n=24), adolescent boys (n=21), pre-term/LBW infants (n=20) and stillbirth and bereaved parents (n=6).

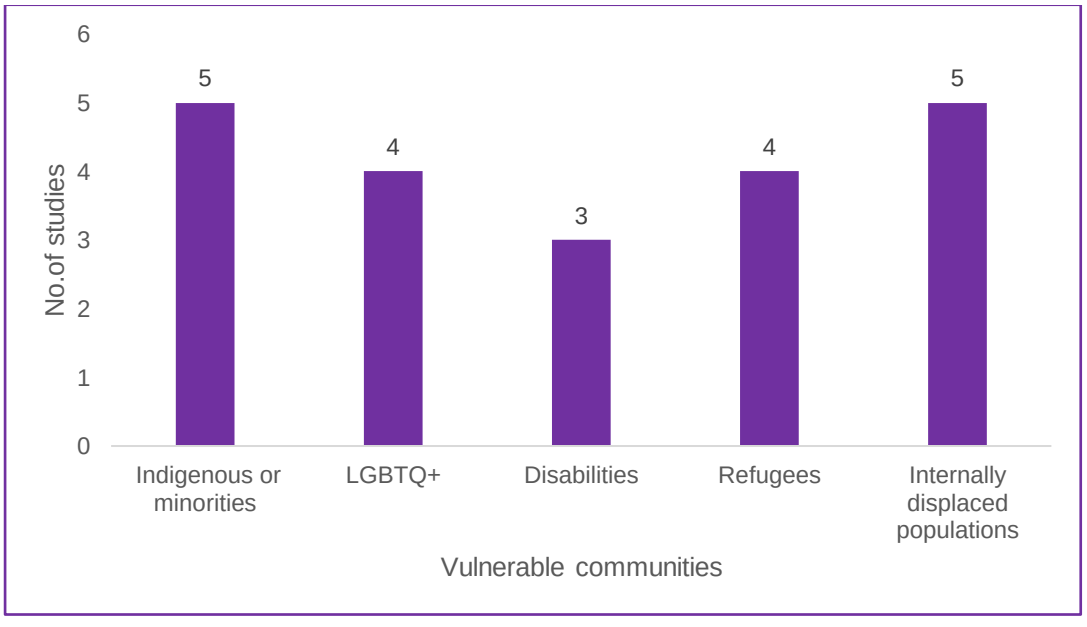
Box 2 Example of CEA on adolescent health intervention

A global cost-effectiveness study conducted in 40 countries by Sweeny et al. (2019) indicates substantial benefits from a program of interventions to improve adolescent health, which are greatest in countries where mortality rates are highest. For the 66 adolescent health interventions modelled for 40 countries and invested in between 2015 and 2030 with US$ 358.4 billion, or an average of US$ 4.5 per capita each year, seven million deaths were averted and 1.5 million serious disabilities averted.

At a 3% discount rate, the average BCRs were 12.6, 9.9 and 6.4 for low-income, lower, and upper-middle-income countries, respectively. Countries with adolescent mortality rates in excess of 200 per 100 000 had an average BCR of 14.8. In contrast, countries with adolescent mortality rates less than 100 per 100 000 had an average BCR of 5.7. These results demonstrate that countries with higher adolescent mortality rates benefit more from providing health care to adolescents than those with lower mortality rates.

Limited studies also focussed on interventions targeted at other population groups, such as vulnerable populations, the health workforce, mixed populations, women's groups and populations where subgroups were not defined (Fig. 6).

Figure 6 Number of economic and financial evaluations by other population groups



Note: The number of studies in sub-group categories may not equate to the main population category as some studies target multiple population sub-groups and the same study may be coded under multiple categories.

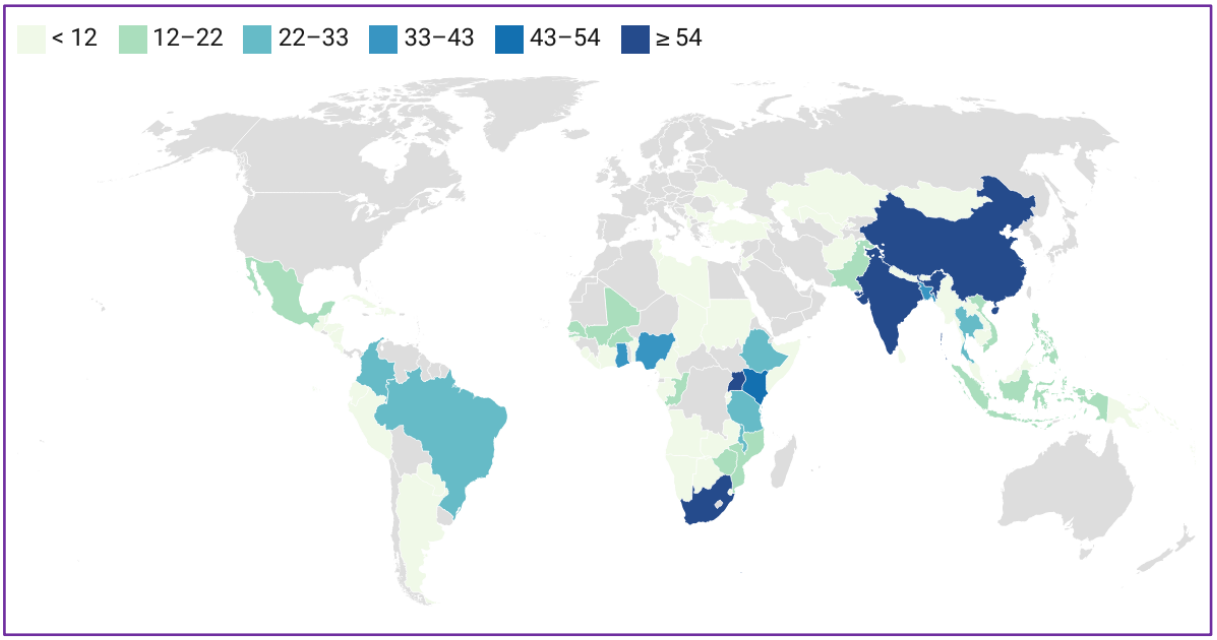
Geographical distribution of studies

The map below (Fig. 7) indicates the number of included economic and financial evaluations by World Bank region. Most studies were conducted in sub-Saharan Africa and South Asia. 42 studies included multiple or unspecified LMICs and were not included in the map. Nearly 50% of the economic and financial evaluations were conducted in sub-Saharan Africa (n=349), 25.4% in South Asia (n=187), and 16.3% in East Asia and the Pacific (n=120). Approximately 16% of studies originated from Latin America and the Caribbean (n=113), and 8% from the Middle East and North Africa (n=58). Only 4% (n=33) were conducted in Europe and Central Asia.

The studies span a total of 94 countries. The countries with the most studies include South Africa (n=64), China (n=63), India (n=62) and Uganda (n=58) (Fig. 8). Most studies from Latin America and the Caribbean were from Brazil (n=32). Francophone Africa was mostly represented by Burkina Faso (n=18), the Democratic Republic of Congo (n=13), Mali (n=12), Senegal (n=12) and Rwanda (n=11).

Although studies published in French and Spanish were included, as identified through database searches, language-specific databases were not searched. It is, therefore, possible that some of the gaps in the Francophone region are not absolute gaps, but gaps in the availability of English language literature.

Figure 7 Number of included economic and financial evaluations in LMICs by countries



Interactive link: https://datawrapper.dwcdn.net/9y22J/1/

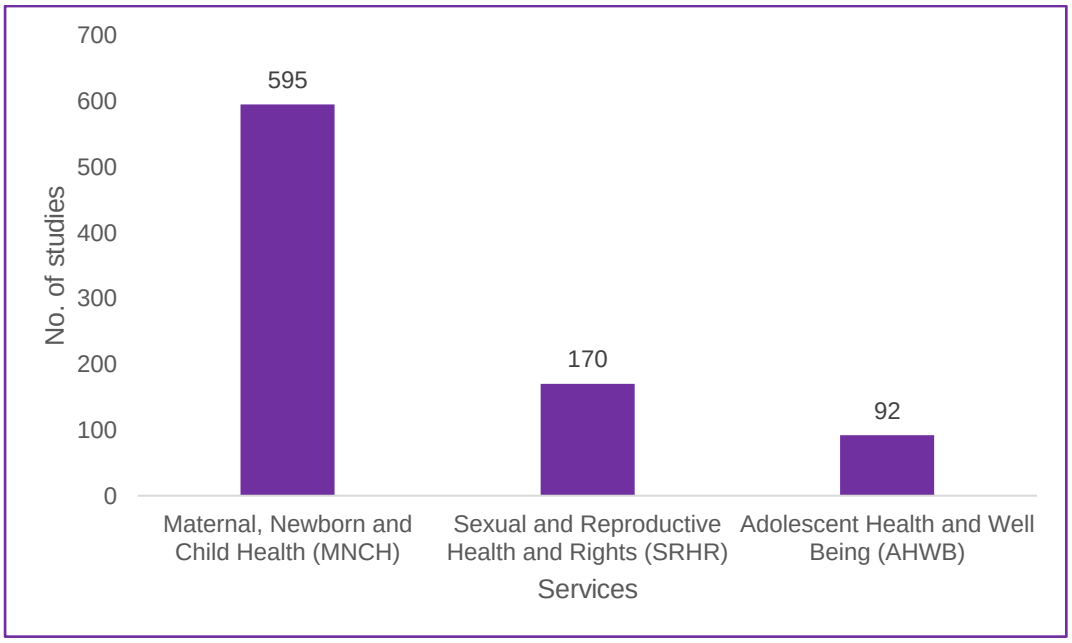
Map generated by Ashrita Saran, Global Development Network. Note: This map is stylized and not to scale. The presentation of the material does not imply the expression of any opinion concerning the legal status of any country or territory, or of its authorities or the delimitations of its frontiers.

Figure 8 Countries with more than 10 economic and financial evaluations

Intervention categories: services

The most concentrated category was MNCH with 81% (n=595) of studies falling under this category. This is followed by SRHR with 23% (n=170) and AHWB with 12% (n=92) of studies. There's a striking difference between MNCH and SRHR because most studies focussed on immunization and infectious diseases (Fig. 9).

Figure 9 Number of economic and financial evaluations by services

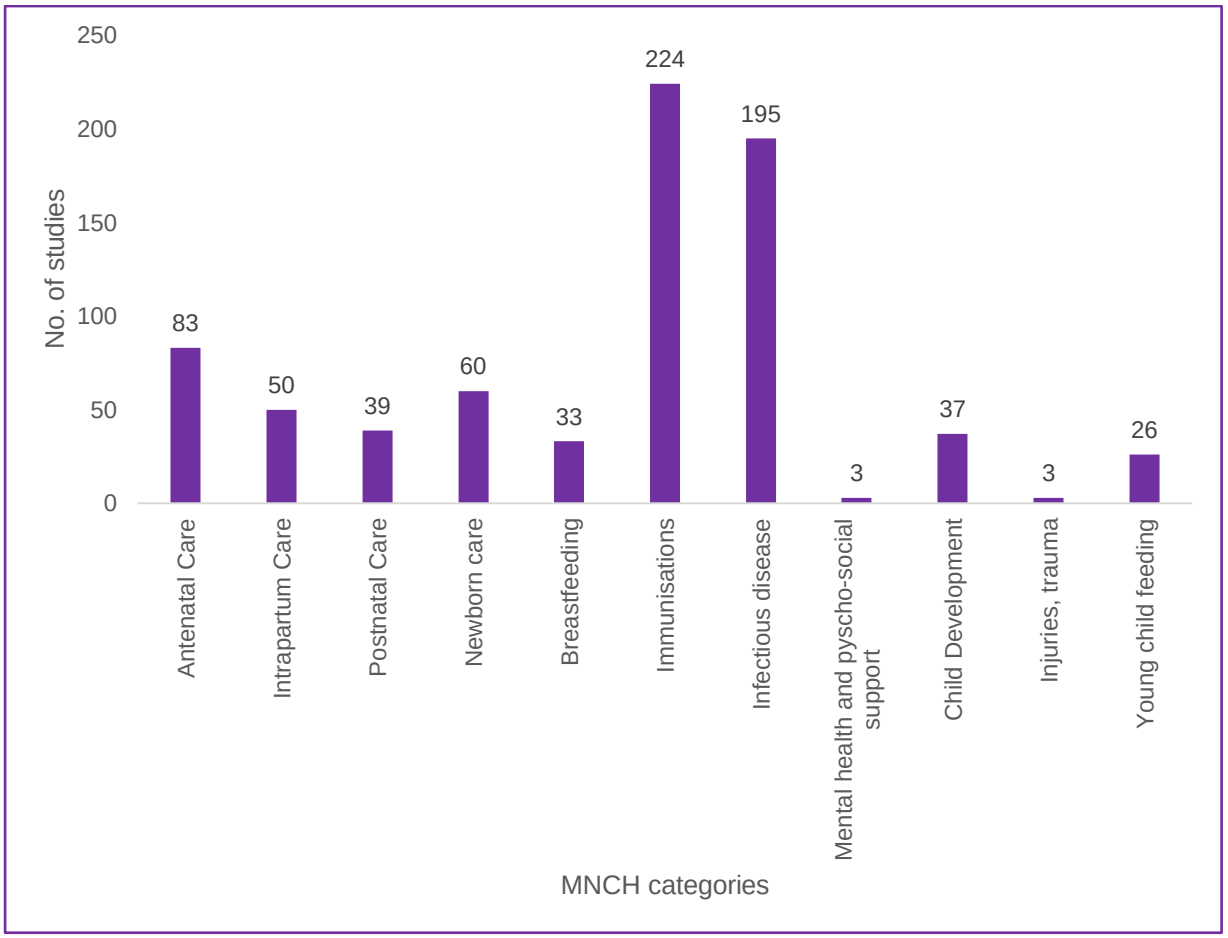


Note: The number of studies in each figure refers to the total number of studies that fall under each category. Individual studies may be classified under multiple categories.

MNCH

The most frequently reported MNCH intervention was immunization with 38% (n=224) of studies focussing on this. 32% looked at interventions to combact infectious diseases (n=195), 11% focussed on antenatal care (n=83) and 10% looked at newborn care (n=60) (Fig. 11). Almost 8% (n=50) of the studies examined intrapartum care and 7% each on postnatal care (n=39) and child development (n=37). Approximately 5% of the studies were related to breastfeeding (n=33) and young child feeding (n=26). There are significant gaps in the evidence regarding injuries and trauma (n=3) and mental health and psychosocial support (n=3).

Figure 10 Number of economic and financial evaluations by MNCH categories



Note: The number of studies shown in each figure refers to the total number of studies falling under each category presented. Individual studies may be classified under multiple categories.

Box 3 Example of economic and financial evaluation on mental health and psychosocial support

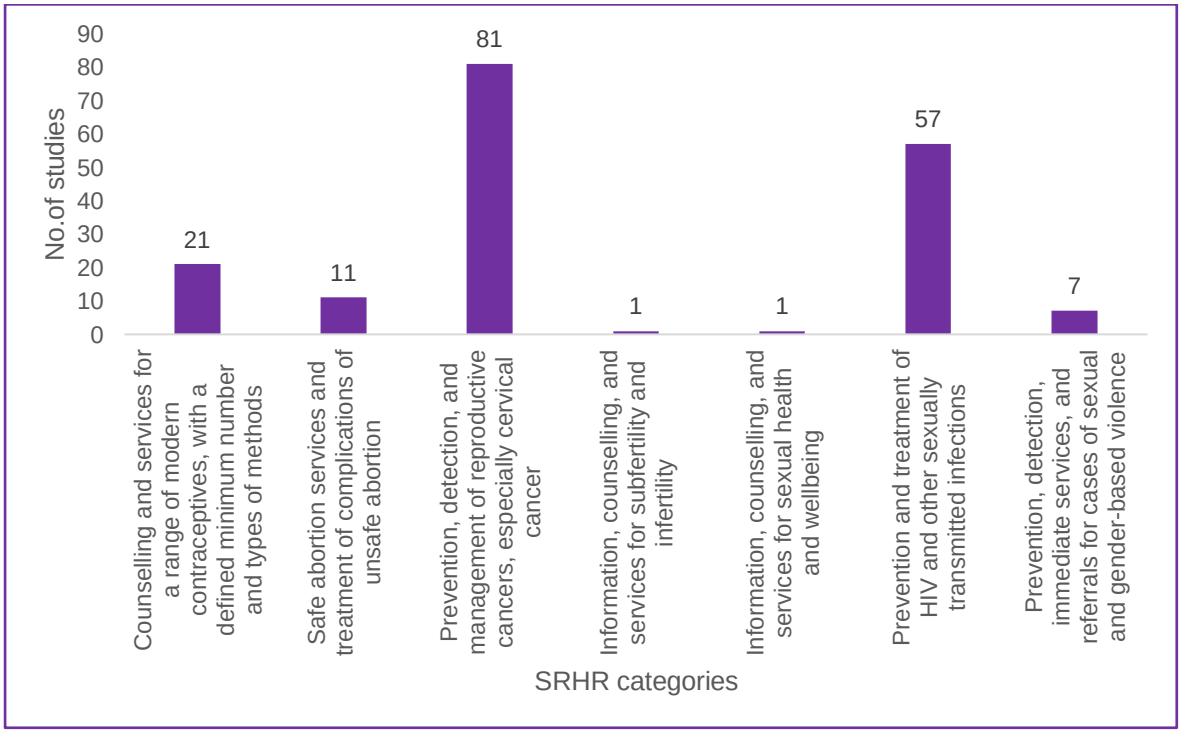
Stelmach et al. (2022) investigated the ROI for interventions aiming to improve adolescent mental health for a wide range of countries (36). Using a Markov model and drawing on the best available estimates of intervention sizes, costs and the value of human and economic benefits, these authors estimate a benefit/cost ratio of 23.6 for these interventions. The high ROI and low cost per DALYs averted suggest the importance and value of addressing mental disorders among adolescents globally.

An ECEA by Johnson et al. (2017) on mental health services in Ethiopia found that for US$ 1 invested in mental health services, the expected financial risk protection return does not exceed US$ 0.00001. The lowest-income quintile is expected to gain 41 970 HLYs for all mental health treatments, whereas the highest-income quintile has an expected gain of 19 160. The annual cost of mental health care is expected to be close to US$ 48 million in the lowest-income quintile and US$ 22 million in the highest-income quintile. While targeting mental health care treatments to the poorest quintile may appear to be the most cost-effective approach with the highest ROI, a comprehensive strategy that includes population-wide interventions is necessary to achieve a sustained effect.

SRHR

For SRHR, studies focussed on the prevention, detection and treatment of reproductive cancers, especially cervical cancer, accounted for 47% (n=81) followed by HIV and other STIs at 37% (n=57) (Fig. 11). Close to 12% (n=21) of studies reported counselling and services for a range of modern contraceptives with a defined minimum number and types of methods and 6% (n=11) on safe abortion services and treatment for complications arising from unsafe abortion. Only 4% (n=7) of studies looked at the prevention, detection and immediate services and referrals for cases of sexual and GBV. There are critical gaps in evidence with only one study identified each on information, counselling, and services for subfertility, infertility and information and counselling and services for sexual health and well-being. No studies were identified on CSE.

Figure 11 Number of economic and financial evaluations by SRHR



Note: The number of studies shown in each figure refers to the total number of studies falling under each category presented. Individual studies may be classified under multiple categories.

The available studies provide a comprehensive overview of the cost-effectiveness of different interventions, which is essential for making informed decisions (Box 4).

Box 4 Example of studies with robust evidence on GBV

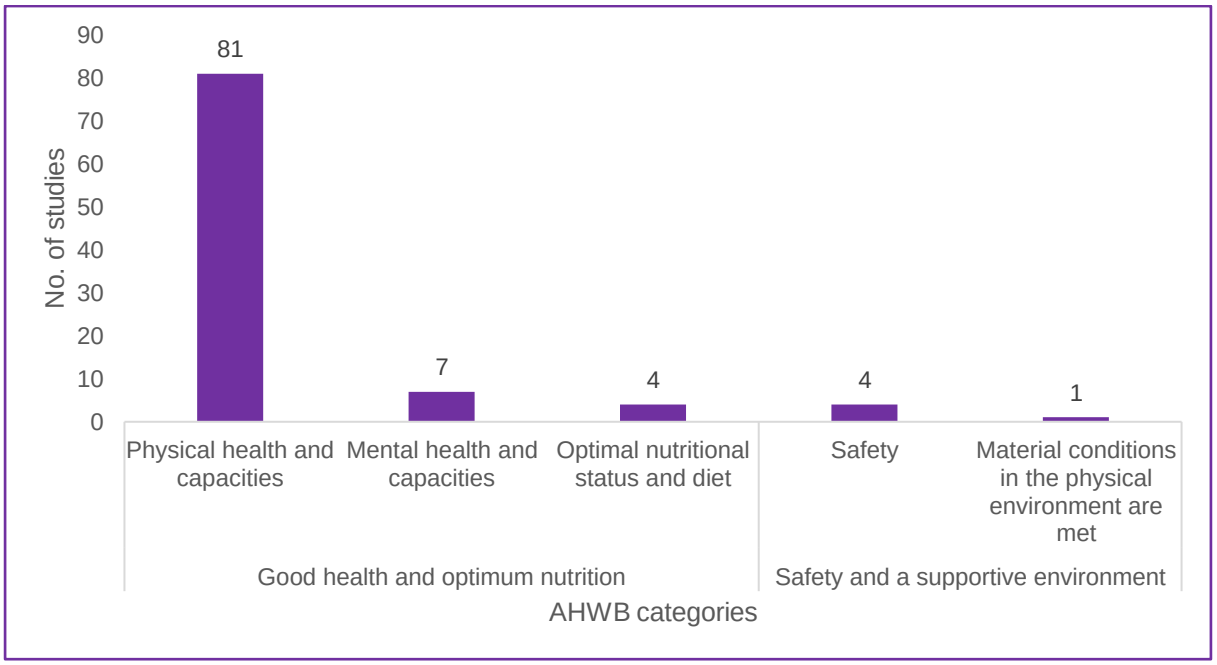
Leight et al. (2021) evaluated the cost-effectiveness of Unite for a Better Life (UBL), a gender-transformative intervention aimed at preventing intimate partner violence (IPV) in rural southern Ethiopia. The intervention involved participatory skill-building courses on various topics, which were facilitated among women, men, and couples, and incorporated into a local ceremony. The annual cost of implementing UBL was estimated at US$
296 772. For the direct beneficiaries, the cost per case of past year physical and/or sexual IPV averted was estimated at US$ 2726 in 2015, and US$ 194 for community-level beneficiaries, indicating that IPV prevention programmes are both efficient and cost-effective methods for protecting communities against physical and/or sexual IPV. Such investments yield benefits not only for direct beneficiaries but also for the broader community. The relatively low cost per case of IPV averted, especially at the community level, suggests that such investments can lead to substantial reductions in IPV, benefiting both individuals and broader communities. This could be advocated in national health and social policy frameworks as a proven strategy to reduce violence and enhance community health.

Greco et al. (2018) analyzed the cost-effectiveness of the 'Good School Kit' in reducing physical violence perpetrated by school staff toward students in Uganda. The total cost per case of violence averted was US$ 244. With an annual implementation cost of US$ 96 per case averted during the trial. The 'Good School Kit' represents a cost-effective intervention for reducing violence against pupils in primary schools in Uganda, compared to other violence reduction interventions in the region. However, direct comparisons were not possible as this was the first school-based violence prevention programme evaluated through a randomized controlled trial (RCT) with an accompanying cost analysis. The affordability of the programme, indicated by the low annual implementation cost per case averted, makes it an attractive option for widespread adoption.

AHWB

AHWB subcategories are classified according to the AHWB framework (Ross et al., 2020). Approximately 94% (n=88) of the studies reported on good health and optimum nutrition, 6% (n=6) safety and supportive environments or 2% (n=2) learning, competence, education, skills and employability (Fig. 12).

Figure 12 Number of economic and financial evaluations by AHWB categories



Note: The number of studies shown in each figure refers to the total number of studies falling under each category presented. Individual studies may be classified under multiple categories.

Health system enablers

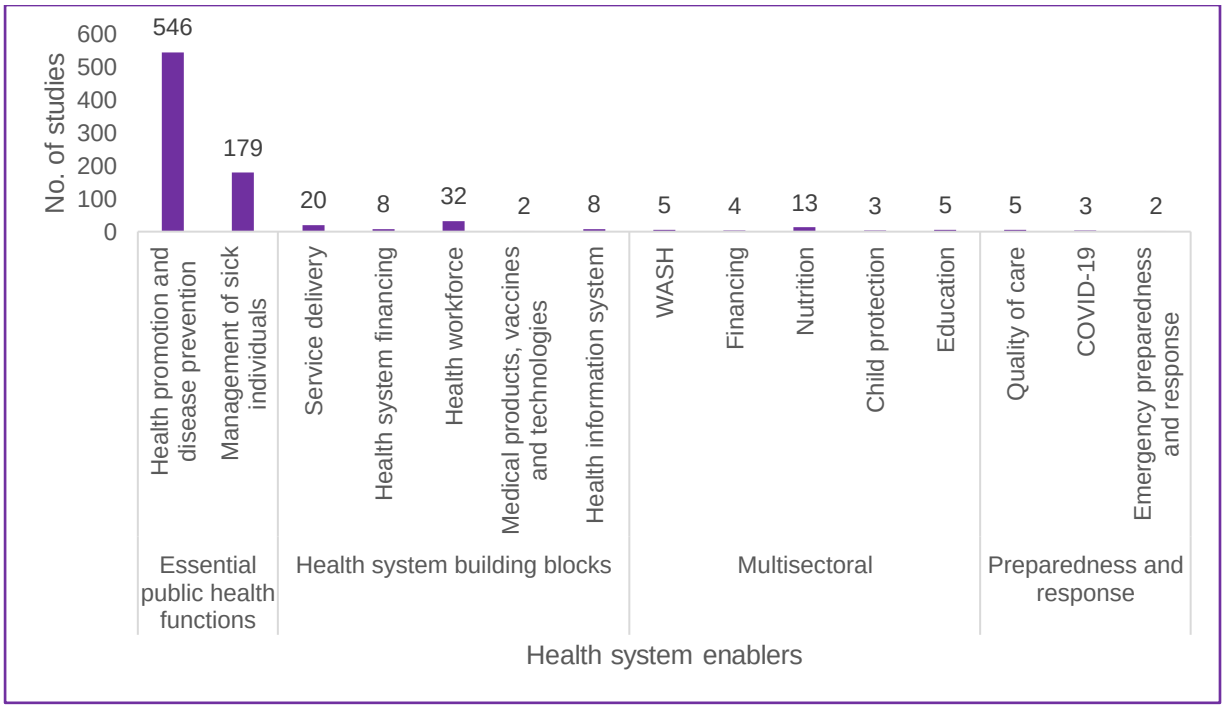
A total of 81% (n=545) of studies focused on health promotion and disease prevention while only 27% (n=180) focused on managing sick individuals. This is evident as most included economic and financial evaluations on immunization and on preventing infectious diseases such as HIV/AIDS (Fig. 13).

Less than 10% of studies reported on the health workforce, including community health workers, nurses and tertiary health care workers (n=32), service delivery (n=20), health system financing (n=8) and health information systems (n=8). While there were a limited number of studies that focussed on health system building blocks, the data they produced is crucial as it supports a better understanding of how investments in health workforces affect health outcomes and can support the monitoring of reforms in health systems. Additionally, they provide insight into which health workforce investments are most cost-effective, which supports in making policy decisions. Close to 30 economic and financial evaluations were identified on multisectoral interventions in conjunction with WCAH. 11 incorporated nutritional interventions.

There were gaps in evidence on multisectoral interventions in education (n=5) and WASH (n=5) (Fig. 13). Highlighting a striking gap in evidence, less than five studies focussed on child protection

(n=2) and financing (n=4), which suggests increased investment in research in these critical areas is needed.

Figure 13 Number of economic and financial evaluations by health system enablers

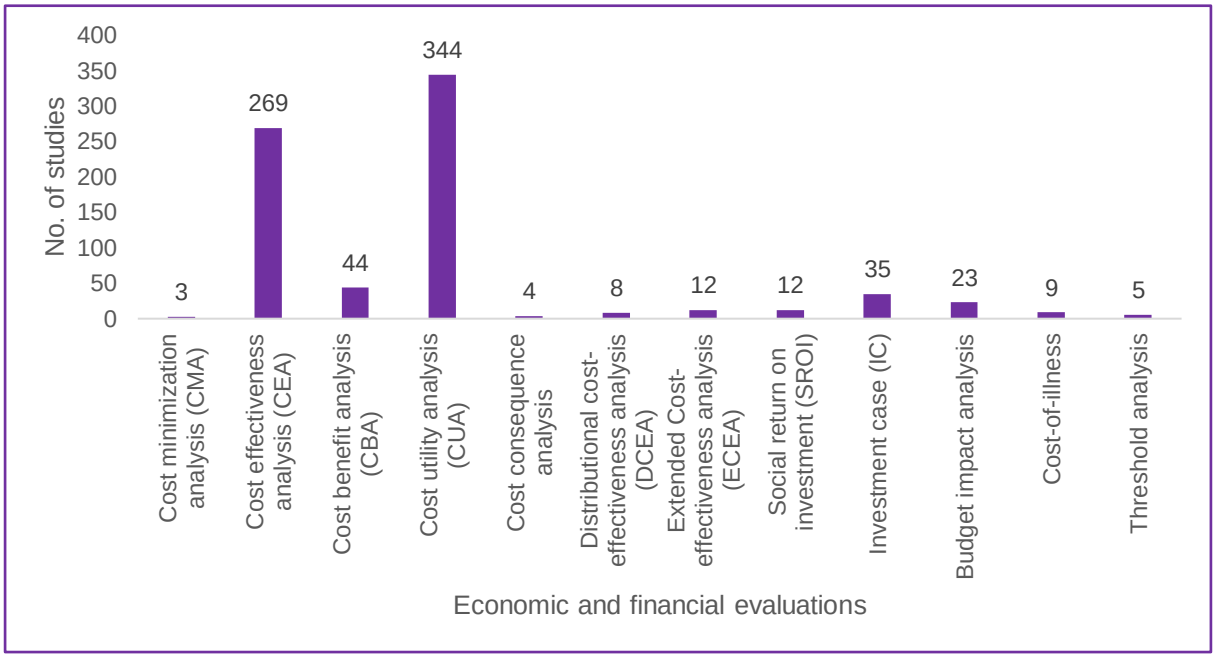


Note: The number of studies shown in each figure refers to the total number of studies falling under each category presented. Individual studies may be classified under multiple categories.

Economic and financial evaluations

48% of studies (n=349) used a CUA to estimate health outcomes based on quality-of-life measures whereas 39% used a CEA (n=284) to estimate health outcomes related to specific conditions (Fig. 14). In fewer than 6% of the studies (n=51), a CBA was conducted. Few studies reported cost-minimization (n=4), cost-consequence (n=4) and threshold analysis (n=3). Studies on other types of economic and financial evaluations included budget impact analysis (n=23), investment cases (n=36), SROI (n=11), DCEA programs (n=8), ECEA (n=12) and cost of illness (n=8).

Figure 14 Number of economic and financial evaluations

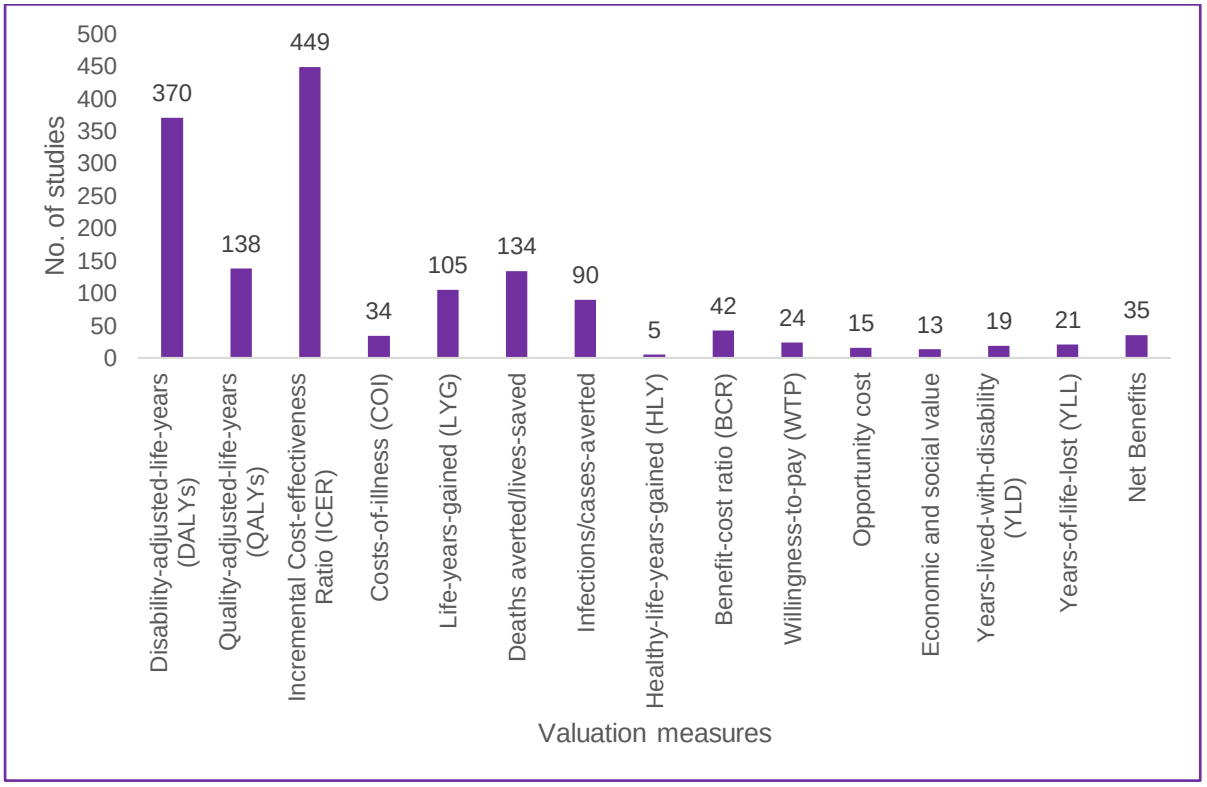


Note: The number of studies shown in each figure refers to the total number of studies falling under each category presented. Individual studies may be classified under multiple categories. For example, in one study CBA estimated net benefits by comparing total costs with monetary benefits of health-related and non-health outcomes for each intervention package, while The ECEA estimated the costs of the intervention packages per unit health and non-health gain stratified by the standards of living.

4.2.3 Valuation methods and outcome measures

Figure 15 illustrates the most common valuation method used for 23 of the most frequently reported outcome measures. In the 732 identified studies, 1651 intervention-specific summary outcome measures were reported with substantial variations. As a measure of benefit, some analyses converted data into utility-based outcomes; 50% (n=370) reported DALYs, 18% (n=138) reported QALYs and 12% (n=135) reported deaths averted. Other measures reported included averted costs of illness or episodes of illness and cost per pregnancy averted.

Figure 15 Number of economic and financial evaluations by valuation method or outcome measures



Note: The number of studies in each figure refers to the total number of studies that fall under each category. Individual studies may be classified under multiple categories.

The 346 cost-utility analyses reported 890 intervention-specific cost-effectiveness ratios, including ICERs (n=273), dollars per DALYs (n=258) and dollars per QALYs (n=113), The 284 CEAs reported 583 intervention-specific cost-effectiveness ratios, including ICERs (n=162), infections averted (n=67), dollars per life-year gained (n=65), dollars per deaths averted (n=53) and dollars per deaths averted (n=51), dollars per years lived with disability (n=19), averted COI (n=10) and willingness to pay (n=10). 51 CBAs reported 45 net monetary benefit measures and four values of net health benefit.

Notably, six ECEAs evaluated the catastrophic health expenditure averted (n=3), dollars per QALY gained (n=2), deaths averted (n=5) and financial risk protection afforded (n=3). Two DCEAs evaluated the impacts of interventions across geographical inequality in rural populations as dollars per health-adjusted life years, dollars per life-years gained and dollars per deaths averted.

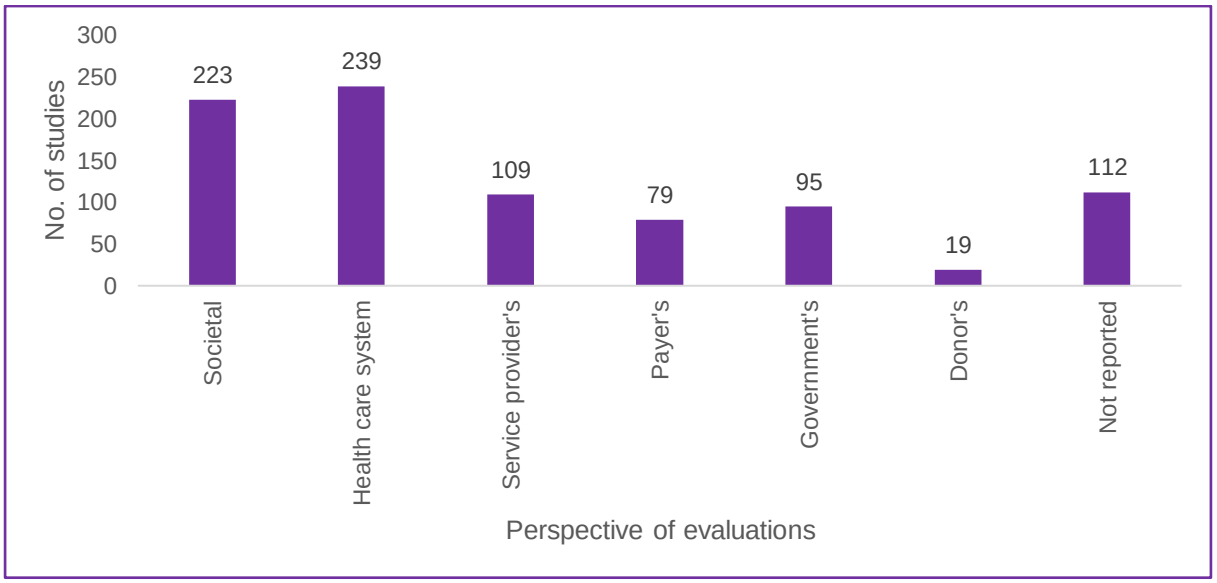
4.2.4 Perspective of evaluations

Depending on the study perspective, such as that of the patient, payer, health system provider, various costs and outcomes are considered. Economic and financial evaluations incorporating a societal perspective are preferred because they include both direct and indirect costs, such as direct costs to patients and opportunity costs, regardless of who bears that cost or receives the benefit. It is, thus, critical to think beyond the effectiveness of the intervention and consider the potential to incur opportunity costs.

Of the economic and financial evaluations included in this report, 32% (n=240) used a health care system perspective and 30% (n=222) used the broadest perspective, a societal perspective (Fig. 16). A societal perspective considers a policy's long-term effects on all stakeholders.

While some analyses were conducted from a societal viewpoint, capturing a broad spectrum of consequences, there was a limited exploration of costs, with a focus predominantly on direct costs. Only 14% (n=108) of the studies adopted a service provider perspective. Governmental perspectives were considered in 12% (n=95) of the cases. A narrower focus, such as that of payers, was evident in only 8% (n=78) of the analyses, and a mere 2% (n=19) incorporated perspectives from donors. The perspective from which the evaluation was conducted was either unspecified or not reported in approximately 15% (n=112) of instances. This ambiguity in the perspectives utilised for the evaluations complicates the identification of key stakeholders and the optimal targeting of the evaluations. Moreover, it casts doubts on the credibility of the evidence and the efficacy of the evaluation processes.

Figure 16 Number of economic and financial evaluations by the perspective of evaluations

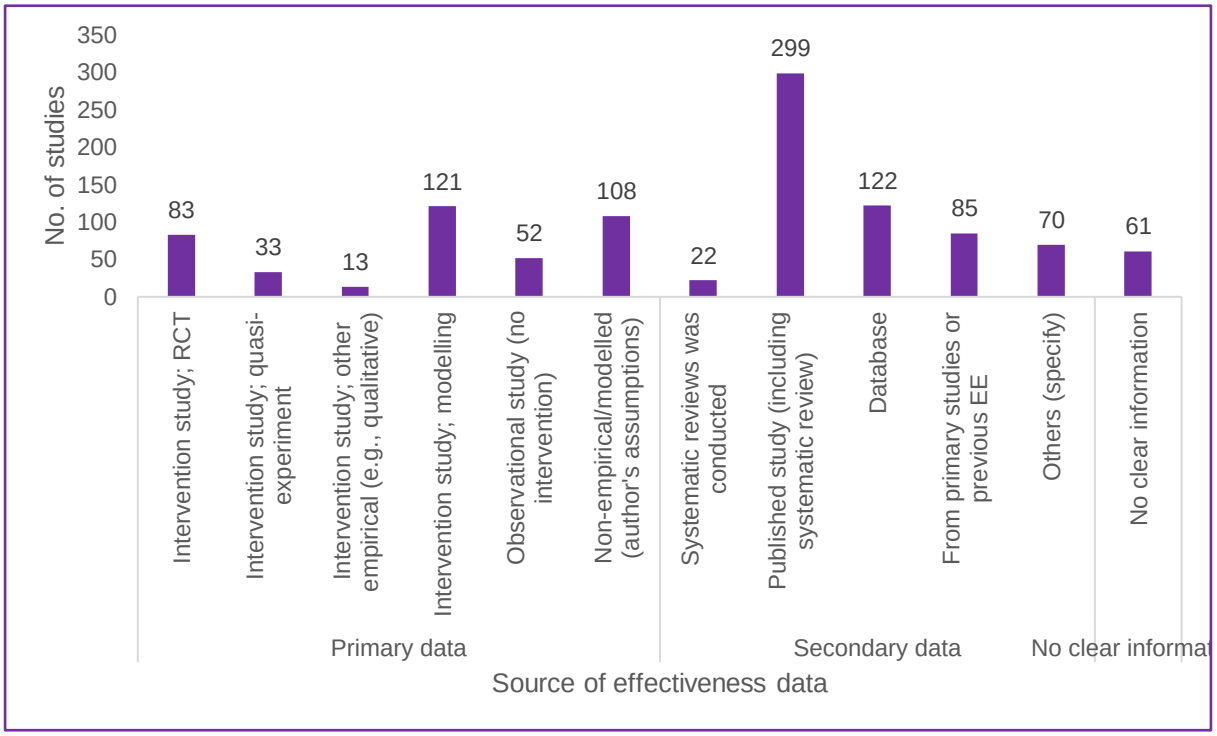


Note: The number of studies shown in each figure refers to the total number of studies falling under each category presented. Individual studies may be classified under multiple categories.

4.2.5 Attribution of effects

Most studies in this review valued effectiveness using previously published data or made assumptions about the effect or impact. Limited evidence of the effects in program evaluation data or limited costing data can result in an under- or over-estimation of the impact of a program, which can impact the quality and precision of an economic analysis. Most evaluations (n=484) reported using secondary data to measure effectiveness. Previously published studies were the most common source (n=283); systematic reviews were conducted for 24 studies (Fig. 17). Evidence from databases (n=124) and previously published economic and financial evaluations (n=89) were also included. The primary data source was reported in 406 evaluations. Intervention study designs included RCTs (n=86), quasi-experimental designs (n=35), modelling studies (n=120) and non-empirical designs (n=108).

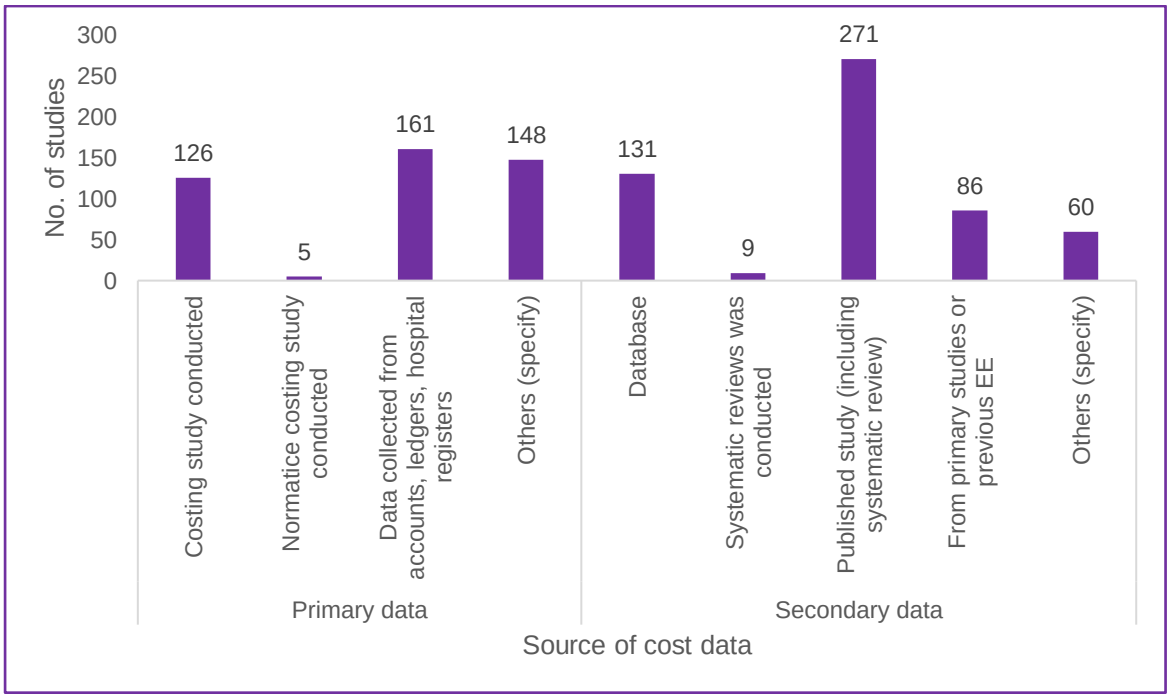
Figure 17 Number of economic and financial evaluations by source of effectiveness data



Note: The number of studies shown in each figure refers to the total number of studies falling under each category presented. Individual studies may be classified under multiple categories.

When primary data on costs was used, it was frequently collected from official records, such as hospital registers (n=162), or a dedicated costing study was conducted (n=134) (Fig. 18). Secondary data sources included previous studies (n=340) and databases (n=133).

Figure 18 Number of economic and financial evaluations by the source of cost data



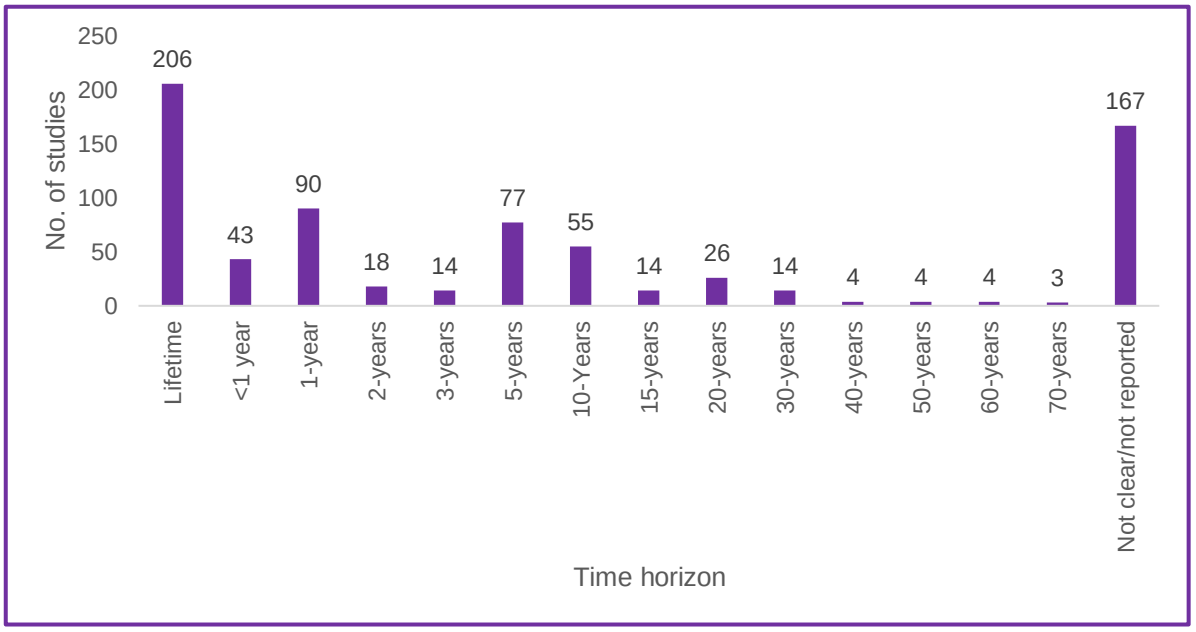
Note: The number of studies in each figure refers to the total number of studies that fall under each category. Individual studies may be classified under multiple categories.

4.2.6 Time horizons

Generally, economic and financial evaluations should be conducted over a period of time sufficient to capture the full cost and effects of an intervention. The time horizon for a high-quality study should exceed 10 years. 30% (n=206) of economic and financial evaluations reported having lifetime time horizons (Fig. 19). These evaluations considered the preference for future benefits over immediate benefits and applied a discount rate, typically between 3% and 5%.

For some studies, a short time horizon of less than one year seemed appropriate as they evaluated response rates or attendance at health care centers during pregnancy for antenatal care or postnatal care check-ups rather than long-term outcomes, such as health outcomes. Using a discount rate, these evaluations could consider the preference for future benefits over immediate ones while still considering the relatively short time horizon.

Figure 19 Number of economic and financial evaluations by time horizons



4.3 Assessment of the risk of bias

Overall, the studies were conducted well. Close to 30% (n=217) were assessed as having a low risk of bias and, therefore, as having high-quality findings. 52% (n=387) were considered as having a moderate risk of bias and hence considered of medium quality (Fig. 20). The high-quality studies had a clearly defined research question and a clear comparator, although that was not always explicitly stated. The studies used a design relevant to the research question–CEA or CUA–and appropriate benefits measures such as life-years gained, QALYs or DALYs. These measures are widely recognized and commonly used in health economics to quantify the impact of interventions on individuals' health outcomes. Furthermore, the studies included in this review aimed to demonstrate the long-term cost-effectiveness of the interventions under consideration. To achieve this, they utilized a lifetime or a time horizon appropriate for the specific disease being evaluated. By extending the analysis to a longer time frame, the studies were able to capture the potential long-term benefits and costs associated with the interventions.

The studies conducted sensitivity analyses to account for uncertainties in the parameter values used in the economic evaluations. Sensitivity analyses are important in assessing the robustness of the findings and provide insights into how the results might change under different scenarios or assumptions. These sensitivity analyses help policy-makers to understand the potential range of outcomes and to make informed decisions based on the available evidence. The majority reported analysis from a societal perspective and included both full direct and indirect costs, such

as direct costs to patients and opportunity costs, regardless of who bears the costs or receives the benefits.

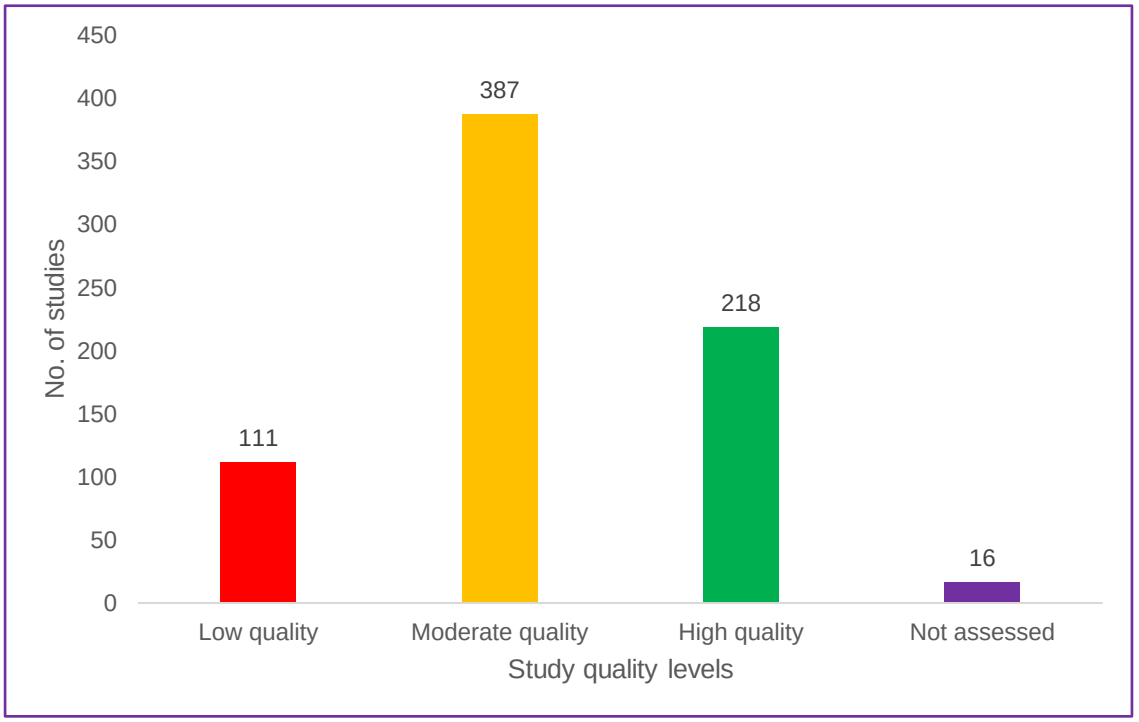
Overall, the evidence suggests that the interventions evaluated in these studies have the potential to be cost-effective in the long term. The use of appropriate measures of benefits, such as QALYs or DALYs, along with lifetime horizons and sensitivity analyses, strengthens the credibility and reliability of the findings.

Evaluations with a potentially high risk of bias, and therefore considered to have low-quality findings, often did not describe the perspective. In such cases, from the costs calculated, it can be assumed that the perspective is that of the intervention implementer. Sometimes, patient or service user costs were also included. Some studies included a mix of perspectives, for example, the health care system and government.

Similarly, although the majority of the studies included the currency used in their analysis, most failed to include the date or year the that costs were calculated. The lack of this information limits reviewers' ability to convert and compare to other studies. Also, the time horizon was not reported in approximately 25% of the studies. Included economic and financial inclusion was also driven by multiple assumptions that differed across research studies and which used discount rates, ranging from 3% to 7%, resulting in dramatic differences in study conclusions. Several evaluations considered to have a high risk of bias also did not measure the uncertainty of estimates. More consensus regarding analytic procedures and assumptions would enhance the comparability and rigour of economic and financial evaluations in WCAH, improving opportunities to synthesize findings across studies.

Since there is no published tool for evaluating specific designs, such as investment cases and project appraisal documents by funders, the risk of bias for 16 evaluations was not assessed as the methods employed differed slightly from standard economic and financial evaluations.

Figure 20 Number of economic and financial evaluations by quality in study findings



Chapter 5: An equity-informative Cost-effective analysis

Distributional cost-effective analysis (DCEA) and Extended Cost-effectiveness economic analysis (ECEA)

According to our analysis, 20 studies assessed health interventions' financial risk protection and distributional impacts based on various equity criteria, including differential social valuation of QALYs and population-specific parameters such as rural settings.

Most studies (57%) used lives saved or deaths averted as a measure of the health benefits; the majority of studies considered were on immunization where close to 30% used DALYs and QALYs.

This review highlights that DCEA and ECEA that examine equity effects are available and increasing in number. Some (n=12), of moderate and high quality (n=8), meet the standards and recommendations for high-quality reporting of CEA. However, the majority of these are dated and there is a strong need to update the evidence base. Although government (n=5), health care (n=3), and societal (n=4) perspectives were common among the studies included, approximately 33% did not state a perspective in their analysis.

63% of the economic and financial evaluations were assessed as having a moderate risk of bias and therefore considered of overall moderate quality. The remaining ones were considered as being of high or low quality. The most common omissions in low-quality studies were study perspective (28%), assumptions underpinning the decision analytic model used (22%), characterizing uncertainty (19%) and a structured abstract (19%). The studies included explored three unique equity or distributional criteria, the most common being socioeconomic status (62%) and geography (26%). Only one included access to care.

Table 6 Selected characteristics of included equity informative economic and financial evaluations

Summary of key characteristics	Number of economic and financial evaluations
Measure of effectiveness	
Lives saved/Deaths averted	11
QALY	2

DALY	5
Life years gained	1
Perspective	
Societal	4
Health care system	3
Government	5
Not stated	6
Equity or distributional criteria	
Socioeconomic	12
Access to care	1
Geography	5
I**ntervention**	
MNCH	
Immunization	10
Infectious diseases	4
Young child feeding	1
SRHR	
Prevention, detection and management of reproductive cancers, especially cervical cancer	3
Counselling and services for a range of modern contraceptives with a defined minimum number and types of methods	3
Quality of study's findings	
High	3

Moderate	12
Low	4

Box 5 Example of ECEA

Levin et al. (2015) conducted an ECEA to evaluate public financing of the human papillomavirus (HPV) vaccination in preventing cervical cancer in China. It was found that the cost benefits received by women in the bottom income quintile were higher than those received by women in the upper wealth quintile. In the bottom income quintile, the cost savings associated with the vaccination accounted for a greater share of per capita income (60% compared to 30%). HPV vaccination prevents 15% more cancer cases in the lowest quintiles and 18% more deaths than in the highest income quintile. The absolute number of cervical cancer deaths averted and the financial risk protection from HPV vaccination were highest among women in the lowest income quintile. Given that the financial risk protection from HPV vaccination is highest among the lowest income quintile, integrating HPV vaccination into public health insurance programs could be a strategic move to prevent financial hardship due to healthcare costs. This approach would also support broader economic stability for vulnerable populations.

5.1 Findings from the equity-informative economic and financial evaluations

Evidence from the equity-informative economic and financial evaluations suggests the interventions are highly pro-poor (Table 7). For example, interventions such as financial incentives and increased coverage positively impact health equity with health gains in the form of deaths averted. Additionally, financial protection is higher in the lowest-income communities than those of a higher-income background. This suggests that the interventions provide the largest benefits to populations with limited access to services before their implementation. This could include regions with inadequate healthcare facilities or areas with high poverty levels and limited resources. This indicates that the interventions successfully bridge the gap in health care disparities and address the specific needs of disadvantaged populations.

Table 7 includes findings from selected economic and financial evaluations below alongside a brief narrative.

Table 7 Findings from equity informative economic and financial evaluations

Author and year	Country	Target group	Condition and interventions	ICER

Campos et al., 2017	Uganda	All women	Cervical cancer andHPV screening	ICER 50% coverage one screening: ICER: US$140 per YLS and two screening ICER: US$270 per YLS and three screenings ICER: US$530 per YLS
Dawkins et al., 2018	Ethiopia	Children under-five	Rotavirus vaccination via a re-designed, pro-poor vaccination program (compared to standard program)	ICER: US$ 69 per health-adjusted life year found ineffective. However, based on the Atkinson inequality aversion parameter, health gains were weighted at least 3.86 times more highly in the poorest wealth quintile group.
Driessen et al., 2015	Ethiopia	Children under-five	Measles vaccination	Routine immunization (vs. status quo): US$ 427 per death averted. Routine immunization with financial incentive (vs. status quo): US$ 2183 per death averted. Supplemental immunization activity (vs. status quo): $US 576 per death averted. Increased vaccination coverage. Household expenditures averted are three times higher for the bottom two quintiles under the incentive option.

Johansson et al., 2015	Ethiopia	Children under-five	Pneumococcal vaccination	Pneumococcal vaccination (vs. status quo) ICER: US$ 40 per year of healthy life. Pneumonia treatment (vs. status quo) ICER: US$ 107 per year of healthy life. Scaling-up pneumococcal vaccines at around 40% coverage would cost about US$ 11.5 million and avert about 2090 child deaths annually while a 10% increase of pneumonia treatment to all children under-five would cost about US$ 13.9 million and avert 2610 deaths annually. The financial risk protection benefits would also be largely concentrated among the bottom income quintile.
Levin et al., 2015	China	All women	Cervical cancer and HPV vaccination	HPV vaccination (vs. status quo) ICER: US$ 10 920 (quintile 1)-$US 13 277 (quintile V) per death averted. In the lowest income quintile, HPV vaccination prevents 15% more cancer cases and 18% more deaths than in the highest income quintile.

Nandi et al., 2016	India	Children under-five	Home-based newborn care program	Home-based neonatal care (scenario 1 vs. status quo) ICER: US$ 382 per death averted. Intervention benefits are greater for lower socioeconomic groups and in the poorer states of Chhattisgarh, Uttarakhand, Bihar, Assam and Uttar Pradesh.
Nandi et al., 2017	India	Age not defined	Diarrhoea and WASH	Water and sanitation in 95% of randomly selected households (vs. status quo) ICER: US$ 85 per episode averted. The number of deaths averted ranges from US$ 105 to US$ 10 per US$ 100 000 in the lowest to highest quintiles in intervention one, and from 113 to 11 per US$ 100 000 children under intervention.
Pecenka et al., 2015	Ethiopia	Children under-five	Diarrhoea treatment and rotavirus vaccination	Diarrheal treatment (vs. status quo) ICER: US$ 23 000 per life saved. Diarrheal treatment and rotavirus vaccination (vs. status quo) ICER: US$ 18 000 per life saved. In the poorest quintile, five times as many deaths were averted as in the wealthiest quintile for every US$ 1 million invested in universal public financing of diarrheal treatment.

Rheingans et al., 2012	25 countries	Child age not defined	Rotavirus vaccination	ICERs differed most significantly in Cameroon, India, Nigeria, Senegal and Mozambique where the ICER of the richest quintile was 355%, 273%, 265%, 253% and 227% higher than that of the poorest quintile. Zambia, Chad, Burkina Faso, Liberia and Niger showed the lowest differences (all less than 75% higher).
Rheingans et al., 2014	India	Children under-five	Rotavirus vaccination	Rotavirus vaccination (vs. status quo) ICER: US$ 118 per DALY
Rheingans et al., 2018	Baluchistan, Sindh, Punjab, and Khyber Pakhtunkhwa, Pakistan	Children under-five	Rotavirus vaccination	Rotavirus vaccination (vs. status quo): US$ 279 per DALY from a payer (donor and government) perspective, US$ 224 per DALY from a government perspective. ICERs vary within region and are lowest in the poorest quintiles in all regions due to the higher burden of disease.

Shirme et al., 2016	Ethiopia	Age not defined	Health system financing	UPF (vs. status quo) ICER: US$ 50 000 per death averted. Task sharing (vs. status quo) ICER: US$ 1500 per death averted. UPF and task sharing (vs. status quo) ICER: US$ 8300 per death averted. When UPF and task-sharing policies are combined, the gradient of health benefits observed with UPF alone is maintained, meaning the poorest still benefit significantly.
Uruena et al., 2015	Argentina	Children under-five	Rotavirus vaccination (RV1 and RV2)	Rotavirus vaccination (vs. status quo, health care perspective) ICER: ARS 3,870 per DALY for RV1, ARS 2,414 per DALY for RV2 Rotavirus vaccination (vs. status quo, societal perspective) ICER: ARS 1802 per DALY for RV1, ARS 358 per DALY for RV2
Verguet et al., 2013	India and Ethiopia	Children under-five	Rotavirus vaccination	For the base case scenario, 32 000 lives would be saved in India (1200 per million births) and 3700 lives in Ethiopia (1400 per million births). In India and Ethiopia, total household expenditures averted per million infants vaccinated would be 1 800 000 and 800 000.

Verguet et al., 2015	Ethiopia	Child age not specified and all women	Vaccination and caesarean section surgery	Measles vaccination, pneumococcal conjugate vaccination and caesarean section surgery avert the most deaths per US$ 100 000 spent (367 deaths, 170 deaths and 141 deaths averted per US$ 100 000 spent, respectively).
Verguet et al., 2018	Niger and India	Adolescent (15-19 years)		The magnitude for the size of the maternal deaths averted (160 for Niger and 1200 for India), out-of-pocket payments averted (US$ 150 000 and US$ 3 million, respectively) and cases of catastrophic health expenditures averted (1110 and 5150, respectively) differ significantly between Niger and India. In both countries, more adolescent women's lives would be saved in the bottom two quintiles (49% in Niger and 61% in India) compared with the top two quintiles (30% and 20%, respectively).

Campos et al. (2017) quantified the impact of expanding coverage (screening more individuals) versus increasing frequency (screening the same individuals more often) on cancer risk reduction, health disparities and costs. The researchers used mathematical modelling to simulate different screening scenarios. The findings showed that when baseline screening coverage is low, for example, 30%, expanding coverage once in a lifetime, for example, to 50%, achieves comparable reductions in cancer risk compared to screening two or three times in a lifetime at 30% coverage. The study also showed that expanding coverage leads to greater reductions in

health disparities and is cost-effective, costing approximately 150 US dollars per year of life saved. The results show that the ICER is consistent for the first and second screenings when coverage is increased from 50% to 70%. This could mean that the cost of screening and the effectiveness in terms of YLS do not significantly change with the increased coverage, suggesting that the screening program scales well and that the efficacy of the screening is not dependent on the coverage rate in this range.

Dawkins et al. (2018) compared a hypothetical re-designed vaccination program, which allocates additional resources for vaccine delivery in rural areas with the standard program currently implemented in Ethiopia. The re-designed program demonstrated an ICEA of US$ 69 per health-adjusted life year compared to the standard program. However, this cost-effectiveness threshold may be considered potentially cost-ineffective when compared to current estimates of health opportunity cost in Ethiopia. The authors analyzed the trade-off between cost-effectiveness and equity using the Atkinson inequality aversion parameter (ε), which indicates that an equitable program would be considered worthwhile by a decision-maker whose inequality concern is greater than ε = -5.66. In this case, health gains are weighted at least 3.86 times higher in the poorest wealth quintile group compared to the richest group. The study highlights the importance of considering both cost-effectiveness and equity when designing health programs in LMICs. While the re-designed vaccination program may be less cost-effective, prioritizing equity can lead to more socially just outcomes.

Driessen et al. (2015), using ECEA, compared three distinct vaccine delivery strategies for measles vaccination in Ethiopia: routine immunization, routine immunization with financial incentives; and mass campaigns (supplemental immunization activities [SIAs]). The findings suggest that routine immunization is the most cost-effective strategy. SIAs are less cost-effective due to their periodic nature. Routine immunization with financial incentives costs more but provides value. In summary, the study underscores the importance of routine immunization as a sustainable and effective approach for measles control in Ethiopia.

Johansson et al. (2015) explored the impact of two publicly financed interventions in Ethiopia: pneumococcal vaccination for newborns and pneumonia treatment for children under-five. The findings suggest that scaling up pneumococcal vaccines to approximately 40% coverage would cost around US$ 11.5 million. This intervention would avert approximately 2090 child deaths annually. The health benefits of pneumococcal vaccination would be concentrated among the bottom income quintile where 30–40% of all deaths averted would occur in the poorest quintile. A 10% increase in pneumonia treatment coverage for all children under-five would cost approximately US$ 13.9 million. This intervention would avert approximately 2610 deaths

annually. Similar to vaccination, the health benefits of pneumonia treatment would be most pronounced among the poorest socioeconomic groups. The financial risk protection benefits would also be largely concentrated among the bottom income quintile.

Levin et al. (2015) aimed to evaluate the impact of publicly financed HPV vaccinations in China. The study compared vaccination paired with screening against cervical screening without the routine use of a publicly financed HPV vaccination. Using a Monte Carlo simulation model, the authors estimated the distribution of deaths averted by income quintile. The findings showed the cost benefits received by women in the lowest income quintile were higher than those received by women from the highest wealth quintile. Absolute number of cervical cancer deaths averted and the financial risk protection from HPV vaccinations was highest among women in the lowest income quintile.

Nandi et al. (2016) aimed to assess the potential impact of scaling up the Home Based Newborn Care Package (HBNC). The findings indicate that compared to no coverage, providing the HBNC package through the existing community health worker network could avert 48 incident cases of severe neonatal morbidity, prevent five related deaths, save US$ 4411 in out-of-pocket treatment costs and provide US$ 285 in value of insurance per 1000 live births in rural India. Notably, these benefits were more pronounced among lower socioeconomic groups and in the poorer states of India.

Nandi et al. (2017) estimated a saving of US$ 357 788 (in 2013 US dollars) in out-of-pocket diarrhoea treatment expenditure per 100 000 under-5 children annually. Additionally, there is an incremental value of insurance amounting to US$ 1646 per 100 000 under-five children annually over the baseline. The health benefits are substantial and have a progressive impact, reaching poorer households more effectively. The authors examined the cost-benefits of two interventions. In intervention one, characterized by a broad, non-discriminative approach aiming for high coverage but potentially overlooking regional disparities and specific needs, the coverage rates of piped water and improved sanitation increased across all Indian households. The goal is to achieve 95% coverage for both piped water and improved sanitation. The scaling of coverage occurs randomly across the entire nation. Intervention two, a more nuanced, aiming to address the public health challenge by considering local conditions and inequalities, potentially leading to more equitable health outcomes focuses on state-specific scaling to achieve equitable outcomes, considering variations in baseline coverage and demographics. The findings highlight that scaling up access to piped water and improved sanitation can lead to equitable reductions in the burden of childhood diarrhoeal diseases in India. Interventions are more effective at averting deaths in the lowest wealth quintiles, indicating that they have a greater impact on poorer populations.

However, the costs associated with scaling up these interventions are higher for the poorest quintile in the case of intervention two, and the second quintile has the highest costs for both interventions, indicating a non-linear relationship between costs and wealth levels. This information could be crucial for policy-makers and health planners as they decide how to allocate resources effectively to maximize health outcomes.

Rheingans et al. (2012) demonstrated the impact and cost-effectiveness of rotavirus vaccination in 25 countries. The ICER was highest for the richest quintile, meaning the cost for each unit of health benefit from the rotavirus vaccination was greater compared to other quintiles. However, the health benefit, measured in terms of disease prevention or life-years saved, was the lowest for the richest quintile. This could be due to pre-existing low baseline rates of rotavirus infection or better access to health care. In contrast, the benefit of vaccination tends to be higher in poorer quintiles due to higher mortality rates from rotavirus. However, this benefit may be offset by lower vaccination coverage rates in these groups. The study found significant differences in ICERs between the richest and poorest quintiles in countries like Cameroon, India, Nigeria, Senegal and Mozambique, with the richest quintile having an ICER up to 355% higher than the poorest. Conversely, countries like Zambia, Chad, Burkina Faso, Liberia and Niger showed much smaller differences (all less than 75% higher).

Rheingans et al. (2014) presented results for six geographic regions in India, including Bihar, Uttar Pradesh, and Madhya Pradesh, three high-mortality states, which account for 56% of national mortality estimates. ICERs by region ranged from 105 to 298 per DALY averted. The most favorable (lowest) ICERs were observed in the high-mortality regions of Bihar, Uttar Pradesh and Madhya Pradesh, suggesting that targeted interventions in these areas can yield significant health benefits at a reasonable cost.

Shirme et al. (2016) provided an analysis of the cost-effectiveness of various health policies, namely UPF, task sharing and their combination. The findings revealed that UPF was associated with a cost-effectiveness ratio of US$ 50 000 per death averted. Task sharing, on the other hand, had a cost-effectiveness ratio of US$ 1500 per death averted. When UPF and task sharing were combined, the cost-effectiveness ratio increased to US$ 8300 per death averted. The analysis revealed that the primary beneficiaries of UPF were the poorest. When UPF and task sharing policies are combined, the gradient of health benefits observed with UPF alone is maintained, meaning the poorest still benefit significantly. However, with the addition of task sharing, there are additional health benefits that accrue to the richest quintile. This suggests that the combination of policies does not disrupt the positive impact on the poorest, but it also extends

benefits to the richest quintile, likely due to their better initial access to health services, which is further enhanced by the task sharing policy accruing to the richest quintile.

Verguet et al. (2016) examined the impact of maternal deaths on adolescent girls' well-being and financial stability, considering socioeconomic disparities in Niger, which has the highest total fertility rate globally, and India, which has the largest number of maternal deaths. The potential impact of increasing adolescent girls' education by one year on maternal deaths and poverty was also explored. The magnitude for the size of the maternal deaths averted (160 for Niger and 1200 for India), out-of-pocket payments averted (US$ 150 000 and US$ 3 million, respectively), and cases of catastrophic health expenditures averted (1110 and 5150, respectively) differs significantly between Niger and India. However, increasing educational attainment among adolescent girls could prevent a significant number of maternal deaths and cases of catastrophic health expenditure in both countries.

Chapter 6: Social Return on Investment (SROI)

This report identified 12 studies that evaluated evidence on the social value of WCAH interventions using the SROI method. These studies were conducted in different countries with various objectives and approaches, and used different data sources and methods. Therefore, it was difficult to draw general conclusions about the overall effectiveness of WCAH interventions. However, the findings can inform policy-makers, budget holders and funding agencies about the value of investing in WCAH to generate wider social, economic and environmental returns towards building healthier populations and communities.

In 75% (n=9) of the studies, the direct beneficiaries were children under-five, 33% (n=4) focussed on pregnant and lactating women and 25% (n=3) looked at adolescents (10-19 years). The studies evaluated the SROI of different interventions related to WCAH, including immunization (n=5; 41%), infectious disease treatment (n=3; 25%), prevention, detection and management of reproductive cancers, especially cervical cancer (n=3; 25%), physical health and capacities (n=3; 25%), breastfeeding (n=2; 16%), prevention and treatment of HIV and other STIs (n=1; 8%).

Approximately 83% of the SROI focussed on health promotion and disease prevention (n=10), 16% on managing sick individuals and only one study looked at health system building blocks.

Of the 12 studies, 83% were assessed as being of high (n=2) or moderate (n=8) quality. 79% of the studies conducted a sensitivity analysis to ensure robust SROI results. Only two studies (16%) were considered to be of low quality.

Box 6 Examples of robust evidence on SROI

Pramono et al. (2022) assessed the economic advantages of implementing the Ten Steps Baby-Friendly Hospital Initiative (BHFI) programme. The Social Return on Investment (SROI) for implementing BHFI in this healthcare facility was calculated to be US$ 49, indicating that for every dollar invested, the initiative generates social value 49 times greater than the cost of investment. The BHFI programme involves a series of steps designed to support successful breastfeeding and includes practices such as helping mothers initiate breastfeeding within an hour of birth, providing mothers with the information and skills needed to breastfeed exclusively, and fostering the establishment of breastfeeding support groups. The program supports community health by fostering early child development and maternal health.

Hospitals and health systems may consider integrating such programs into their standard operating procedures as a cost-effective strategy to improve public health outcomes.

Sim et al. (2020) estimated the global value of investing in immunisation programmes across 94 countries. Utilising the Cost of Illness (COI) approach, the Return on Investment (ROI) for every US$ 1 invested in immunisation against 10 pathogens was 26.1 for the period from 2011 to 2020 and 19.8 from 2021 to 2030. Employing the Value of Statistical Life (VSL) approach, the ROI was 51.0 from 2011 to 2020 and 52.2 from 2021 to 2030. The COI approach calculates the costs associated with treating illnesses that could be prevented through immunisation, while the VSL approach estimates the economic value of lives saved. Both methodologies demonstrate that the ROI from immunisation programmes is substantial, and this trend is anticipated to continue over the next decade. The use of both COI and VSL approaches provides a comprehensive view of the economic impacts of immunization. This dual approach could serve as a model for evaluating other public health interventions, providing a more holistic view of their economic and humanistic benefits.

Chapter 7: Cost of illness

In the nine studies on the cost of illness, 77% (n=7) were conducted on children under-five, 33% (n=3) on pregnant and lactating women and only one study was conducted on adolescents (10-19 years). Analyses of costs depends on the perspective of those making decisions, but the societal perspective is generally considered to be the most comprehensive and the one preferred by health economists. A societal perspective was most frequently used in the cost of illness studies on WCAH, although it was not always explicitly stated. A third party payer perspective, such as that of the health insurer or public health provider, was also used in a quarter of the studies. Direct medical costs were included in all studies in accordance with the protocol. There is evidence available for the following conditions: immunization (n=5; 55%), diarrhoea, hepatitis and cervical cancer (n=2; 22%) and young child feeding (n=2; 22%).

Two of the nine studies were determined to be of high quality and three were classified as being of moderate quality. The quality of four studies was rated as low.

Box 7 Examples of cost of illness on pneumonia burden

Two examples of cost of illness analyses are presented here, looking at how these may be beneficial in guiding policy-makers in making informed decisions about resource allocation and public health investments. Both studies demonstrate the importance of considering indirect costs, long-term savings and the overall economic impact when evaluating the effectiveness of health interventions. Kobayashi et al. (2021) assessed the economic impact of PCV13-type diseases, such as pneumococcal meningitis and pneumonia, in northern Ghana. The researchers found that indirect costs, including lost future income and end-of-life medical expenses, were much higher than the direct treatment costs for these diseases. The economic burden of PCV13-type diseases remained substantial, especially among older children and adults who were expected to benefit from the indirect effects of infant immunization. Sim et al. (2020) estimated the cost savings associated with vaccinations against 10 pathogens across 94 LMICs. The projected savings over the next decade amounted to a staggering US$ 828.5 billion. When considering vaccination programs, the calculated BCR was 19.8. This means that for every US$ 1 spent on vaccinations, US$ 19.8 would be saved in costs related to the illnesses prevented by the vaccines.

These findings emphasize the economic benefit of adopting a comprehensive approach that considers both direct and indirect costs, evaluates long-term savings and prioritizes evidence-based interventions with favorable BCRs.

Chapter 8: Investment cases

An investment case, or a business case, is an ex-ante assessment of the expected return on a project. Expected project costs are known so the main challenge is to make a plausible estimate of project benefits. This report identified 36 investment cases: four on strategies to prevent malnutrition, stunting and providing adequate nutrition, namely breastfeeding promotion, complementary feeding, vitamin supplementation, hand washing with soap, hygienic disposal of children's stools and oral rehydration solution; three on health system building blocks such as service delivery, health care worker training, health system financing and procurement of essential medicines; four focussed on infectious diseases including HIV and hepatitis B; two focussed on childhood development; and 20 others which included multiple interventions.

Across the 36 included investment cases, the most common measures of benefits were lives saved and DALYs averted (Table 7). The second most common was a dollar value of benefits (n=4) and life years gained (n=3). Only a minority of studies reported economic measures. Just four studies reported the value of benefits, a BCR or the ICER. No study reported an expected rate of return. The focus was on benefits rather than costs with a minority of measures using costs: the cost of illness averted (n=4), BCR (n=3), cost per life year gained (n=2) and COI (n=1).

A small sample of five World Bank project appraisals were also reviewed. Three of the studies made an appeal for global or regional evidence of the economic value of MNCH investments. But all five also reported a project-specific analysis with economic and financial evaluations in four of the five cases. This contrasts with the investment cases this report identified, which mostly reported benefits as lives saved or DALYs averted with no economic analysis. Three reported a BCR (1.3, 4.3 and 19.6), two reported cost per life saved (US$ 7101 and US$ 30 152), and one an internal rate of return of 7%. One project did not report any economic analysis but estimated the DALYs averted by a predecessor project. The discount rate for the BCRs was 3% in all cases with one reporting sensitivity analysis for different rates. There are no apparent institutional thresholds for an acceptable cost per life. Two studies cited Shepherd et al. (2015) as the approach taken in the analysis. The most commonly calculated benefit was child and maternal deaths averted. This figure is used to calculate additional years gained of productive activity and the value of that production. Only one study considered the benefits of reduced stunting and anaemia. Two of the studies explicitly mentioned using the Lives Saved Tool (LiST) and it seems likely that one other also used LiST. The studies also list unquantifiable benefits.

The most striking finding across all investment cases is the lack of uniformity in approach. The five World Bank studies are most closely related, but even they have marked differences. There is thus the implication that greater professional consensus and subsequent guidance in this area would be useful.

Table 8 Selected characteristics of included investment cases

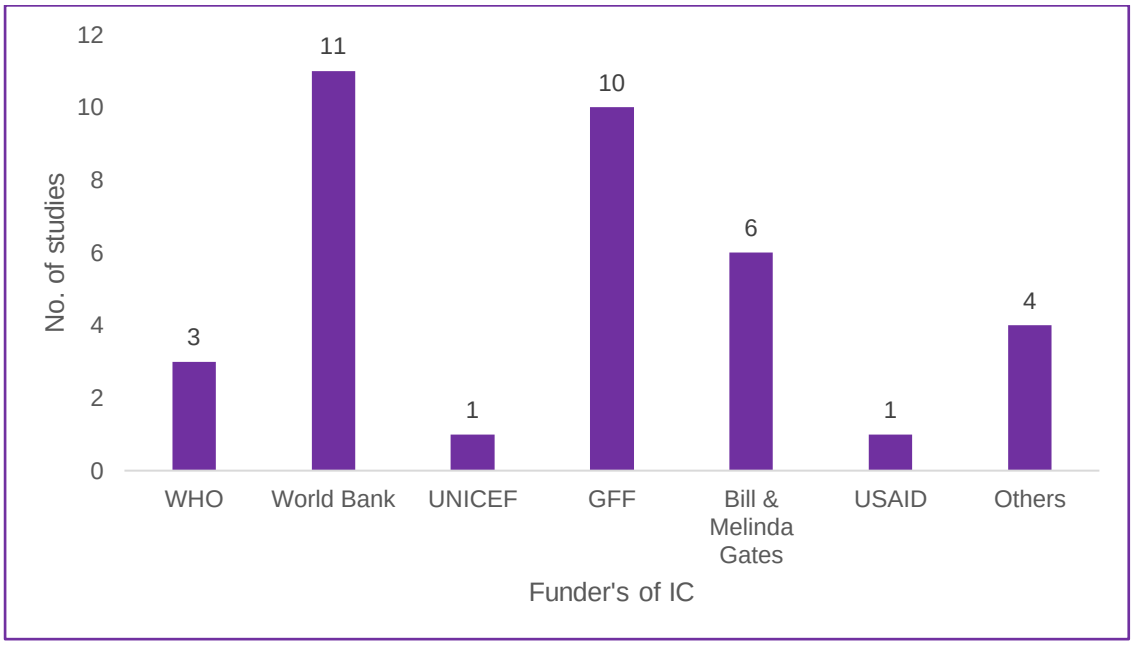
Measures	No. of cases	No. of studies
Deaths averted or lives saved	14	13
DALYs averted	9	9
Cost of illness averted	4	4
Value of benefits	4	4
BCR	3	
ICER	3	
Life years gained	3	
Cost per life year gained	2	
QALY gained	2	
Reduction in number of cases	2	
COI	1	
Months of education gained due to teenage pregnancy averted	1	
Stunting averted	1	

Overview of funders of the investment cases

The majority of investment cases were from the World Bank (11, 30%) and GFF (10, 28%) followed closely by the Bill & Melinda Gates Foundation (6, 16%). Most investment (26, 72%) cases from these stakeholders included a variety of interventions and generally included various combinations of maternal health interventions, immunizations and SRHR intervention among

others. Three investment cases were on nutrition only, three were on SRHR only and four focussed on immunization (Fig. 24).

Figure 21 Investment cases by funders of the investment cases



Methods used to assess health outcomes and costs

10% (n=78) of studies report ways to maximize investment resources using cost-effectiveness thresholds (n=51), league tables (n=1), the LiST (n=17), WHO Choice (n=8) and optimization models (n=1) (Fig. 17). These methodologies provide an effective way for decision-makers to assess the value of different programmes and interventions and to allocate resources accordingly. For instance, cost-effectiveness thresholds provide a framework for determining the value for money of different interventions. By setting a threshold, decision-makers can prioritize interventions that offer the greatest health benefits for the resources invested. This helps to ensure that limited resources are allocated to interventions that have the highest impact on population health.

League tables offer a way to compare the cost-effectiveness of different interventions or strategies. By ranking interventions based on their cost-effectiveness ratios, decision-makers can identify those that offer the greatest value for money. This information can then inform resource allocation decisions and prioritize interventions accordingly.

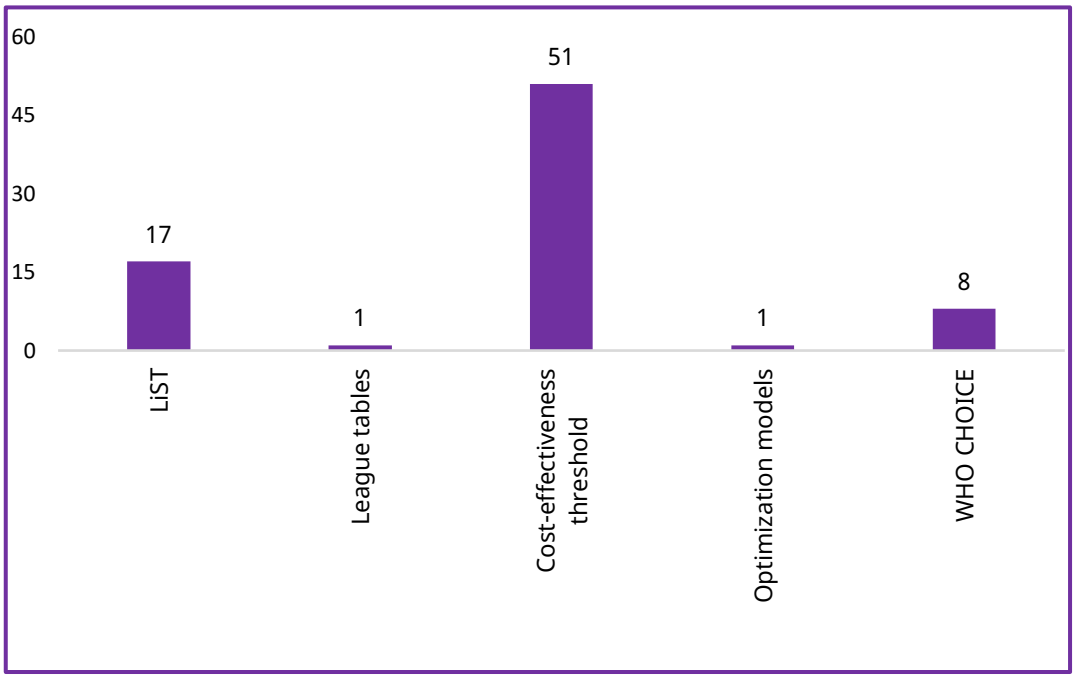
The LiST is a powerful modelling tool that can estimate the impact of different interventions on child and maternal mortality. By inputting data on coverage levels and efficacy of interventions,

decision-makers can assess the potential health benefits of investing in specific interventions. LiST can help to identify the interventions that have the greatest potential for saving lives and guide resource allocation accordingly.

WHO Choice is another valuable resource that provides information on the cost-effectiveness of different health interventions. It offers a comprehensive database of cost-effectiveness studies and allows decision-makers to compare the costs and impacts of different interventions. Using WHO Choice, decision-makers can make informed choices about which interventions to prioritize based on their cost-effectiveness.

Optimization models are mathematical models that can be used to maximize the impact of investment resources. Optimization models can help decision-makers to identify the combination of interventions that will yield the greatest overall impact by considering multiple factors, such as costs, health benefits and budget constraints. These models can guide resource allocation decisions and ensure that investments are optimized to achieve the best possible outcomes.

Figure 22 Number of economic and financial evaluations by method used to assess health outcomes and costs



Chapter 9: Emerging findings from the review

9.1 Areas of robust evidence

The findings indicate robust evidence on key interventions focusing on MNCH, including immunization services; infectious disease prevention and treatment; antenatal care and routine newborn care; SRHR, including the prevention, detection and treatment of reproductive cancers (especially cervical cancer); prevention and treatment of HIV and STIs and counselling for modern contraceptives; and AHWB, including physical health and capacities, mental health and optimal nutrition. The majority of studies were conducted in South Africa, China, India, Uganda and Brazil. Children aged under-five years, pregnant women and women of reproductive age predominated. This evidence base thus provides robust and up-to-date data to support policy decisions and investments in essential interventions for WCAH in LMICs.

Evidence from economic and financial evaluations that emphasize equity suggests that the intervention is strongly pro-poor. These evaluations focused on regions with insufficient healthcare facilities or areas characterized by high poverty levels and limited resources. The findings indicate a positive impact on individuals and communities with lower socioeconomic status.

The findings of this report underscore the importance of considering opportunity costs in health care policy decision-making. Researchers should investigate the broader economic impact of health interventions, including the costs incurred by individuals and society as a whole. By examining opportunity costs, researchers can provide valuable insights that inform decisions about resource allocation, reimbursement policies, and the overall value of healthcare interventions. Additionally, the review's focus on women, who usually make major unremunerated contributions to society and economic productivity compared to men, suggests that the opportunity costs from inadequate investment in WCAH will be substantially underestimated (Chaaban & Cunningham, 2011; Wodon et al., 2018).

9.2 Remaining gaps and emerging priorities

The review also highlights evidence gaps from Europe, Central Asia, the Middle East and North Africa. There are gaps in the evidence for certain age groups with less than 5% each on school-age children (5-9 years), adolescents (15-19 years), adolescent boys, preterm/LBW infants, stillbirth and bereaved parents. There are gaps in evidence on injuries, trauma, mental health and

psychosocial support, safe abortion services and treatment of complications of unsafe abortion and the prevention, detection and immediate services and referrals for cases of sexual and GBV, information, counselling and services for sexual health and well-being. Lastly, there are gaps in evidence on multisectoral interventions such as WASH, child protection, education and preparedness and response.

While most studies pointed towards the positive and cost-effective impact of interventions on WCAH, such impact was not quantitatively comparable across studies. This is attributable to three main reasons: heterogeneity of impact measures (both benefits and costs); different implementation conditions (settings, length of follow-up, time horizons); and a large variety of analytical methods employed to understand the economic value. Thus, biases associated with those methods make it difficult to draw firm conclusions and limit the synthesis of findings.

9.3 Implications

Implications for researchers and funders

1. **Utilise high-confidence evidence:** Funders should utilize the existing robust evidence on economic and financial evaluations at the country level to facilitate decision-making through a knowledge translation approach. This approach uses evidence to inform research priorities. The online interactive EGM provides a searchable, navigable resource for researchers to assess the robust evidence available and to identify areas where evidence can be better utilized to inform policies and investments.
2. **Address evidence gaps:** Researchers should advocate for funders to direct resources towards filling the identified gaps in research, particularly in underrepresented regions and health areas. This will ensure a more balanced evidence base for policy formulation. Some of these gaps include:
    - Expand Geographical Coverage: More research is needed in underrepresented regions such as Europe, Central Asia, the Middle East, and North Africa. This will ensure a more comprehensive understanding of health interventions' economic impacts worldwide.
    - Target Understudied Populations: More research is needed on currently underrepresented population groups in the literature, such as children aged 5-9 years, adolescents, preterm/low birth weight infants, and bereaved parents. This will

provide crucial insights into the economic implications of interventions targeting these groups.

- Address Critical Gaps in Health Areas: Researchers should prioritize studies on critical health areas with limited evidence, including mental health, injuries and trauma, sexual and gender-based violence (GBV), and comprehensive sexuality education (CSE). These areas are essential for holistic health improvement and require robust economic evaluations.
- Multisectoral Interventions: Researchers should investigate the economic impact of multisectoral interventions such as water, sanitation, hygiene (WASH), child protection, and education. These interventions are crucial for sustainable development and warrant thorough economic analysis.
- Preparedness and Response: Researchers should conduct studies on preparedness and response to health emergencies. Given the recent global health crises, understanding the economic aspects of these interventions is vital for future planning.

3. **Standardize Evaluation Methods**: To enable comparability across studies, there should be efforts to standardize impact measures and evaluation methods, which can help in synthesizing findings and drawing firm conclusions.

Implications for decision-makers

1. **Investment in Key Interventions**: The robust evidence on interventions related to MNCH, SRHR, and AHWB suggests that investments in these areas are crucial. Policymakers should prioritize funding and support for these interventions, especially in LMICs.
2. **Holistic Policy Approaches**: Policies should consider multisectoral approaches that integrate health with education, child protection, and other social services to address the complex needs of women, children, and adolescents.

9.4 Conclusion and next steps

The robust evidence on key maternal, neonatal, and child health (MNCH) interventions, including sexual and reproductive health and rights (SRHR) and adolescent health and well-being (AHWB), highlights significant positive impacts on women, children, and adolescents, particularly in low-

and middle-income countries (LMICs). These findings underscore the importance of equity-focused interventions that prioritize regions with inadequate healthcare facilities and high poverty levels. However, the evidence gaps identified in certain geographical regions and demographic groups point to the need for further research and targeted policy interventions. Addressing these gaps and standardizing evaluation methods can enhance the comparability of studies, allowing for more effective policy decisions and resource allocation.

Next Steps

1. **Expand Research in Underrepresented Areas**: Researchers should focus on filling evidence gaps in regions such as Europe, Central Asia, the Middle East, and North Africa, and on age groups like school-age children and adolescents.
2. **Enhance Methodological Consistency**: Efforts should be made to standardize evaluation methods and impact measures to improve the comparability of studies and support more reliable policy and investment decisions.
3. **Integrate Multisectoral Approaches**: Policymakers should consider holistic strategies that integrate health interventions with education, child protection, and other social services to address the complex needs of women, children, and adolescents.
4. **Prioritize Equity-Focused Policies**: Policies should be designed to address healthcare inequities, ensuring that vulnerable populations, particularly those in resource-limited settings, benefit from targeted interventions.
5. **Focus on Opportunity Costs**: Researchers and policymakers should consider the broader economic impacts of health interventions, including opportunity costs, to better inform decisions about resource allocation and the value of healthcare investments.

By addressing these next steps, stakeholders can work towards more effective and equitable health solutions that improve the well-being of women, children, and adolescents globally.

Chapter 10: EGM: Interactive interventions and outcomes

EGMs are systematic and visual presentations of the available evidence for a particular sector or sub-sector (Saran and White, 2019). Evidence is usually represented in a row and column matrix, representing intervention outcomes for effectiveness studies or regions, and economics for regional evaluations. The primary dimensions of the map are rows and columns. Secondary dimensions of the map for included studies are often referred to as filters.

The interactive file primarily plots the evidence on the economic and financial evaluations for women, children and adolescents in LMICs.

A bubble indicates the included economic and financial evaluations for each intervention outcome cell. The colour of the bubble indicates the quality of the findings of the included economic and financial evaluations. Red signifies low-quality, orange is for medium-quality and green represents high-quality. The bubble size represents the evidence available for a particular section of rows (for example, interventions) and columns (for example, region). Thus, a larger bubble size for specific cells indicates that more studies exist. In contrast, smaller bubbles refer to a relative lack of studies for a specific intervention and outcome subcategory. However, a single study might appear under more than one cell as it may fall under more than one intervention and outcome combination.

An EGM has been produced that includes several filters related to geography, population, intervention and outcome characteristics (Fig. 19). Users may select one or more filters to see the corresponding studies along the matrix.

How to locate the evidence using the map?

The EGM organizes the studies according to:

- economic and financial evaluations (prevention, disclosure, response and treatment) in columns; and
- region of the study in rows.

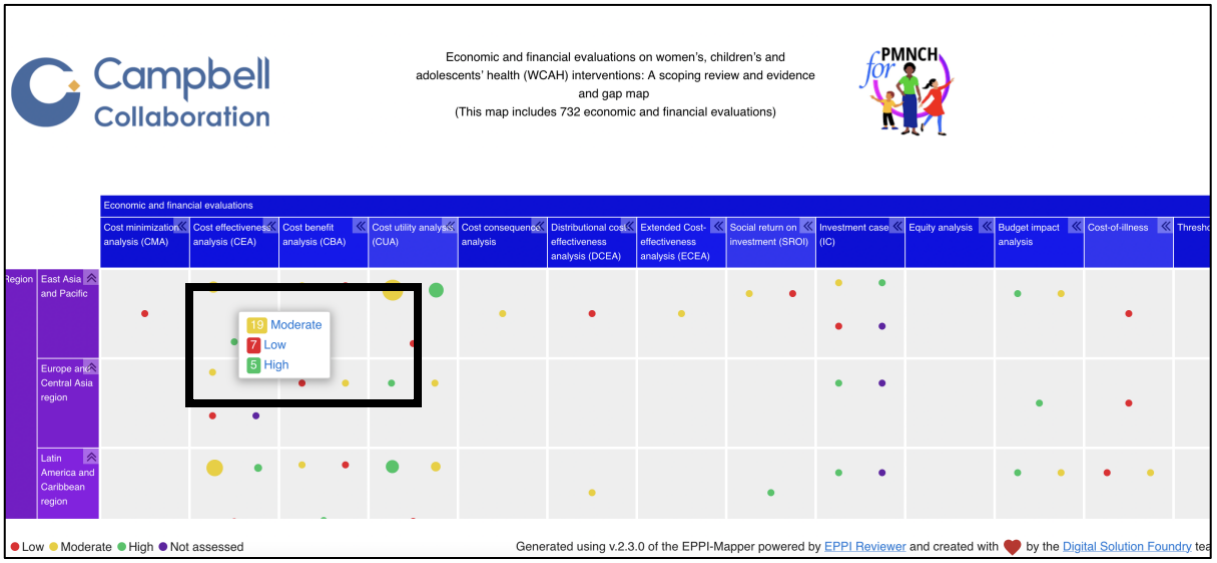
If a study is from sub-Saharan Africa and is a CEA, all the corresponding studies will be found in that cell (intersection of row and column), shown by a dot (or square depending on the view preference).

Colours

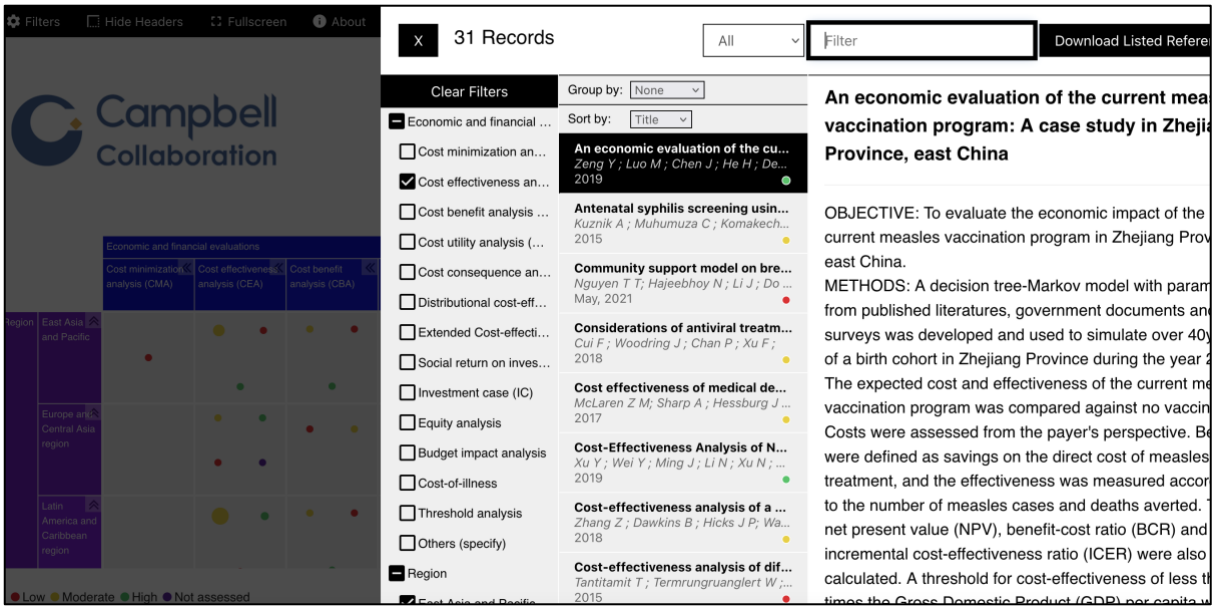
The EGM contains economic and financial evaluations, which are represented by different colours and assessed for confidence in the findings.

- High confidence. **These are in green**.
- Medium confidence. **These are shown in yellow.**
- Low confidence. **These are shown in red**.

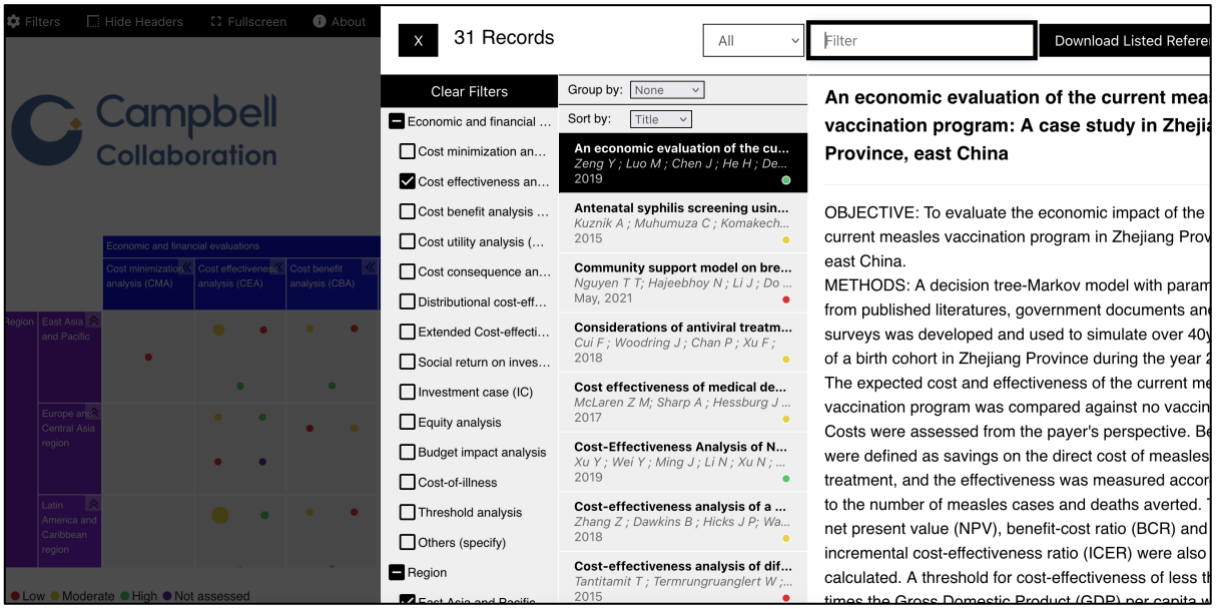
To see the number of studies in a particular cell, for example to see how many CEA have been conducted in East Asia and the Pacific, hover over the cell and it will highlight the numbers (in this case, 19 moderate, seven low and five high confidence evaluations).



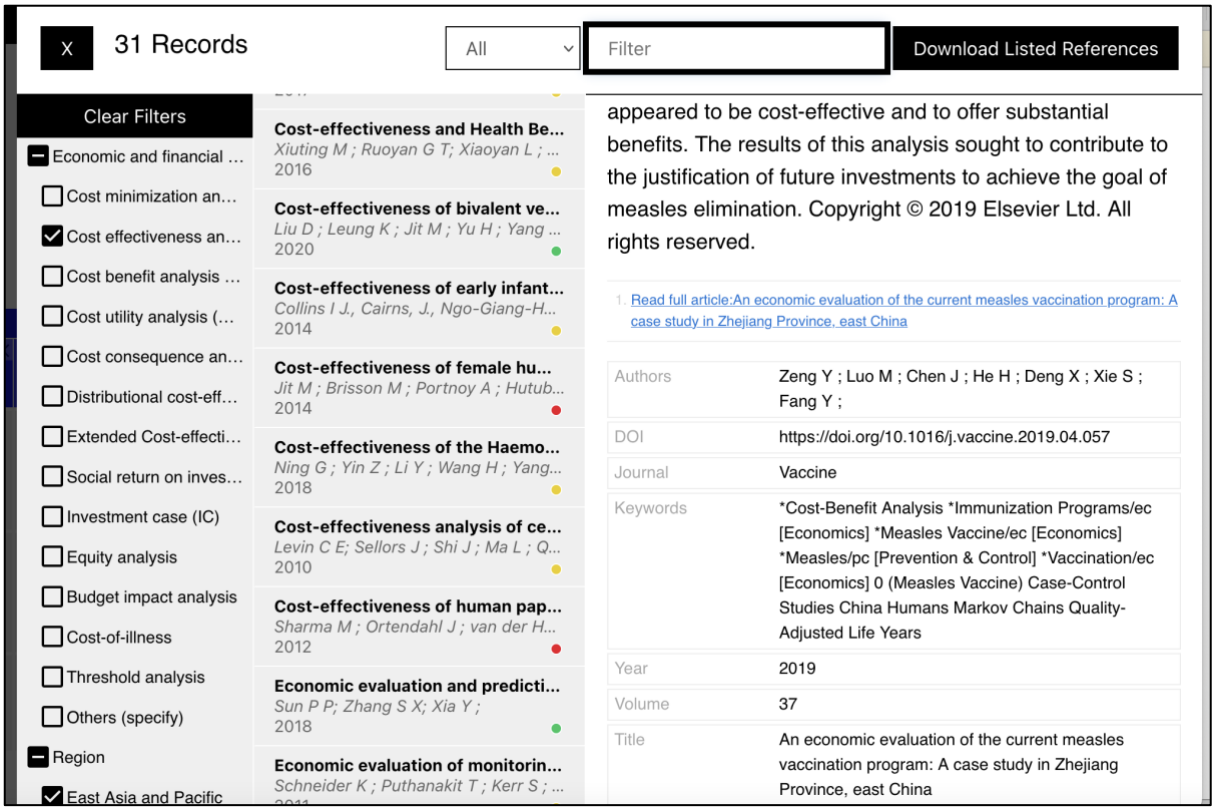
To see the studies in that cell, click on the corresponding cell. A list of the studies will come up (in this case, 31 studies).



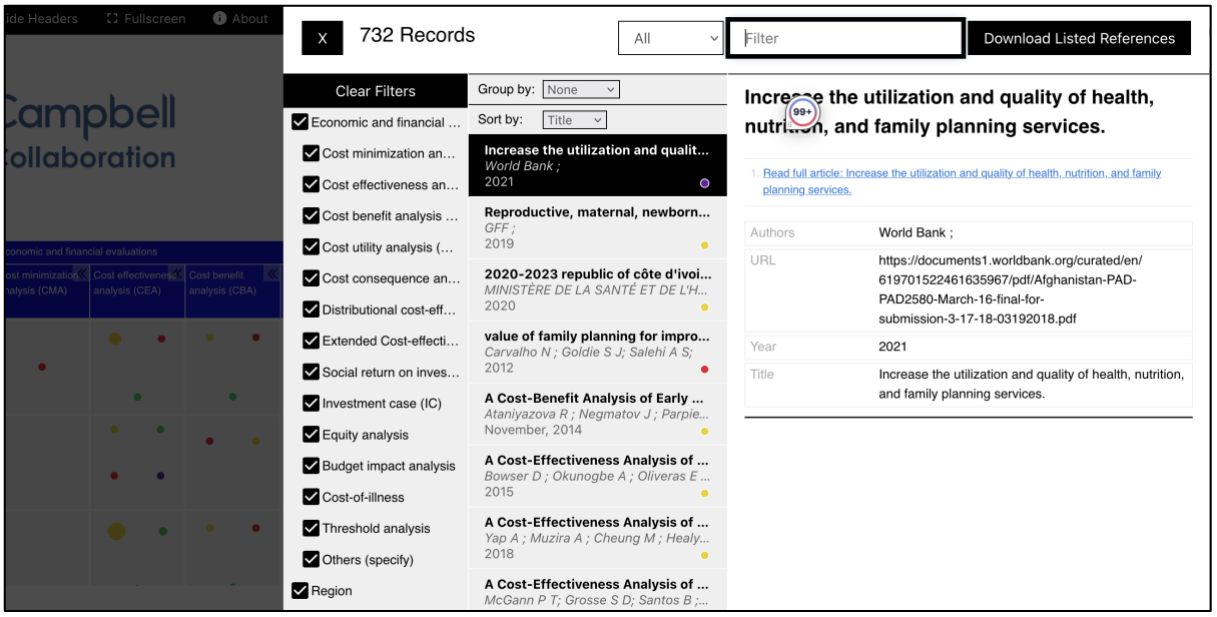
For each study, the column on the right has the study abstract. This is a summary of the study written by the study's authors. Against each one is a dot, the color of which indicates the confidence level (low, medium or high).



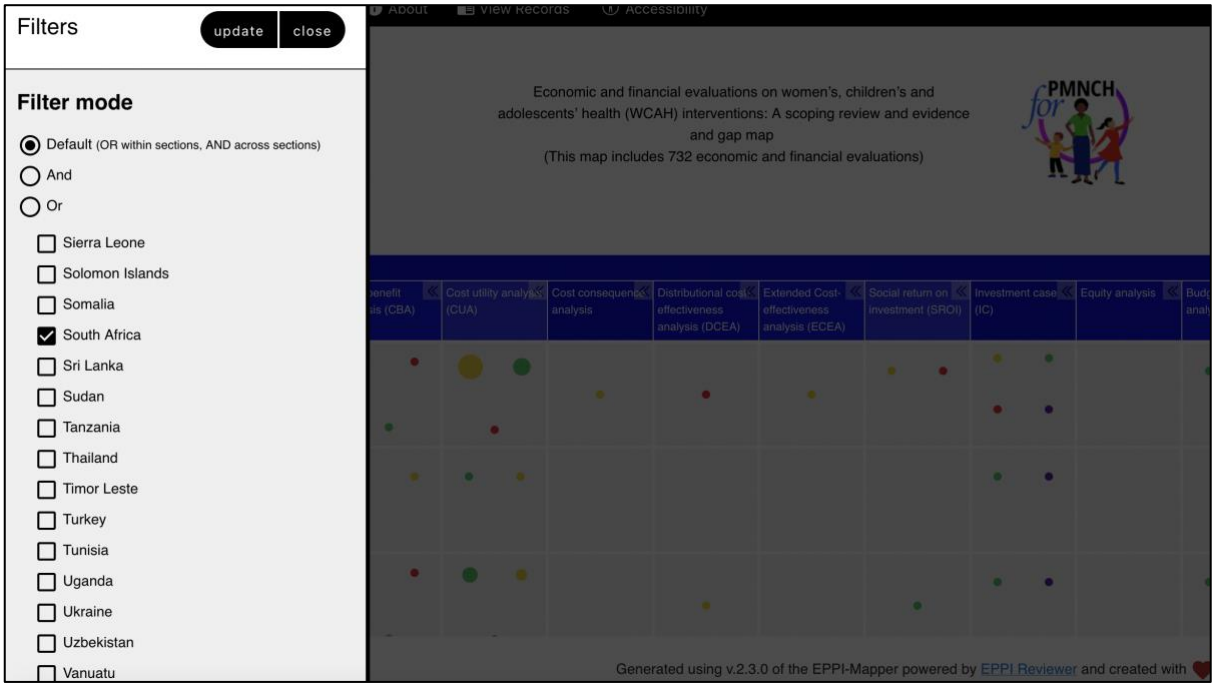
To access the original study, scroll down to the link situated at the bottom of the abstract.



To see all studies about a particular type of intervention, click on “view records.” This will generate the full list. There is also the option to download the reference list.



To find studies from a particular location, click on “filters” on the top left before scrolling down to the tick lists for region or country. Select the ones of interest and, when finished, click “update.”



Similarly, use the menu on the left to select studies:

- of particular intervention (services or strategies);
- of particular target group;
- scale of evaluation;
- year of publication; and
- disease or condition.

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