III. Congress Proceedings

The Congress proper held on 25th and 26th March 2021 with series of activities rolled out that included breakfast meetings, opening ceremony, plenaries, symposia, abstract sessions and exhibitions made by a number of companies and corporate bodies to mark the event.

a. Breakfast meeting

A breakfast meeting sponsored by the Delta State Government and entitled, 'Improving Networking among African Health Professionals' took place before the opening ceremony and in the early hours of the day. The meeting was chaired by Dr Mininim Oseji, National President of the MWAN, and a Permanent Secretary, in Delta State Ministry of Health. The panellists and the topics they presented were as follows: Dr Rose Macaulay (presented on 'Doctors as Educators'), Prof Afua Hesse (Medical Education in Africa), Prof Hippolite Amadi (The Role of Biomedical Engineering in Promoting Quality Healthcare), Prof Elizabeth Bukusi (Resource Mobilisation for Promoting Clinical Trials) and Dr Ibrahim Bolaji (Current Trends in Cervical Cancer Screening).

Dr Macaulay began her presentation titled, 'Doctors as Educators' by asking whether doctors are prepared to serve as educators. To this end, she emphasised that doctors always end up as educators – whether knowingly, deliberately, or otherwise. Teaching was also recognised to be an integral role of a doctor who doubles as a caregiver. Unfortunately, however, effective teaching skills are not part of what is being taught in our medical schools' curriculum today. To be an effective educator, the following factors, which are said to be necessary ingredients, are needed:

- Effective teaching skills
- Being prepared to teach
- Mastery of the science
- Learner-centred educational methods

The influence of globalisation on medical education was emphasised given that globalisation has rapidly reformed medical education. It is now possible to see more medical educators applying learner-centred educational methods in their approach. She concluded her presentation with the following recommendations:

- Encourage members to upgrade as educators
- Work with similar organisations to make courses available for members
- Make it mandatory for all female doctors to acquire effective teaching skills
- Support female doctors to participate in courses that prepare them to be educators
- Encourage members to upgrade as educators
- Work with similar organisations to make courses available for members
- Make it mandatory for all female doctors to acquire effective teaching skills
- Support female doctors to participate in courses that prepare them to be educators.

Prof Afua A. J. Hesse's paper was on 'Medical Education in Africa' where she talked about the current unmet need, how it is being addressed and the role of public–private partnership in enhancing medical education across the continent. In terms of the unmet need, and according to the World Health Organization (WHO) estimates, the current workforce in some of the most affected countries in sub-Saharan Africa (SSA) would need to be scaled up by as much as 140% to attain international health development targets such as those in the Millennium Declaration. Reasons vary including investment shortfalls (past and present) in pre-service training, international migration (push and pull factors), career changes among health workers, premature retirement and morbidity and premature mortality. For every 1000 physicians practicing in 12 countries, 59 medical graduates are produced each year. Even among countries with positive net growth rates, only two countries (Côte d'Ivoire and Ethiopia) stand a chance of meeting some of the current unmet demands in the future because they have a faster-growing number of health workers than inhabitants. Educational training facilities are said to be inadequate (quantity over quality?).

As regards how these deficits are being addressed, Prof Hesse alluded to the use of task-shifting albeit not a long-term solution (her view). She also highlighted the need to institute aggressive retention policies, such as improving the remuneration and working conditions of health workers, address rising unemployment rates, using telemedicine, and encouraging short-term in-migration from surplus to deficit countries as a stop-gap measure of mitigating the health workforce shortage. These measures are however shortlived with its many drawbacks, which include culture. She also said that sustainable public health funding for medical education and training is difficult in face of pressure to increase numbers with unrealistic class sizes, with no increase in infrastructure as finances remain scarce. Public training facilities are also reluctant to charge realistic fees (muzzling effect for a public good?), she said. She went further to present the Accra College of Medicine

as a case study using the supply and demand lens. From the demand-side perspective, she said that there is still huge deficit of doctors and health professionals for a country with a population of 25 m – physicians' density: 0.09 physicians/1000 population (WHO-2009). Over 4000 qualified Ghanaian students apply for places in medical schools each year. Political stability and strong educational heritage attract foreign students from neighbouring countries in West Africa such as Nigeria to apply to attend the existing medical schools in Ghana. Currently, there are approximately 5000 registered doctors in Ghana with the Ghana Medical Association. A large number of hospitals in the country are under-resourced, and Ghana as a country is in dire need of more medical doctors.

On the supply-side perspective, however, there are only five public medical schools in Ghana graduating a total of approximately 500 medical doctors a year with the University of Ghana singularly turning away over 2000 qualified applicants for entry into its medical programme last year. Foreign medical education is said to be expensive and reduces the chances of them coming back to Ghana. She went further to highlight Ghana's medical curriculum as such that promotes hands-on and practical teachings based on international best practices in medical education. It is also said to be an integrated liberal medical school curriculum that incorporates other subjects so as to train entrepreneurial and well-rounded doctors using latest teaching materials, tools and equipment.

b. Sponsored presentations

Sponsored Presentation: SWIPHA
Venue: Africa Hall, International Conference Centre **(**ICC) and Virtual Meeting Rooms
Theme: The role of quality antibiotics in mitigating antimicrobial resistance and the easy switch concept

Figure 1: Dr Jude Azai, SWIPHA Representative

Chairman: Dr Chioma Ajator
Rapporteur: Miss Sofia Duke and Dr Ehi Isa
Presenter: Pharm Jude Azai

The second breakfast session that held before the plenary was a presentation sponsored by SWIPHA and entitled, 'The role of quality antibiotics in mitigating antimicrobials resistance and the easy switch concept'. The session was chaired by Dr Chioma Ajator who introduced the session by welcoming the attendees and acknowledging the presenter and rapporteurs see Figures 1-3. The topics covered during the session ranged from mechanism of antimicrobial resistance, antimicrobial stewardship, quality/quantity versus antimicrobial resistance, ensuring patients get the right medication and the role of SWIPHA.

The presenter, Pharm Jude Asia, introduced the topic by defining the term antimicrobial resistance as 'a situation that occurs when a microorganism, which conforms to a particular agent later begins to resist that agent they were initially susceptible to'. Epidemiologically speaking, he stated that in SSA, one out of 10 medical products is said to be substandard or falsified and this substandard medication causes 4%–5% of mortality (WHO). He also expounded the mechanism of this antimicrobial resistance which includes pumping out of drugs by the organism, inactivation of the drugs and conformational change in the nature of the binding site.

He also stated that antimicrobial stewardship is essential in fighting antimicrobial resistance, where if an antibiotic is not needed, it should not be given, and when it is needed, the right drug choice, dosage and duration should be administered. On connection between antimicrobial resistance and drug quality, he noted that poor-quality antibiotics and low concentrations can lead to antimicrobial resistance and treatment failure. Of importance, he noted that cheap is not the same as cost-effective because they are frequently of poor quality and that SWIPHA over the years has consistently ensured patients get the right medications by producing good-quality and affordable products.

He concluded by introducing some brand of third-generation cephalosporin which comes in parenteral and oral formulations; finally, he called on MWAN/MWIA to prescribe the said third-generation cephalosporin to our patients where the need arises.

Comments, questions and answers from the session

1 'Everybody prescribes drugs'. This can result in inadequate dose. Does this contribute to antimicrobial resistance? What is SWIPHA doing about this?

'Antimicrobial prescribed by SWIPHA is unaffordable'... throw more light

2 For the first question, the presenter expressed how SWIPHA engaged healthcare providers to institute the culture of best medical practices. The second question was not answered due to time constraint.

Recommendations

- Need for good antimicrobial stewardship by clinicians and all stakeholders. Prescriptions should be made only when needed, at the right dose and with strict adherence to the duration of use
- SWIPHA recommends an easy switch from parenteral third-generation cephalosporin to an oral third-generation cephalosporin, which maintains same pharmacokinetics and same coverage
- The MWAN/MWIA should create more awareness on antimicrobial resistance among its members
- Doctors should prescribe the right medication, at the right regimen, for the right duration and for the right patient
- There should be a good control and regulation of prescriptions and sales of antibiotics
- SWIPHA and similar pharmaceutical companies should further bridge the knowledge, stock and availability gap by ensuring that good quality antibiotics are not necessarily more expensive, especially in low and middle income countries (LMICs) in order to reduce the limitation of prescription of these medications.

Attendance

a. Virtual: 57
b. Physical: 38
Total: 95 (female: 72; male: 23).

Sponsored Presentation: Pfizer
Theme: Preventing pneumococcal disease in adult population
Chairperson: Prof Rosemary Ogu
Speakers: Dr Ogugua Osi-Ogbu, Pharm Andrew Ikeasogbe

Figure 2: Cross-section of attendees at the SWIPHA event that held on 25th March 2021 at the International Conference Centre, Abuja

Rapporteur: Dr Onyinye Anyanwu
Venue: Africa Hall, ICC and All Virtual Rooms

In this session, Pfizer representatives provided a brief background on pneumococcal disease burden in the pre- and post-vaccination era, risk factors for pneumococcal disease and the indications for its WHO-approved expanded pneumococcal conjugate vaccine 13 product. Disease burden was defined as the impact of a health problem as measured by financial cost, mortality, morbidity, or other indicators. It is often quantified in terms of quality-adjusted life years or disability-adjusted life years, both of which quantify the number of years lost due to disease.

They established the fact that pneumococcal disease, caused by *Streptococcus pneumoniae*, a Gram-positive diplococcic, an important pathogen in humans that commonly colonises the human nasopharynx, especially in children, is indeed remains a problem of public health importance see Figure 5. They went further to pose the questions, What evidence do we have? How easily is pneumococcus identified as cause of pneumonia (community-acquired pneumonia [CAP]/non-CAP)? What are the diagnostic challenges? Who are those at risk? Do we have effective treatment? Is antibiotic resistance an issue? and How effective is the available vaccine for prevention? To answer these, the presenters opined that the burden of pneumococcal disease was probably underestimated on account of lack of specific diagnostic tools. Pneumococcus is also said to be one of the vaccine-preventable diseases with significant morbidity and mortality. Those with severe pneumococcal pneumonia and invasive pneumococcal disease (IPD) who require hospitalisation should be identified in a timely manner and offered appropriate treatment promptly. Adults who survive CAP and previously unvaccinated should be offered polyvalent conjugate vaccine on discharge or within weeks. Routine vaccine should be used for those at high risk: <5 years, >65 years and younger adults <64 years

Figure 3: Virtual attendees at the SWIPHA event on 24th March 2021

Figure 4: Summary of presentation

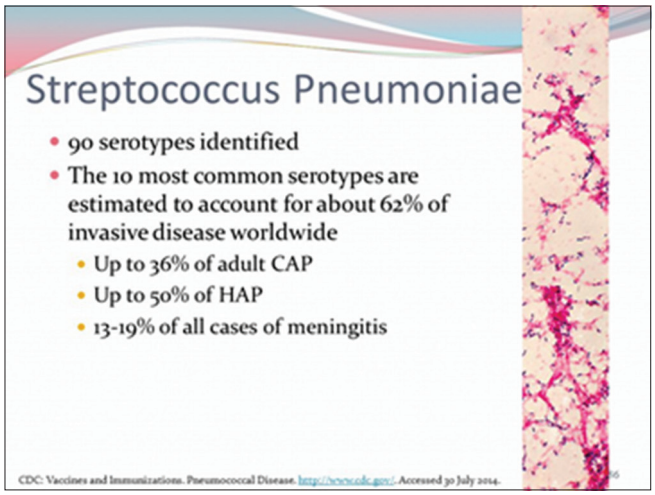

Figure 5: Epidemiology and features of Streptococcus pneumoniae

Figure 6: Nigeria's Minister of Health and Medical Women's International Association President at the Opening Ceremony of the Medical Women's International Association Near East and Africa Region Congress on 25th March 2021

with asplenia, cancer treatment, HIV, CKD, DM, CLD as per the CDC Advisory Committee on Immunization Practices recommendations.

Those issues that still remain unanswered in the quest to eradicate and manage pneumococcal infections were itemised to include dearth of accurate estimates of the burden of pneumococcal disease in the region, challenge of obtaining updated statistics on colonisation rate and age group variability, limited data on the burden of disease both in the hospital and community, constraints in establishing the extent of IPD and non-IPD in the high-risk groups and limited availability of improved diagnostic testing options to isolate the *Pneumococcus* agent. These are areas for further research and advocacy that associations such as MWIA can provide support for or engaged in for improved diagnostics in the management of pneumococcal infections, especially among vulnerable groups of children and those with underlying medical conditions as mentioned inter alia see Figure 4.

Sponsored Presentation: *MegaLife Sciences*
Venue: Africa Hall and All Virtual Rooms
MegaLife Sciences: Effect and management of stress and stress-related disorders. A focus on women
Chairperson: *Dr Vetty Agala*
Speaker: *Pharm Laitan Eseigbe*
Rapporteurs: Dr Anthonia Njoku, Dr Sandra Okekemba
(No Report of Session Submitted)

c. Opening ceremony

The opening ceremony held on day 2 of the Congress. On hand to declare open the congress was Nigeria's Minister of Health, Dr Osagie Ehanire, who gave the opening remarks and was accompanied by the Minister of Women Affairs, Dame Pauline Tallen, Chairmen Senate and House Committees on Health, respectively, the Nigerian Medical Association Chairman and the President of the MWAN, as well as a host of other dignitaries within and outside Nigeria. The MWIA was led by its President, Dr Eleanor Nwadinobi, who served as the Special Guest of Honour at the event see Figures 6 and 7.

The keynote speaker was Dr Grange, Former Minister of Health, during President Olusegun Obasanjo regime following the return of the country to democratic rule from the Military era. Dr Grange spoke on the theme of the Congress entitled, 'Accelerating Universal Health Coverage: Priorities, Opportunities and Challenges'. This set the stage for further discourse on the issues, approaches and strategies towards addressing and advancing effective delivery and implementation of UHC in the NEAR region as the Congress progressed.

d. Plenary sessions

A total of three plenary sessions were held over a 2-day period on days 2 and 3 of the Congress.

Plenary Session 1: Status of universal health coverage in the region

Venue: *Physical-Africa Hall, ICC and All Virtual Rooms*
Date: Thursday, 25th March 2021

Time: 9 a.m.–11 a.m.
Chairperson: Her Excellency, Dr Hadiza Sabuwa Balarabe, Deputy Governor, Kaduna State
Co-Chairperson: Dr Alero Roberts

Panellists:
- Mr Onoriode Esiri, Health Economist, World Bank
- Prof Obinna Onwujekwe, Health Economist, University of Nigeria, Nsukka
- Prof Akin Osibogun, Former CMD, Lagos University Teaching Hospital (LUTH)
- Dr Sanjana Bhardwaj, UNICEF
- Dr Wondi Alemu, WHO.

Rapporteurs: Dr Zainab Kwaru Muhammad-Idris and Dr Yetunde Oludare

Background

UHC is about all people having access to the healthcare they need without suffering financial hardships (World Bank, 2013). It is important that we analyse the status of UHC in our region, so we can celebrate successes, identify gaps and challenges and subsequently create a roadmap to the desired status of coverage. The three dimensions are equity, quality and financial protection and achieving these will significantly improve the health status of Africans. The Chairperson and Co-Chair greeted the participants. This session is to check if Africa is on track to achieve UHC, to engage stakeholders on the need to do more, as the pandemic has tested our health systems and our readiness for UHC.

The objectives were to:
i. Assess the status of UHC coverage in the region
ii. Explore options of finance for UHC
iii. Identify approaches/strategies of increasing government expenditure on health
iv. Find ways of reducing maternal mortality, infant mortality and under-five mortality across countries.

Technical presentations topics

i. Strengthening health systems/status of UHC in the region and what it will take to make progress towards UHC
ii. Health financing for UHC in Nigeria
iii. Human resources (HR) for health for UHC
iv. Strengthening PHC for UHC
v. Challenges and prospects towards UHC in the region.

Highlights from the panel presentations

I. Mr Onoriode Esiri, Health Economist, World Bank. Strengthening Health Systems

If the health systems are strengthened, this will hasten the achievement of UHC. There are numerous gaps such as gender gap that need to be bridged in the current structure of provision of healthcare. This can be addressed through the establishment of social capacity and empowerment of the vulnerable groups especially focusing on the education of the girl-child. Multisectoral collaboration is a key for the achievement of UHC as the health sector cannot do it alone. Social issues involving sectors such as education, energy, finance, water and technology need to be incorporated to enhance the UHC plan. Micro-policies should be modified to ensure affordability of care and governments should ensure adequate allocation of resources for health as recommended by the WHO and World Bank.

Figure 7: Hon. Minister of Health of the Federal Republic of Nigeria, Dr Osagie Ehanire and his entourage entering the venue for the Medical Women's International Association Near East and Africa Region Congress opening ceremony at International Conference Centre Abuja on 25th March 2021

II. Prof Obinna Onwujekwe, Health Economist, University of Nigeria, Nsukka. Financing UHC in Nigeria

The WHO and World Bank proposed target indicators to monitor progress to achieving UHC, e.g. the total health expenditure (THE) should be at least 4%–5% of gross domestic product and also out-of-pocket (OOP) spending should not exceed 30%–40% of THE. Statistics reveal the progress made by each country based on the indicators. A challenge with financing UHC is that financing is usually viewed as a narrow concept of mobilising financial resources, but health financing functions include revenue mobilisation, pooling and management of funds/resources and purchasing. With respect to purchasing, there is a need to change from passive purchasing, using limited information, to strategic purchasing using detailed information. The strategic utilisation of information to make deliberate decisions about what to buy, from whom and how to buy it will help to improve Universal Health Coverage (UHC) in a most profound way. Further, the avoidance of wastage, leakages, etc., will ensure strategic spending for efficient and equitable distribution of resources. The five pillars of strategic purchasing include institutional

responsibility for purchasing, defined package of service, strategic provider payment, provider autonomy and monitoring and accountability. If we ensure best practices, engage in public–private partnerships and allocate resources smartly, we will continue to progress towards the achievement of UHC.

III. Prof Akin Osibogun, Former CMD, LUTH. HRs for UHC

The dimensions of UHC are equity, quality and financial protection. Numerous resources are required to deliver healthcare, but HR is critical because the quality of HR is a determining factor for the deployment of other resources. According to the WHO, there is a significant relationship between health outcomes and HR density. Africa accounts for about 24% of global burden of disease and has access to 3% of the health workforce and less than 1% of the world's financial resources. A huge gap indeed and there is need for adequate, skilled, well-trained and motivated workforce to accelerate progress towards UHC. Other than numerical disparity, there is also geographical disparity, i.e., urban areas and rural areas. Numerous factors, including demotivation, inadequate training and brain drain, are contributory, while solutions need to be holistic to involve development of the health workforce with technical, political and financial input. To achieve UHC, we should ensure productivity and efficiency of the health workforce, give financial and non-financial incentives, dedicate some taxes for health and find innovative methods of retaining skilled workforce to ensure equitable distribution and the improvement of healthcare.

IV. Dr Sanjana Bhardwaj, UNICEF. Strengthening PHC for UHC

A vision for PHC in the 21st Century by UNICEF for health and well-being involves PHC and essential public health, multisectoral policy and action, empowered people and communities. PHC and essential public health function as the core of integrated health services. There must be a reaffirmation of commitment to PHC at all levels to achieve UHC and the achievement of sustainable development goals (SDGs) see Figure 12. Numerous lives of women and children have been saved and can be saved with the PHC delivery approach, e.g. one functional PHC center per ward. Majority of burden of disease can be treated at PHC level; UNICEF data revealed that malaria, diarrhoea, pneumonia and HIV were the major causes of under-five mortality in Nigeria. Challenges to PHC include access, quality and demand, enabling environment, etc. There are opportunities for UHC, and these include innovation for financing and service delivery, data management for action, widening of partnerships, utilising community structures and maximising engagement to increase coverage and improving health indices.

V. Dr Wondimaagegegnehu Alemu, Former WHO Expert. Challenges and Prospects towards UHC in the Region: Case Studies from Ghana, Kenya, Nigeria and Tanzania

The United Nations proclaimed that health is a fundamental right of all people. UHC is inclusive of promotive, preventive, curative, rehabilitative and palliative care. The pandemic has disrupted progress in UHC, the challenges are real, but the prospect is optimistic. Chimezie (2015) reported that PHC was not working optimally in Africa. The challenges are numerous and include issues with population, poverty, systems, cultural beliefs, political interference, low level of investment, high user fee, gaps in health system supply and demand, disruption of health services. The prospects are political leverage, technological advancement and the ability to monitor progress. The solutions will include learning, accountability, collaboration, communication and community engagement. There is a promising economic growth trajectory in Africa and the WHO reported that many countries are on the progressive path to UHC, but we need to build stronger health systems that can withstand future pandemics or force majeure.

Comments from participants on the presentations

- Get finance to train and retrain skilled workforce
- Ensue equitable distribution
- Quality care for emergencies
- Make country feel safe to curb brain drain
- Employ skilled workforce
- Monitor strategic purchasing.

Implication to Medical Women's International Association/Medical Women's Association of Nigeria

Engage stakeholders on ways that can be adopted for the attainment of UHC.

Recommendations/action points

- Prepare public health systems according to the WHO standards
- Prioritise UHC to attain UHC
- Promote healthier services.

End-of-session evaluation

- Great flow of topics and speakers
- Brilliant session with fantastic speakers who did not exceed the time allotted for their speeches.

Participants

124 attendees participated virtually.

What worked well and challenges encountered

- Session started on time

- Speakers kept to time
- Network issues necessitated a switch in the arrangement of the speakers
- There was an issue of discordant slide change with a speaker whose slides were shared by the virtual host.

Plenary Session 2: Critical healthcare needs and services for vulnerable groups, especially women and children

Venue: *Physical - Africa Hall, ICC and All Virtual Rooms*
Date: Thursday, 25th March, 2021
Time: 9 a.m.–11 a.m.
Chairperson: Dr Christine Sadia, Regional Vice President, MWIA
Co-Chairperson: Dr Lucy Idoko
Rapporteurs: Dr Omosivie Maduka and Yetunde Oludare

Background

According to the WHO, millions of women and children die from preventable causes annually. This is because the world has failed to invest enough in the health of women, adolescent girls, new-borns, infants, children and other vulnerable groups. To address this, high priority has to be accorded to these most vulnerable groups within national health agendas across the region. To discuss these and related issues, the second plenary session focussed on the following objectives, which were to:

i. Identify those healthcare needs of the most vulnerable populations across the region
ii. Discuss priorities and strategies available for delivering high-quality interventions towards optimising women's and adolescents' health
iii. Emphasise the approaches/strategies/interventions that work
iv. Identify existing initiatives to advance UHC particularly at the community level.

Topics presented

i. Critical healthcare needs of vulnerable groups for universal healthcare coverage in the region – Prof Segun Fatusi
ii. Women's health priorities and interventions – Prof Afua Hesse
iii. Promoting adolescent health in the region – Dr Senan Hodonou
iv. Delivering high-quality interventions on a continuum of care – Dr Hally Mahler
v. Eliminating barriers to accessing essential services for women and children – Prof Angela Okolo
vi. Community-based initiatives to advance UHC – Prof Emmanuel Otolorin.

The presentation by Prof Fatusi noted that provision of essential healthcare services to meet the needs of these vulnerable groups, especially women, new-borns, children and adolescents, is critical to meeting the UHC goal of leaving no one behind. Unfortunately, critical gaps in availability and access to these services remain, with wide inequalities between countries and at subnational levels. Social determinants of health, education, poverty levels, place of residence, among others influence access to these services. In addition, evidence abound of limited programming for some of these key target groups, including adolescents and persons with disability. Further, there is little investment in programming for some key health concerns, especially the prevalent gender-based violence. Access to life-saving commodities for mothers and children, including family planning commodities, is becoming a challenge in many countries, with diversion of funds to respond to COVID-19 and failure of governments to budget or release the budget funds. The congress decried the marginalisation of women in decision-making from the private to the public sphere, which could have ensured the participation of the women in decisions concerning their health and overall well-being.

In her presentation titled, 'Women's health priorities and interventions in the region', Prof Afua Hesse pointed out and catalogued women's health priorities, identifying a few crucial ones and outlining interventions proposed to address the shortcomings identified. She concluded by saying that it goes without saying that the needs of children must be subsumed and included in all priorities involving women who without hesitation would prioritise the needs of their children and families well above their own.

Dr Senan Hodonou in her piece entitled, 'Promoting Adolescent Health in the Region', stated that adolescents needs are linked to about six key SDGs; namely health (SDG3), economic growth and job creation (SDG8), gender equality (SDG5), education (SDG4), nutrition (SDG2) and poverty reduction (SDG1). The global community has set the goal to achieve UHC as a priority, so all individuals and communities have access to quality health services where and when they need them, without suffering catastrophic hardship (WHO, UHC, 2019). The SDGs and global political momentum behind UHC offer significant opportunities to build collective global and national action towards achieving UHC for adolescents.

The Africa Health Agenda International Conference (AHAIC21) in March 2021 has reinforced the need to make the UHC aspiration a reality. Her presentation highlighted where the President of Kenya said that African nations need to focus more on the expansion of primary health, increase access to health services, make healthcare affordable and harness the innovativeness of its youth.

In 2021, adolescents and youths constitute almost a quarter (24%) of the world's population (United Nations, Department of Economic and Social Affairs, World Population Prospects: The 2019 Revision). In SSA, adolescents aged 10–19 years constitute the largest proportion (23%) of the total population (United Nations Children's Fund. Adolescent Demographics – UNICEF DATA. New York: UNICEF; 2016). She also said that adolescents face various challenges in accessing the knowledge, information, healthcare and services needed. These challenges can be exacerbated by age, sex, ethnicity, religion, disability, location, wealth, marital status, migratory status and other factors. Adolescents are also said to carry 11% of the global disease burden, and each year, there are more than 1.1 million adolescent deaths. Adolescents are therefore in need of health services and policies that promote enabling and safe environments that protect and improve their health and overall development. Health services package need to move from merely being adolescent-friendly to being adolescent responsive. A health package includes a large variety of services on prevention of diseases including the non-communicable diseases (NCDs), healthy eating and nutrition, stress management and mental healthcare, sexual and reproductive health (SRH), reduction of tobacco and other substance abuse.

In terms of pregnancies and maternal health, adolescent girls are especially vulnerable to complications of unsafe abortion and pregnancy. They are less well covered by services than older women. Adolescence represents a period of vulnerability for mental health. Nearly 50% of mental health conditions occurring by the age of 14 and 75% by the age of 24. This population group's mental health status is often overlooked by health providers, parents, or adolescents themselves, and they are also often undetected due to stigma or lack of knowledge. In terms of access to and utilisation of health services package, the conditions needed for success include having access to appropriate, timely and quality health knowledge and information, messages tailored to adolescents needs and practices, communication channels that are attractive for adolescents, ability to reach out to the most vulnerable and targeting in and out of schools adolescents. Girls are most at risk of abuse in their right to access and use healthcare services. As such, there is need for greater partnership with and collaboration with opinion, community and religious leaders, who have a role to play in providing the socio-cultural ambience for them to thrive.

A number of challenges faced at this period of adolescents' development include financial limitation to access quality-friendly and responsive services, unemployment and/or informal employment, limited access to health insurance, service fees, pharmaceuticals and significantly high cost of transportation. Added to these, support or permission of parents and partners is often required to use health services, including for sensitive issues such as SRH. The low health literacy, poverty and marginalisation, lack of healthcare financing arrangements with a particular lens to adolescents' needs and lack of evidence to plan and ensure equity for adolescents within national plans for UHC also negatively affect adolescents' access to and utilisation of the healthcare and related services that they need.

The consequences of poor utilisation of SRH services were also highlighted during this presentation. At least 777,000 girls under 15 years were reported to give birth each year in developing regions.[1,2] Complications during pregnancy and childbirth are the leading cause of death for 15–19-year-old girls globally.[3] Adolescent mothers (aged 10–19 years) face higher risks of eclampsia, puerperal endometritis and systemic infections than women aged 20–24 years, and babies of adolescent mothers face higher risks of low birth weight, preterm delivery and severe neonatal conditions.[4] Furthermore, statistics show that at least 10 million unintended pregnancies occur each year among adolescent girls aged 15–19 years in the developing world. This she said may lead to stigma, rejection or violence by partners, parents and peers. It can lead to them dropping out of school, thus jeopardising the girls' future education and employment opportunities. (WHO. Global standards for quality healthcare services for adolescents. Geneva: WHO; 2015).

In terms of opportunities, Dr Hodonou said for every dollar invested in selected adolescent health interventions, there is an estimated ten-fold health, social and economic return. Even though adolescents carry 11% of the global disease burden, they received only 1.6% of developmental assistance for health through 2019. The UN Strategy for Women's, Children's and Adolescents Health recognises that investments in keeping adolescents' health fuels economic growth by contributing to increased productivity, reduced health expenditure and ensuring reduced inequities across generations.

She went on to say, 'what adolescents want us to know include the complexities and uniqueness of their health challenges, which result from their changing bodies and minds, and from social pressures around them. They need an approach that covers all these factors'. Gender is a critical factor given that boys as well as girls face health challenges that are defined by gender and social pressures. Mental health is a significant challenge: 50% of mental health conditions first appear in adolescence, before the age of 14. Adolescents also need services that are accessible and adolescent-friendly. Health staff should be appropriately qualified and able to respect

adolescents' confidentiality. They want to be involved with designing, delivering, promoting and monitoring the health services intended for them. They want to be part of health campaigns, speak for themselves, help design outreaches and have their voices included at every stage. (WHO, Plan International and other partners – Adolescent Health: The Missing Population in Universal Health Coverage.)

To make progress towards UHC, countries will need to transform how health systems respond to the health needs of adolescents. Dr Hodonou ended the discussion by proferring the following recommendations:

1. Develop alliances with health financing partners for UHC with particular focus on adolescents' needs
2. Invest in health policies and interventions tailored to youth's needs
3. Conduct capacity development for health workers on adolescent responsive services
4. Promote adolescent responsive health centres infrastructure
5. Disseminate and appropriate the Global Standards for Quality Health-Care Services for Adolescents
6. Enhance disaggregated data collection and report on adolescent health at national/provincial/regional and district levels.

The next in line of presenters was Dr Hally Mahler, HIV Director, Infectious Disease and Health Systems Department of FHI360. She started by providing an overview of FHI360, which is an international non-profit organisation working to improve the health and well-being of people in the United States and around the world. She also highlighted the organisation's HIV Continuum of prevention, treatment and care portfolio including strategies for delivering high-quality interventions, knowledge management and research and development projects, requiring expertise in methods and programme delivery. Its areas of expertise span health, education, agriculture, finance, economic strengthening, food security and emergency nutrition, gender and social norms, gender-based violence, implementation science, institutional strengthening and a host of others see Figure 8.

She stated that FHI360's comprehensive approach to HIV and AIDS is driven by innovative research, the use of data and a long-track record of engaging directly with populations and communities most impacted by the epidemic. They partner with funders, health ministries and non-governmental organisations to pioneer HIV research, prevention and treatment programmes in 46 countries. Their work has focussed on access to HIV testing, prevention, care and treatment services; capacity building in resource-limited settings; cutting-edge HIV prevention research; and improving standards of HIV prevention and care. Last fiscal year, they reached 4,317,347 clients with HIV services, supported 790,001 people living with HIV on anti-retroviral therapy and 92% of those who had a documented viral load were suppressed. In Nigeria, FHI360 has 11 projects spread across six technical areas of HIV and TB, humanitarian response, nutrition, sexual and gender-based violence (GBV), education and COVID-19 response see Figure 9.

Dr Mahler went further to give examples of cutting-edge HIV prevention research and work done in Africa and other countries like Nigeria (GIS analysis to identify gaps in case finding in target districts and identify hot spots for targeted testing and Improving client adherence and retention through community pharmacy ARV refill), Burkina Faso (Overcoming impact of COVID-19 pandemic on HIV case finding in Burkina Faso), Zimbabwe (Innovations in HIV case finding through HIV self-testing), and Nepal (Virtual case management for mitigating the impact of COVID-19 on HIV services).

She concluded her presentation by observing that:

i. The HIV care continuum is useful both as an individual-level tool to assess care outcomes and a population-level framework to analyse the proportion of people with HIV who are engaged in each successive step
ii. Real-time analysis and use of data are important to identifying gaps in programming and facilitating early course corrections
iii. Innovative approaches are required to deliver high-quality services and overcome programming challenges to retain clients on the care continuum
iv. COVID-19 has been an engine for ingenuity and opened the door to policy changes that in the long run will benefit clients.

Prof Angela Anene Okolo of the Department of Pediatrics, Federal Medical Center, Asaba, presented the topic 'Eliminating or removing barriers to accessing essential services for women and children'. The objectives were to highlight the barriers to access their demand-side as well as the supply-side causes, learning through lessons derived from the results of implementation of practices that have contributed to raising healthcare utilisation and to present proposal for alleviation and utilising lessons learned from implementation of strategies and scaling up of such implementation.

The socio-demographic characteristics of SSA countries were said to include maternal and childhood mortality that remain a major public health challenge in most SSA countries, wide disparities and uneven distribution of mortalities – higher among urban poor and rural dwellers with limited access to healthcare, gross underutlisation

of health services as underlying cause (and barriers to accessing healthcare is a major contributing factor to underutilisation; this in itself is associated with the high maternal and under-five mortalities in the SSA countries). Although utilisation of modern healthcare is closely related to child survival, a number of barriers prevent many people from access. Such preventable deaths result from underutilisation due to poor access to timely and quality healthcare interventions, inequitable distribution of healthcare facilities and HRs for health-limits provision of quality care and influencing community conditions such as physical, social and service provision. Such is exemplified by the fact that children born or raised in communities that lack a healthcare facility relative to those from communities with better availability of health facilities, which are likely to suffer poorer health outcomes.

Contributory factors in some SSA settings range from cultural practices such as very strict purdah in some parts of the region-limit access of women and children to healthcare, husbands permission needed to access care (low status of women), high female illiteracy rate – a higher level of maternal education is associated with greater access to household resource and improved access to healthcare. Factors so far highlight the mixture of supply and demand factors – interplay of these barriers to health services utilisation is highlighted to include underutilisation of effective healthcare interventions in the developing world and large income-related disparities. Utilisation of modern healthcare is closely related to mortality rates, and the gross underutilisation of healthcare services is due to many reasons. On the demand side,

i. Long distances to services – more in rural areas where there is low density of modern healthcare facilities and poor transportation systems and road infrastructures lead to delays in the decision to seek care (demand- and supply-side factors)
ii. Adverse socio-cultural practices (low status of women [gender issues] [demand side])
iii. High illiteracy rates (demand- and supply-side factors)
iv. Socio-economic or resource-related barriers (demand and supply side)

Specific supply-side barriers include HS finance cut backs-limited funding for health in SSA with resultant acute shortage of HR for Health ratio lower than the recommended 2.28:1000 population, inadequate supply of drugs, limited coverage and quality of healthcare interventions, understaffing of healthcare personnel, inequitable distribution of healthcare facilities and HR for health-limits provision of quality care – inequities in mortality reductions; higher mortalities in poorer communities with poorer access to care – this is more in the rural communities where healthcare facilities and high quality of care are limited. Studies have established

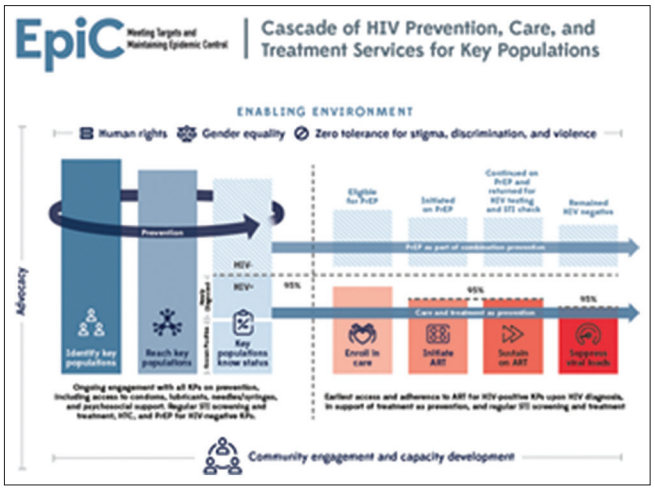

Figure 8: FHI 360 Areas of Expertise

Figure 9: FHI 360 in Nigeria

Figure 10: Sustainable Development Goal 3 Statement

that long distance to healthcare facilities cause delays in the decision to seek care. This problem is particularly heightened in the rural areas where the density of modern healthcare facilities is low, and transportation systems and road infrastructures are poor. These create wide gaps in child mortality reductions. Frankenberg noted that the proximity to a healthcare facility significantly decreases child mortality while a slight increase in the distance to a healthcare facility leads to a corresponding increase in child mortality.

Other notable barriers in demand and supply that impair timely access to quality care include education- and resource-related barriers that impair utilisation, such as exemplified by difficulty in getting money needed for medical treatment, shortage of health workers and inadequate supply of drugs.

The solutions to addressing these gaps should include strategies that will ensure:

i. Equitable distribution of healthcare facilities across regions of the country. An increase in the density of modern healthcare facilities, particularly in the rural areas and settings where transportation systems and road infrastructures are poor, will bring about high proximity to healthcare facilities. (Thus, strengthening of PHC structures and implementation of the full concept)
ii. Identify and implement strategies to cover the gaps in the shortage of health personnel and inadequate supply of drugs – cover the gaps in health funds due to health budget cutbacks resulting from the economic crisis
iii. Strengthen strategies that prioritise women's health in Africa by adopting a holistic, multidisciplinary approach that links together biomedical, sociocultural and economic factors. Such policies will address women's health, education and economic benefits to the advantage of labour productivity, national economy, child life and child health
iv. Adopt a holistic, multidisciplinary approach links together biomedical, sociocultural and economic factors through policies that will address women's health, education and economic benefits to the advantage of labour productivity, national economy, child life and child health. Most studies highlight that barriers are best addressed by considering them holistically and in the way that different factors intersect to combined effect. Prioritising one barrier over another may not achieve positive results. Community-level approaches including decision-makers and men are also recommended, to overcome intersecting barriers. In addition, supply- and demand-side barriers often work in tandem, and where possible, multiple levels of the health system as a whole should be taken into account
v. User fees removal: Many low- and middle-income countries' financing methods do not mobilise sufficient resources to provide the desired levels of healthcare for their entire population. Available resources are not pooled to provide protection against household expenditure variance or channelled through some form of pre-payment mechanisms; scarce resources that were mobilised are often insufficient to cover the cost of healthcare expenditure. The poor and other vulnerable groups who need healthcare the most are the most affected by these shortcomings, especially the high reliance on user fees and other OOP expenditures on health which are both impoverishing and provide a financial barrier to needed care. Hence, removal of user fees had led to observed increase in utilisation of services in Uganda, South Africa and Madagascar. However, concerns about drug availability for the poor and the effects on preventive services have limited these success stories and made these to be better qualified successes. This actually led to a reintroduction of user fees in the case of Madagascar.

From the session, the solution and way forward to these myriad of problems were to introduce results-based financing (RBF), which emerged as a potentially

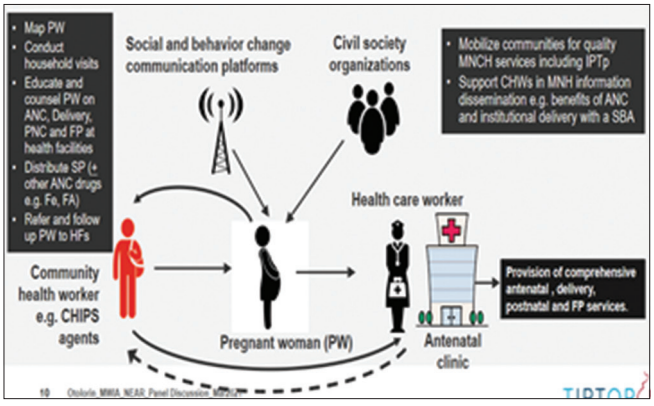

Figure 11: The Transforming Intermittent Preventive Treatment for Optimal Pregnancy Programme Approach

Figure 12: The 17 Sustainable Development Goal

significant strategy to finance health and other social protection services in the health sector. It is mainly used for expanding the quantity and quality of targeted subsidised health services. The RBF includes initiatives such as output-based aid (OBA), pay for performance, cash-on-delivery and performance-based financing (PBF). It includes a range of health initiatives aimed at achieving health targets such as improvement in health outcomes, greater output of specific health services and changes in health-related behaviours with increased use of health services by individuals and identifying the financial strategy to address barriers holistically. Improvements in utilisation of services and quality of care can be obtained through performance OBA programmes.

The theoretical context of the OBA or voucher mechanism is found in the basic economics theories of supply and demand with the aim of using market mechanisms to efficiently subsidise health services for individuals who would likely go without the service in the absence of the voucher. The main rationale behind subsiding healthcare is the inequitable distribution of wealth and health. Providers perceive value in the voucher programme as a healthcare financing model. They recognise that it has the potential to significantly increase demand for reproductive health services, improve quality of care and reduce inequities in the use of reproductive health services. In particular, governments should invest more in basic education and infrastructural development to begin to remove the structural causes of non-use of maternal health services.

Demand-side financing approaches have been seen as a means to ameliorate this situation and have been employed in many different contexts in low- and middle-income countries in attempts to help overcome barriers to access to maternity care. Five models were considered: unconditional cash transfers, conditional cash transfers, short-term payments to offset costs of accessing maternity services, vouchers for maternity services and vouchers for merit goods, among others.

As a way forward, a holistic approach is said to be needed. The proposed approach put forth by the presenter is the voucher method, which she says addresses both supply- and demand-side barriers to improve utilisation of services and reduce mortalities with better health outcomes, especially for the vulnerable groups.

During this plenary, on hand to present the next and last topic titled 'Community-Based Initiatives to Advance Universal Health Coverage - A Malaria in Pregnancy Case Study' was Prof Emmanuel Otolorin. He commenced his presentation by saying UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care. He also defined 'Community-based services' as 'an integrated system of care designed to meet the health needs of individuals, families and communities in their local settings'. It includes services delivered by a broadly defined community health workforce, formal and informal, paid and unpaid, providing outreach services and campaigns. It can be used for health promotion, disease prevention, treatment and support.

The 2018 Declaration of Astana, which was built on the 1978 Alma Ata Declaration, unanimously endorsed by all WHO Member States, makes pledges in four key areas that range from making bold political choices for health across all sectors; building sustainable PHC; empowering individuals and communities and aligning stakeholder support to national policies, strategies and plans.

He went further to explain the link between SDGs and UHC. The SDG3, which specifies 'Good health and well-being', aims to achieve UHC that seeks equitable access of healthcare services to all men and women. It proposes to end the preventable death of new-borns, infants and children under-5 (child mortality) and end epidemics see Figures 10 and 12.

Thereafter, the 16 essential health services that are important for UHC [Figure 13] and a case study on community distribution of sulphadoxine-pyrimethamine (SP) for intermittent preventive treatment of malaria in pregnancy (IPTp-SP) across four SSA countries through the Transforming Intermittent Preventive Treatment for Optimal Pregnancy (TIPTOP) project were presented. The 5-year project whose period of implementation spans from May 2017 to April 2022 aimed to save the lives of thousands of mothers and new-borns. The specific programme objectives are to generate evidence for potential WHO policy change, introduce and set the stage for scale-up of community intermittent preventive treatment during pregnancy (C-IPTp), introduce and increase demand for quality-assured IPTp-SP. The key

Figure 13: Essential health services for attaining universal health coverage

partners on the project are Jhpiego (Prime Grantee) and ISGlobal (Research Partner) while WHO and Medicines for Malaria Venture are enabler partners.

The TIPTOP Programme approach was also highlighted [Figure 14] to include among others, mapping, selection and orientation of eligible beneficiaries, use of available platforms for social and behaviour change communication and provision of comprehensive services. The vehicle and key stakeholders needed to deliver these services include health workers at the community and health facility levels and the CSOs among others. The beneficiaries of this programme are classified as primary and secondary. Primary beneficiaries include pregnant women (reduced risk of mortality and morbidity) and new-borns (reduced risks of mortality and morbidity) while the secondary ones are community health workers (CHWs, trainings), facility-based healthcare workers (HCWs, trainings), families and communities. Prof Otolorin also presented the preliminary results of ISGlobal's midline survey that showed that IPTp3 increased significantly in Phase 1 Districts in 3 of 4 countries [Figure 14] and a case study of the Nigerian project [Figure 15].

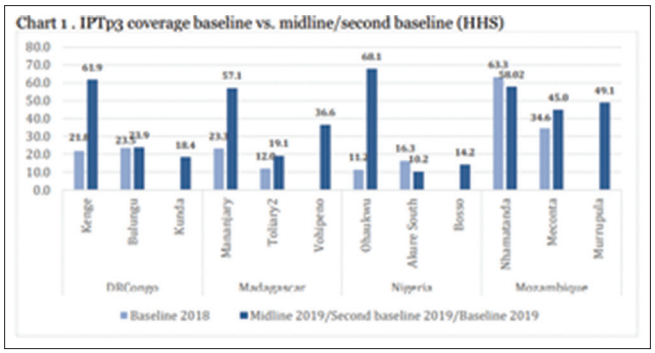

Figure 14: Preliminary results of the Transforming Intermittent Preventive Treatment for Optimal Pregnancy IPT Survey from 4 African Countries

Initial successes recorded in the course of implementing the C-IPTp project across these four countries include the establishment of strong partnerships, increased IPTp3 coverage in Phase I districts in three of the four countries, steady or slightly increased ANC4 coverage and strengthened data collection and use. A few challenges were also encountered. Some of these were CSO motivation and incentive issues, variable literacy levels of CHWs, weak community health management information systems (MIS), slow progress in activities related to sustainability, natural disasters, epidemics and pandemics, e.g. Cyclone Idai and flooding in Mozambique, the Ebola, Measles, Lassa fever, and COVID-19 epidemics/pandemics, insecurity, e.g. Armed conflicts in Mozambique, Nigeria, and DRC.

Prof Otolorin concluded his presentation by emphasising [Figure 16] the importance of community engagement, which he said, allows for quick dissemination of preventive health messages, identification of cases and referrals at community level (being community-based is particularly important in areas with limits on population movement), supports continued delivery of essential health services and minimises health risks, encourages positive healthcare-seeking behaviours especially during the pandemic, provides trusted sources of information and messaging around the pandemic and helps communities to be more resilient when facility-based health services are impacted by a crisis.

This presentation marked the end of the second plenary session.

Plenary Session 3: Actions to advance universal health coverage

Venue: *Physical - Africa Hall, ICC and All Virtual Rooms*
Date: Friday, 26th March, 2021
Time: 2–4 pm

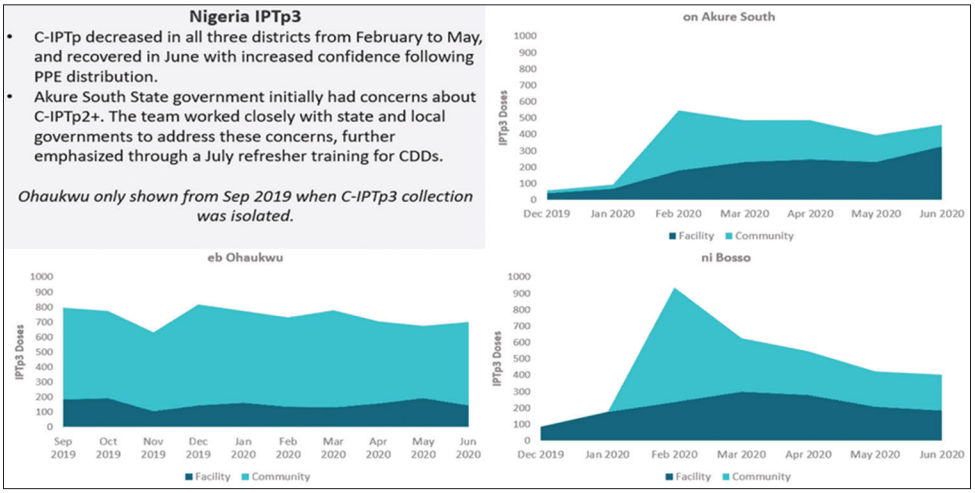

Figure 15: Case Study of Nigeria Community Intermittent Preventive Treatment during Pregnancy Project

Chairperson: Prof Hadiza Shehu Galadanci
Co-Chairperson: Prof O. Chirdan
Rapporteurs: Dr Vetty Agala and Dr Lilian Ekwem

Panellists:

1. Dr Mohammed Pate – Executive Director, World Bank
2. Dr Padmini Murthy – Secretary General, MWIA, Professor and Global Health Director
3. Dr Faisal Shuaib – Executive Director, National PHC Development Agency (NPHCDA) represented by Dr Garba, the Director Planning, Research and Statistics, NPHCDA
4. Dr Joannie Marlewa Bewa – Global Youth Advocate, Specialist in Clinical Care, Research and Advocacy from South Florida, USA
5. Dr Sam Oboche Agbo– Sr. Health Advisor, Foreign Commonwealth and Development Office
6. Dr Bolanle Oyelodun – Country Director, CHP

Background

The chairman of the session Prof Galadanci welcomed all participants to the third and last panel of the scientific conference in which the theme would be explored by seasoned panellists, mostly public and global health professionals. She summarised the CVs and gave citations of all panellists except Dr Pate who was unavoidably absent. The session essentially discussed and consolidated the key outputs from the congress proceedings made thus far.

Methodology

It was a hybrid event with only Dr Garba physically present while the other panellists participated online in the discourse. Each panellist was asked a question and other panellists could make contributions. Thereafter, questions and comments from the participants were addressed with a concluding word allowed from each panellist.

Technical presentation

Question 1. How do we reduce inequalities in health in the African region? Dr Bewa in her response made the following points

i. There is still high unmet need for health in the continent. We need to eliminate preventable maternal and infant deaths and reduce malaria and other communicable diseases and NCDs. It is however possible and within reach to close the gaps, but this would require deliberately identifying the most vulnerable and those left behind through data analysis to map geographical disparity, age, sex, socio-economic status, etc. and then focus on what we find
ii. Target and tailor services to address these needs, explore barriers to acceptability of services
iii. Build capacity for health workers to provide services both in public and private sectors
iv. Strengthen community-based actors, empower them
v. Improve quality of care, affordability and availability of services
vi. Outreaches via home visits, eHealth, mHealth.

In summary, she noted that to accelerate access to the last mile, adolescent and women's SRH must be addressed through gender-sensitive UHC approach and programming, strong political will and availability of social safety nets to reduce OOP expenditure.

Other panellists contributed to this question highlighted the need for:

i. Political commitment through all response and responsible bodies
ii. Understanding and addressing contexts
iii. Community ownership – bottom-top approach
iv. Girl child education
v. Women empowerment
vi. N/B women need to be at the table of discussion. It is our right to make our decisions, so they must talk to us. Women must also look out for other women.

Question 2. How do we specifically meet the needs of vulnerable women and children?

Dr Padmini in her response said the following:

i. Putting women and adolescents at the heart of UHC is crucial, irrespective of where they are
ii. No one size fits all, but policies must be gender-sensitive, age-specific
iii. Service delivery must be equitable and affordable with use of affordable technology. She highlighted inequity in vaccine distribution, poor access to sanitary products and commercialisation of products with different costs in different locations
iv. We must factor human rights in healthcare delivery
v. UHC cannot be achieved without women, children and adolescent health and vice versa
vi. Dr Sam reiterated that the solution is women empowerment and girl child education. Let no woman die! Leave no one behind!!

Question 3. What is on the agenda as we look towards accelerating universal health coverage in the region?

In her response, Dr Oyeledun listed the following:

i. Address violence against women and girls (VAWG)
ii. Prioritise healthcare financing by increasing domestic financing, invest more in health and reduce systemic waste
iii. Engage private sector to mobilise resources
iv. Political will make health a priority, walk the talk
v. Invest in data, strengthen health security, and ensure policies are operationalised to give desired effects
vi. Invest in PHC
vii. Use simple techniques and life-saving innovations
viii. Speak out for the most vulnerable.

Other contributors said that the problem with the region is the demographic transition. We need to get family planning right and over population is stretching the scarce resources. Addressing patriarchy and get a seat on the table or sit on the table if no seat is provided

Question 4. How do we address political, economic and financial accountability in universal health coverage?

Dr Garba responded by emphasising the following:

i. UHC is a political choice. Health is a fundamental human right and accountability is a prerequisite for UHC
ii. The people's voice matter and the role of civil society is key in pushing for accountability
iii. Politicians must show commitment and the people must hold them accountable
iv. He used the polio eradication as example to show the need for accountability framework and transparency as key factors in achieving desired goals

Question 5. Share innovations that can be harnessed for health system strengthening, especially in the post-COVID-19

Dr Sam in his response listed the following:

i. Address barriers to girl child education
ii. Some innovations during the pandemic include rapid development of vaccines, vaccination digital record and tracking, direct solar technology and solar-driven PHCs, scale-up of the help babies breathe technique, PPP investment, use of drones to deliver products, GIS, trainings on zoom, ethical financing (Islamic financing), digital technology
iii. A few challenges include state security, government interference, lack of trust, non-state actors exploiting the technology
iv. He noted that the future is bright and Africa takes it. We can do it!

Other contributions included:

i. Documenting our ideas in the region
ii. Change our fixed minds and be amenable to change so we can catch up
iii. Promote home grown practices, advocacies on best practices
iv. Improve government commitment, sincerity
v. Use effective communication tools
vi. Doctors, medical women should get into politics and decision-making.

Virtual and physical participants asked questions and made contributions on:

i. Inclusion of the elderly as a vulnerable group who needs attention
ii. Advice for NEAR countries to take deliberate steps to facilitate and strengthen patient participation in their care, among other things, make health systems more user-friendly, and mandate health providers to use health literacy principles in patient–provider communication

Implications to Medical Women's International Association/Medical Women's Association of Nigeria

1. Need for more women interested in politics to be supported
2. Intensify advocacy and lobbying for addressing all issues pertaining promotion of UHC across the region and especially as it affects women, children, adolescents, the elderly, and other vulnerable population groups
3. Sensitisation of the populace and communities for their active involvement. Be a voice for the vulnerable voiceless

End-of-session evaluation

The session was very stimulating and captured the essence of the conference theme. Attendance was fair with good participation from the participants. There were a few technical hitches but largely excellent presentations from the panellists. Time management was excellent.

e. Panel symposia

Panel Symposium 1: Building a strengthened and resilient primary healthcare system towards achieving universal health coverage: The Nigerian experience

Host: NPHCDA
Venue: Physical - Africa Hall, ICC and Virtual: Meeting Room 2
Chairperson: Dr Daniel Otoh
Rapporteurs: Dr Omosivie Monica Ugwu and Dr S. Adeboye

- Financing PHC in a post-polio, peri-COVID-19 era by Dr Oritseweyimi Ogbe
- Leveraging the experiences with COVID-19 pandemic response and COVID-19 vaccines introduction to strengthen immunisation by Dr Bassey Okpossen
- *NEMCHIC: Prioritising quality RMNCAH + N services by Dr Laila Umar*
- CHIPS Programme: Strengthening the community component of PHC in Nigeria – for improved access to and demand for services by Dr Nana Sandah-Abubakar.

Panel Symposium 2: The Medical Women's Association of Nigeria Rivers gestational diabetes mellitus project: Reflections and lessons learned

Host: Rivers State World Diabetes Foundation Gestational Diabetes Study Group

Date: Thursday 25th March 2021
Time: 11 am to 12:20 pm
Venue: Physical - Banquet Hall 2, ICC and Virtual Meeting Room 3
Chair: Dr Claribel Abam
Rapporteurs: Dr Ireju Ajie and Dr Butulu Mohammad Isa

Background/Introduction

The chair welcomed all present and noted that there are lessons to be learnt from the presentations.

Technical presentation

The topics covered during the session and their presenters were:

- Grant writing and project implementation by Prof Rosemary Ogu
- Summary of baseline findings and Project results by Dr Omosivie Maduka
- Lessons learnt by Dr Vetty Agala
- Conclusions and case for sustainability by Dr Claribel Abam
- Highlights of each presentation and key issues raised.

Grant writing and project implementation (summary)

The project had a goal to prevent and improve gestational diabetes mellitus (GDM) outcomes, the project started February 2017 and ended January 2020 with grant support from the World Diabetes Foundation. It was targeted at screening 20,000 pregnant women and manage hyperglycaemia in 2000 pregnant women

The objectives of the project were to:

1 Promote prevention of GDM through education and awareness campaigns in 42 communities in Rivers State
2 Build the capacity of healthcare providers at primary and private health facilities for screening and pre-referral care for GDM
3 Enhance the capacity of secondary and tertiary public and private health facilities for GDM care
4 Promote GDM intervention activities using evidence-based scientific publications, media reports and stakeholders fora

The implementation of the project was based on its objectives.

Summary of baseline findings and project results/lessons learnt

The project was implemented in 42 communities in the state and across 4 LGAs with 1310 women diagnosed with GDM, 649 health workers were trained on diagnosis and management of hyperglycaemia in pregnancy and four publications have been published based on the project. On comparing the baseline and end-of-project survey, there is an improvement in the knowledge, attitude and utilisation of GDM among women of reproductive age. The MWAN Rivers branch noted that a multipronged approach that addresses demand- and supply-side interventions, stakeholder involvement, community ownership, policy development, monitoring and evaluation and supportive supervision are necessary for sustainable delivery of maternal and child health (MCH) interventions and services.

Conclusion and case for sustainability

- There is a paradigm shift from risk-based screening to universal screening
- A combination of demand- and supply-side interventions has been demonstrated to work
- There is a need to scale up these interventions within Nigeria and Africa
- At the end of the project, a dissemination meeting held with all relevant stakeholders, and they all gave commitment to sustainability

Comments/questions and answers asked (These should be well detailed as they will not be contained in any slide)

1. How does one go about grant writing? Prof Ogu R. responded that there are a lot of resources on the internet on grant writing; most calls for grants come with an outline/instructions on how to write that grant. It is easier when you are passionate about a cause. When writing for grant as a group share tasks, you may not get it initially but keep at it. Dr Abam Claribel noted that as an association is best to have well-kept accounts that have been audited and budget that have been properly implemented
2. Is there a plan for monitoring and supportive supervision so that the good job the project has achieved can continue? Dr Agala responded that the policymakers were brought part of the steering committee of the project. There was a dissemination meeting with all the stakeholders and commitments were gotten for sustainability of GDM screening as part of routine
3. Do you share experiences with follow-up? Yes, although it was not easy but doable; it takes a lot of work. There is a plan for integration of services at PHC level - Dr Vetty Agala

Implications to Medical Women's International Association/Medical Women's Association of Nigeria

- MWAN was able to avert complications associated with hyperglycaemia in pregnancy in 1310 women
- MWAN members on the project implementation team had their skills on grant writing and project implementation strengthened.

Recommendations (general and specific recommendations)

- There is a need to scale up interventions used in the project within Nigeria and Africa.

Total attendance = 31 (16 - virtual, 15 - physical).

Panel Symposium 3: Violence and harassment against doctors with focus on women doctors

Host: Dr Dabota Yvonne Buowari
Venue: Physical - Abuja Hall, ICC Virtual: Meeting Room 4
Chairperson: Prof Elizabeth Nwasor
Moderator: Dr Bilqis Muhammad
Rapporteurs: Dr Stella Rwezaula, Dr H. Omoregbe, Dr Aminat Oluwabukola Jimoh

Background/Introduction

The Chair of the panel welcomed everyone to the session and introduced the panellists as each was to make their presentation.

Technical presentation

The topics covered during the session and their presenters were:

- *Workplace violence in healthcare by Dr Dabota Yvonne Buowari*
- Violence against female doctors: A growing trend by Dr Popoola Margaret Owoloyi
- The role of chief executives in the prevention of violence in the medical workplace by Dr Ogugua Osi-Ogbu

The first panellist, Dr Dabota Yvonne Buowari, was physically present at the venue of the symposium to make her presentation on her topic entitled 'Workplace violence in the healthcare system'. She introduced the topic starting with the WHO definition of violence and what violence in the workplace means. She indicated that the workplace should be free from any type of harassment according to the WHO. She also mentioned a joint programme in 2003 by ILO, ICN, WHO and Public Services International for the reduction and elimination of the impact of violence at the medical workplace. She went on to give cite examples from some studies done in Turkey, Pakistan, Australia, Brazil, Bulgaria and Thailand. She grouped the factors affecting workplace violence into individual, organisational and environmental categories, after which she concluded her session

The second panellist, Dr Ogugua Oshi, who was also physically present, started her presentation by summarising the first panellist's discussions. Her presentation was on the 'Role of Chief Executives in the prevention of violence in the medical workplace'. She quoted the WHO 2013–2018 survey on medical practitioners that found that 50% of female medical doctors were in Africa. She grouped the causes of violence against doctors into two groups which were: systemic and patient-related. The systemic factors were said to include issues such as the cumbersome workflow structure, lack of proper orientation and gender inequality among others while the patient-related ones include poor experience and poor communication between doctors and their patients (or patient's relatives). The preventive measures discussed were the need to do adequate orientation of HCWs, appreciation of HCWs, use of educational posters to sensitise all workers by the management, sanction any perpetrator of violence or harassment of HCWs and encourage female doctors to report any form of violence meted against them without discrimination.

The third panellist, Dr Margaret Popoola, spoke on the growing trends of workplace violence against female doctors. She made a virtual presentation and started with an introduction including the UN declaration to end violence against women in 1993. Epidemiologically, workplace violence was said to be the third leading cause of fatalities in the US and the second most common cause of death for women at work. The aetiology was classified as those that are patient-related such as long awaiting periods, delay in getting medical attention, denial or refusal of admission and constraints of being a colleague or senior colleague, intimidation, bullying and discrimination against female doctors. In addition, the types of workplace violence were also presented as type I (where the assailant is unknown), type II (patients against doctors) and type III (colleagues, senior or acquaintance). The impacts on doctors, hospitals and nations and the challenges of reports on violence against female doctors are grossly under-reported its sensitivity, overarching culture, lack of reports to appropriate authorities and stigmatisation of female doctors among others.

The President of the Medical Women Association of Tanzania (MWAT), Dr Stella Rwerzelua reported on the trends in her country where she said, Tanzania has passed those stages as currently no violence to their female workers at work, and also currently in Tanzania, in her institution, most of the leaders are female and this puts fear in the men who are compelled to behave appropriately towards their female colleagues. She also said that any patient, relatives of patients and/or colleagues who are found wanting as culprits or perpetrators are appropriately sanctioned. This has helped curb the menace of violence against female doctors immensely, she said.

The session was concluded by a vote of thanks from the Chair of Panel. Attendees requested for the slides to be sent to their various e-mails.

Panel Symposium 4 by NHIS Did not hold

Symposium 4 did not hold! You may wish to remove or retain it while stating their absence/no-show.

Panel Symposium 5: Gendered effects of COVID-19

Date: Day 3, Friday, 26th March 2021
Time: 11.00 a.m.–12.30 p.m.
Venue: Physical - Banquet Hall 2 and Virtual Room 3
Chairperson: *Ms Mariama Daboe*
Rapporteurs: Dr Nana Hawwa Madugu and Dr Khadijah Liman Hamza

Topics and presenters

- Introduction and the study methodology by Clara Ladi Ejembi
- Effects of COVID-19 on work and schooling: Any gender differentials? And gender dimensions in effects of COVID-19 on access to information and health services by Muhammad Bello
- Gender-based violence by Zainab Kwaru Muhmmad-Idris
- Conclusions and recommendations by Clara Ladi Ejembi.

Background/Introduction

Prof Clara Ejembi, the lead presenter at this session, also doubled as the Chairman of the session. The session commenced at about 11:09 a.m. There was an initial period when technical difficulties were experienced due to unstable internet connection from the side of the panellist; however, this was soon resolved. We lost some 5 min of the session. The Chairman of the session was not available; thus, the panellists and rapporteurs managed the session. Prof Ejembi opened the session by welcoming all panellists and participants at the session. She went ahead to comment that gender has shaped the pandemic of COVID-19 in significant ways across the globe, with a disproportionately negative impact on females. The pandemic has also widened the gap between the rich and the poor, where the poor became poorer. There were also reports of increased sexual violence, a reduction of access to RMNCH services for women, as well as significant reversal of gains achieved in the reduction of maternal mortality. Further, she stated that even though the disease has been observed not to be gender blind, it is expected that the response ought not to be gender blind, at all levels, whether national or subnational. In the past, several calls were made to mainstream gender, especially in epidemic responses, but this does not appear to have taken place, either at the level of policy document preparation or at planning or implementation of responses to the pandemic. Further, gender was not factored in the process of responding to COVID-19, at all levels.

The objectives of this panel symposium session, therefore, were to share findings of the study which set out to generate evidences, if any, of gender differentials in vulnerability and access to services to support the call to mainstream gender in epidemic response and to share experiences of gendered effects of COVID-19.

Technical presentations

The title of the research shared was 'Gendered vulnerability and effects of COVID-19 in Kaduna state'.

The study objectives were to assess and compare among males and females, knowledge of, vulnerabilities and risks to, as well as access to information and health services related to COVID-19. It also set out to determine gender differences in the impact, interventions and mitigation interventions as well as determine drivers of gender differentials and gender norms. The study employed a mixed-method approach although the presentation mainly focussed on the quantitative component with few points from qualitative aspect interjected.

Key issues identified

- The study affirmed what exists in the literature, i.e. we still promote traditional gender norms as it was observed that women do more work at home as well as take care of children while caring for the sick in the household
- There was an increased workload for women during the pandemic – the only positive change was the increase in the helping of schoolchildren with school work compared to before the pandemic
- Traditional media was found to be the most important source of information for women during COVID-19
- There was reduction in utilisation of MCH services
- The pandemic adversely affected schooling of children of respondents
- Reduction in income became more apparent
- More females than males have ever-experienced intimate partner violence, higher prevalence with marginal increases experienced by females in all three forms of violence (i.e. psychosocial, physical and sexual)
- Males reported increased violence, particularly insults from their spouses/partners
- More females suffered consequences of GBV such as teenage pregnancy
- Qualitative data show report by men of increasing fights at home as there is no money
- Increasing cases of rapes and pregnancy among school girls
- Development partners report that there is no gender in the guidelines from the national and sub-national levels
- Men reported difficulties experienced by their women in getting access to reproductive health services; some have died due to these difficulties. There were no family planning commodities, as HCWs were not at the facilities or the facilities were closed

- Some did not go to facilities due to fear of contracting COVID-19
- Low-risk perception and feeling of invulnerability led to the poor or limited uptake of disease-preventive measures
- The pandemic and interventions in response to it negatively impacted the economy; people could not have access to basic needs – especially food – as markets were locked up in the metropolitan parts of the state
- Respondents also complained that there was no transparency in the distribution of the palliatives given by government.

Recommendations

- Step up community sensitisation
- Keep services available, prioritise MCH services
- Reach out to women with information through the media most available to them such as the radio, as well as time the messages appropriately so that they receive them
- Deploy facilities for schooling to avoid disenfranchisement of some population groups, especially girls in the grass-root areas
- Create safe spaces/platforms for vulnerable groups (women and girls) to get help and support for GBV
- Create and implement policies for prevention of GBV
- Government should establish and develop protocols that will guide management of cases of gender-based or intimate partner violence (GBV/IPV); build capacity through training of all necessary and relevant actors and stakeholders especially health care workers (HCWs) and law enforcement agents to be properly equipped to help and support survivors or those who suffered from GBV.

Comments/Questions

i. As mothers, we have a lot more to do. We need to start educating and indoctrinating our sons to break the culture of patriarchy and traditional gender norms
ii. How we bring up our boys determines how they grow up to become men
iii. We try our best such as we are doing, we try to raise profiles of women, but culture and religion have quite strong impacts, we are changing certain cultural norms such as the ascribed roles of girls and boys and we may be able to influence culture but with religion we face difficult hurdles
iv. We agree culture is dynamic, which is great, so while we educate the boys and men, we empower our girls to stand up for themselves
v. We need lots of education and sensitisation as far as religion is concerned
vi. We identify and make as champions some key religious leaders and maximally use them to reach their constituencies while we continue to educate
vii. We have failed women as key actors lack capacity, the coordination from the protection arm, to the justice system to the healthcare providers who are unable to get the medico-legal evidence
viii. As we move out of this regional conference, we should have a blueprint to help us guide the response – a document which conforms to the structure locally, of our healthcare system, judicial system and the different actors so that if another emergency appears, women do not get affected very direly like we are dealing with teenage pregnancy currently
ix. The document guides the responses for instance when there is curfew and women need to access help, care or support
x. We in Kenya have set up a hotline, a tele-counselling hotline to help women and girls. We really need to develop documents that conform to the different entities in the response to GBV; we need to adapt the documents from the UN to suit our local context and setups
xi. Currently, at the national level of MWAN, there is on-going advocacy for the establishment of policies and laws. There is also a concerted documentation of GBV. We certainly recognise the capacity gaps of key actors involved in the response to curb GBV
xii. Kaduna state, North-west Nigeria, has made public pronouncements about countering GBV; there is also an on-going process of generating a bill, an act of law that will address GBV. This aims to ensure perpetrators are identified, placed in a register for offenders and punished appropriately. Punishments may include loss of/denial of certain privileges. There is also provision of support and protection for those who have suffered GBV
xiii. The comment on the complaint by men that women were unable to access maternal services during the pandemic, the response from the panellist is that this was actually the case, especially at the early stages of the pandemic and following lockdown declaration by the state government. However, the state conducted trainings and provided with personal protective equipment (PPE) to health care workers (HCWs) at the PHC center, especially as most of them were scared of contracting the disease and lacked PPEs. Family planning commodities were also provided by the UNFPA to avoid disruption. At the national level, NPHCDA made a press statement about the facilities remaining open and providing services.

1. **Key next steps/action** post-session
   i. Highly recommended that we have a document/blueprint that is gender sensitive to guide responses to future emergencies
ii. National and sub-national levels of MWAN should go beyond documentation of GBVs but to develop

interventions to close the capacity gabs already identified, especially among actors and responders in the prevention and management of GBV.

2. End-of-session evaluation

Verbal comments from participants stated how interesting they found the session, thoroughly enjoyed it and learnt from it.

Other than the initial hitches encountered at the beginning of the session, which made some to come and then leave the virtual rooms erratically, the session went very well.

No photographs taken as both rapporteurs attended virtually. Very few responded to the repeated message to add their gender to the register of names and sex. Thus, we were able to identify one of the panellists as the only male who participated in the session.

f. Oral and Poster Abstract Sessions

A total of three oral abstract sessions and two poster-driven sessions were held between days 2 and 3 of the congress.

Oral Abstract Session 1

It was premised on the plenary sub-theme of advancing UHC in the NEAR. It held in the Banquet Hall 1 of the ICC with virtual participants linking via Virtual Room 1. Dr Marion Okoh-Owusu, National President, Medical Women Association, Ghana, served as the Chairperson while Dr Funke Lawson co-chaired. Rapporteurs for the session were Dr Olusola Taiwo and Dr Yetunde Oludare. Five of the seven abstract presenters earmarked for the session were available either physically or on-line to present their topics, two did not turn up and one of the remaining five persons substituted her slot with another presenter.

Following the welcome remarks by the Chair, the session ensued in earnest. Highlights of the topics presented include:

Comparative study of health shocks, health expenditures and coping mechanisms in North-Central Nigeria: The gender perspective by Oluwayemisi Deborah Adegboye. In her presentation, Dr Adegboye pointed out that health shocks have continued to gain global attention majorly because many payments for health services are made OOP, a situation that has hampered access to healthcare across Nigeria. Those most affected were said to be the poor, the vulnerable and women. This has pulled Nigeria far from achieving its targets for UHC. The rationale behind this comparative study were that globally, OOP payments and catastrophic health expenditure (CHE) have received very little or no attention. The objectives were therefore to determine the characteristics of the gender of the household head as it influences and impacts health shocks, to assess the gender perspective to health shocks and to identify patterns of health expenditures and available coping mechanisms in North-Central Nigeria. The study, which was a cross-sectional analytical type, applied both quantitative and qualitative methods using multi-stage sampling technique to select a total of 1192 households in rural and urban communities in North-Central Nigeria. Data were analysed using SPSS, Chi-square and regression analysis. The results showed that 458 (38.4%) were female-headed households (FHHs), which were less educated (18.8%) than the male-headed households (MHHs – 17.4%), earned lower income 44,286.35 ± 36,385.57 (MHHs – 97,231.96 ± 60,530.23), resided more in rural communities 48% (MHHs – 38.7%) and are less insured 3.9% than the MHHs (6.9%). The results also showed that health shocks were higher among the FHHs 76.2% (as against the MHHs – 72.6%), they pay higher percentage of their household expenditure for healthcare 8.6% (MHHs – 5.0%) and these were mainly made through OOP payments see Figure 17. Further, more FHHs experienced higher CHE, reported higher effects of health shocks on reduction in food consumption 53.9% (MHHs – 50.9%) and reported loss of income 46.9% (MHHs – 35.2%). These findings buttressed the qualitative information generated whereby a 25-year-old woman who resides in rural Kwara who just put to bed in a private hospital at the time of discussion said, 'The amount spent in the last 1 year is uncountable. I just gave birth and I spent about ₦20,000'. During focus group discussion session, a female respondent from rural Kwara reiterated that 'Caring for sickness affects household spending especially food. It affects feeding a lot. We usually forfeit feeding for healthcare costs'. Similarly, another middle-aged woman from rural Kwara said, 'Sometimes, we even remove the money from the children's school fees, so it affects children education. It also affects feeding because when we pay for healthcare food is reduced'. She concluded her presentation by pointing out that health shocks are part of a human being's living capable of pushing households into CHE or impoverishment, especially the rural FHHs, especially where there are weak social protection schemes that have forced households to adopt informal coping mechanisms. A wide equity gap therefore exists between rural and urban MHHs and FHHs. Recommendations made were for government and policymakers at all levels to strengthen the financial protection mechanisms for all citizens, provide innovative and alternative ways of expanding health insurance coverage, ensure and prioritise equity in healthcare among men and women, attend to the peculiar health needs of rural dwellers and mainly expand the health insurance pool so as to cover the informal sector as well.

The next presentation was on quality of care and service payment methods and other determinants among clients utilising maternal health services in military hospitals in Enugu Metropolis, Nigeria, by Juliet Ango. By way of background, she said that quality of healthcare (QoC) is one of the fundamental components of universal healthcare. Financial barriers serve as a major limiting factor to accessing the needed care of sufficient quality. Tracking progress towards UHC should include measures to assess quality of care and financial access. The main objective of her study was to determine the association between provider payment mechanisms and socio-demographic characteristics of clients and quality of maternal (intra-partum; labour and delivery) care. She also presented a conceptual framework [Figure 18] upon which the study was based – looking at how the health systems structure, process of provision of care by the healthcare providers, experience of beneficiaries/clients in terms of access and uptake of services and the outcomes at the individual, facility and societal levels impact on QoC. The results of her study were thereafter presented in tables and charts, the summary of which were that there was moderately good quality of care and provider payment methods (capitation) were associated with satisfaction with quality of care. Maternal characteristics were found not to be associated with QoC. However, satisfaction was noticed to decrease with age, socio-economic status, civilians' status and direct cash payments. Key recommendation made at the end of her presentation and from the study was that gaps in quality of care need to be addressed and expansion in coverage with pre-payment schemes is required.

The next presentation highlighted findings from a study carried out on 'Availability and adequacy of policies and resources for effective supervision of PHC facilities in local government areas' by Zainab Kwaru Muhammad-Idris. In her presentation, following a brief background on the concept of supervision, which is described as a 'relationship-based activity connecting tasks and processes', and where a 'range of measures is carried out on a regular basis to guide and support staff to become more competent at their work', she pointed out that supportive supervision is a process of helping staff to continually improve on their own work performance. She also emphasised that supervisory policy is vital to the development of quality supervision, the prerequisites of which include a functional healthcare system, health MIS, adequately trained and available healthcare personnel, finances, transportation, supervision plan and supervision tool(s). Availability of these resources can influence quality of supervision and healthcare services provided as well as care outcomes. The main aim of her study, which was cross-sectional, descriptive using mixed qualitative and quantitative methods, was to determine availability and adequacy of relevant policy guidelines, tools and resources needed to carry out supervision of PHC facilities in local government areas of Kaduna State, North-west Nigeria. A multi-stage sampling technique was used for the quantitative data component, while respondents for the qualitative arm were purposively selected. Data were analysed using SPSS version 23 (IBM. Inc. 2010), and data were presented as frequencies and percentages using tables and charts. Relationships and associations were also established using appropriate test statistics. Key findings from the study showed that majority of the respondents (including key informants) were unable to identify existing policies, tools, finances and other resources needed and available for PHC supervision [Figure 19]. Observation made at some PHC facilities also showed limited availability of these resources for supervision. Findings were similar to those reported by some studies conducted in Nigeria, Pakistan and Uganda where limited resources for supervision of their district health system obtains but contrary to other studies conducted in Kenya, Benin, Guinea, Tanzania, Honduras and India where supervisory policy, tools and funds were available and used to conduct and monitor supervision. Key recommendations made from the study were to The Federal Ministry of Health and NPHCDA who were advised to develop a dedicated policy on supervision of PHC facilities in the country. In addition, states like Kaduna are to adapt, widely disseminate and train HCWs on the policy on supervision. Furthermore, she said that adequate resources and provision of specific budget line item/funding should be provided in strategic and annual plans. The SPHCDA should provide simplified and user-friendly supervisory tools such as manuals, checklists and action plan templates for effective supervision and also consider introduction and use of electronic tools such as open data kit software deployed on android phones for supervision.

Safiyya Faruk Usman presented on 'Impact of the COVID-19 Pandemic on Obstetrics and Gynaecology Residency Training in Nigeria'. A total of 221 obstetrics and gynaecology residents from 42 training institutions participated in the cross-sectional descriptive study. Key findings from this study, presented in tables and charts, were that significant training impairment among obstetrics and gynaecology residents was found to be associated with the COVID-19 pandemic and significant reduction in teaching activities in about 67% of the residents was demonstrated – which was slightly higher than the 54.7% reported by Italian obstetrics and gynaecology residents see Figure 20. Respondents also reported an increased virtual learning experience and more time dedicated to individual study. The study also showed that more than three-quarters of the residents experienced some degree of anxiety related to fear of contagion. This is similar to the findings by Bitonti *et al*. Prior studies have reported

severe psychological impact of COVID-19 on healthcare providers. Protecting the physical and psychosocial well-being of obstetrics and gynaecology residents may increase their ability to provide care to women during the COVID-19 emergency response. In conclusion, the presenter pointed out that the COVID-19 pandemic has considerably reduced clinical and academic training exposure of obstetrics and gynaecology resident doctors in Nigeria. This may negatively impact on the practice of future obstetricians and gynaecologists. By way of recommendation, she said that innovative postgraduate academic and clinical training programmes should be evaluated to mitigate the inadequate training exposure and poor psychological well-being among Nigerian obstetrics and gynaecology residents.

Mary Coleman took up the space and replaced Maryam Fadila Isa to present on the topic 'Coverage of IPTp influences delivery outcomes among women with obstetric referrals at district level in Ghana'. The session time was however exhausted and highlights of her presentation were not captured.

The session ended with not enough time to entertain questions and answers, comments and contribution from the audience.

Oral Abstract Session 2

This held between 9:00 a.m. to 10:30 a.m. on day 3 of the Congress (Friday, 26th March 2021) at the Banquet Hall 1 and Virtual Room 1 for physical and virtual attendees, respectively. Chairman of the Session was Dr Stella Rwezaura, President of MWAT with Prof Clara Ejembi serving as the co-chair. Dr Eno Ekop, Dr Vivian Omo-Aghoja and Dr Safiya Yahaya-Kongoila served as rapporteurs for the session. Prof Clara, who joined the session virtually, welcomed the audience and the presentations commenced at about 9:33 am. Overall, five speakers from across the country presented their work. This comprised four virtual presentations and one physical presentation. Three presenters, however, were not available to make their presentations. The session covered topics on healthcare-seeking behaviours, determinants of adoption of birth preparedness and complications readiness (BPCR) among pregnant women and vaccine hesitancy and brain drain. Highlights from the presentation are as presented below.

Figure 16: Importance of community

1. Systematic review: Healthcare-seeking behaviour in relation to SRH services amongst pregnant women in North-Central Nigeria by Bilqis Wuraola Alatishe-Muhammed

It was a systematic review using 12 studies (with quantitative, qualitative or mixed-method study design) which met the inclusion criteria on vulnerable women groups of reproductive age. The women's educational level, poverty, lack of family support and limited awareness of reproductive health services were significantly associated with their health-seeking behaviour. In conclusion, utilisation of health services by these women was low. The challenge responsible included stock out, high cost and distance. The implication for MWAN/MWIA is to target such women in their advocacies and medical outreaches.

2. Assessment of COVID-19 vaccine hesitancy among residents of Plateau state, Nigeria. The study aimed to assess the level and predictors of vaccine hesitancy. By Elizabeth Okoh

This was a cross-sectional study using e-questionnaires among 300 participants. Vaccine hesitancy was at 46% higher than 30% reported in Africa. The main reasons included fear of side effects and doubt of efficacy. The significant predictors were self-risk perception for COVID-19 and previous history of vaccinations. The implication to MWAN and MWIA is that more awareness needs to be created on the benefits/importance of taking the vaccine.

3. Case series of violence against women and girls reported since the MWAN 2019–2021 biennium by Mininim Oseji

Tackling VAWG requires a multi-sectorial approach. The study aimed to determine the magnitude and pattern of VAWG using reports from different MWAN states. Twelve cases had been reported in the time frame with Delta state having the highest of 3, while five female doctors and five students were involved. Various forms of violence had been used. The victims mostly had tertiary level of education while the reports were mainly from attending physicians. MWAN has an eight-point strategy for eliminating VAWG which it recommends. Dr Oseji was commended for her work and asked two questions. (a) If her templates and sample letter could be made available in a collaborative manner for studies in other countries to which she replied in the affirmative. The President of MEWATA said that she would be interested in collaborating to carry out comparative

studies across the region to identify differences and similarities. The implication for MWAN/MWIA is that there is an unmet need for collaborative studies in the region and across other regions, which the associations can mount advocacies on to appropriate government authorities and also carryout further studies on.

4. Determinants of adoption of BPCR among pregnant women in Zaria Metropolis, Kaduna State, Nigeria, by Mohammed Bello

He presented a cross-sectional comparative study among 160 women in their third trimester using e-questionnaires. The significant findings using multivariate regression analysis were that women who were formally educated, with knowledge of BPCR, and had educated husbands were more likely to be adopters. They recommended improved access to quality ANC, female empowerment and male involvement. This topic received the most number of questions as follows:

i. How did you determine the number of adopters and non-adopters of BPCR in your study? He responded that five criteria adopted from a previous study were used. Those who scored ≥3 were taken as adopters
ii. How did ANC affect your findings? His response was that those who were frequent to ANC were adopters, but this was no longer significant using multivariate regression analysis among other questions.

The implications for MWAN/MWIA are to keep encouraging education of the girl child through their various social mobilisation, education and advocacy interventions.

5. **Prevalence,** perception and determinants of intent to emigrate among health workers in a tertiary hospital in **North**-west **Nigeria presented by Maryam Fadila Isa**

She presented in place of the scheduled presenter (Dr Mary Coleman), a topic different from the scheduled presentation. The study aimed to identify factors and solutions to brain drain among health workers with a hospital-based cross-sectional study design among 160 participants using e-questionnaires. The study demonstrated that 77% of the participants intended to migrate mainly to the United Kingdom as they felt that it would be more beneficial, citing lack of equipment and political reasons for wanting to migrate. They recommended increased remuneration, strengthening the health system and improving working conditions for health workers.

The implications for MWAN/MWIA are that there is a need to participate in advocacy for these recommendations proffered by the researchers as well as advocate that policies and laws guiding international migration (ethical

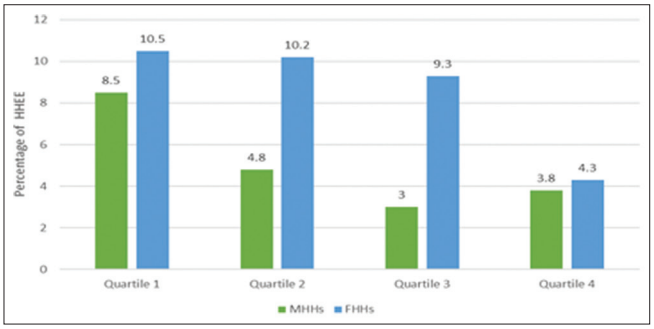

Figure 17: Household health expenditure as a percentage of the total household expenditure among the socio-economic groups in the rural and urban communities in the last 12 months

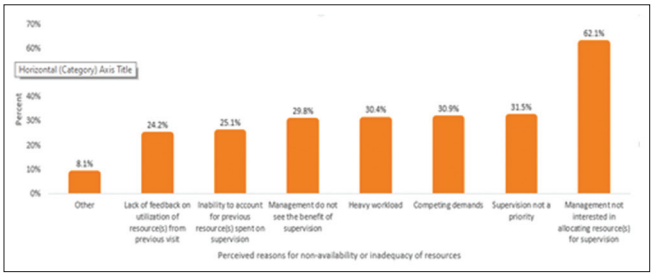

Figure 19: Reasons for non-availability or inadequacy of resources for primary healthcare supervision in LGAs, Kaduna State 2018

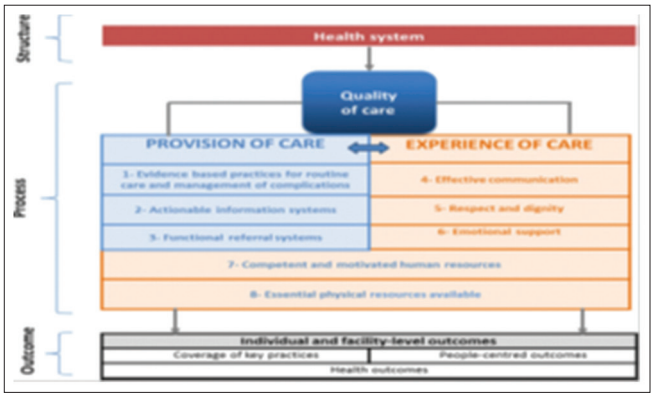

Figure 18: Conceptual framework on quality of care. Source: WHO: Standards for improving quality of maternal care in healthcare facilities, 2016

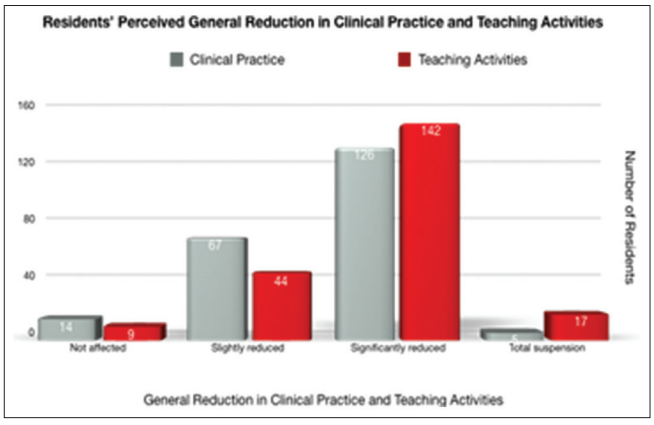

Figure 20: Residents' perceived general reduction in clinical practice and teaching activities during the COVID-19 pandemic

recruitment) of health workers are enforced. MWAN/MWIA should also continue to participate in capacity building and donation of medical equipment and other supplies.

The following presentations were not taken due to absence of the presenters:

1. Coverage of IPTp influences delivery outcomes among women with obstetric referrals at district level in Ghana by Mary Coleman (Substituted with Maryam Fadila Isa)
2. Clinical and haematological profile of women with sickle cell anaemia in pregnancy in Abakaliki, South-Eastern Nigeria, by Dr Ugwu, NI
3. Knowledge, attitude and health-seeking behaviour towards ARI on mothers of under-fives in Mushin LGA, Lagos State, by Dr Iruoma Chiamaka Osonwa.

Key next steps and action post-session

MWAN should ensure that the recommendations from these presentations are stepped down to state branches and also explore avenues for collaboration with other countries in the region for a more regional outlook to be established.

End-of-session evaluation

The session started about 20 min late due to technical challenges. One of the rapporteurs and a presenter, Dr Mary Amoakoh Coleman was not present, although a speaker, Dr Maryam Fadila Isa, who was not scheduled for the presentation, stepped in as a substitute to present her abstract. All speakers kept to time. It will however be good if each venue for presentation has a technical assistance to ensure seamless transition from one presentation to the other. The session ended while Dr Oseji was answering one of her questions.

A total of 90 attendees were recorded for the session out of which 31 were physically present while 59 persons joined virtually.

Oral Abstract Session 3

Venue: Physical - Banquet Hall 1 and Virtual Room 1
Chairperson: *National President, Kenya Medical Women Association*
Co-Chairperson: Dr A. Otolorin
Rapporteurs: Dr Ibironke Sodeinde and Dr Ufuoma Edewor

- Rural–urban differences and correlates of mental health problems among adolescents in a South-western State, Nigeria, by Tolulope Soyannwo
- Determinants of treatment failure among HIV-infected adolescents on first-line ART in Abakaliki, Ebonyi State, South-east Nigeria, by Maria-Lauretta Orji
- Perception, attitudes and notable factors associated with experience of menstruation among post-menarcheal secondary school girls by F. C. J Emegoakor
- Prevalence of Aceto-whitening of the cervix and uptake of cervical cancer screening among market women in Abakaliki, Ebonyi State, Nigeria, by Ugochukwu C. Madubueze
- Community study on the awareness and prevalence of child sexual abuse among adolescent girls living in Owo by E. J. Orji
- Digital patterns and patterns intensity indices of breast cancer in Nigerian women by Dorcas Olubunmi Taiwo-Ola.

Poster Session 1

Venue: Physical - Gallery ICC and Virtual Room 2

- Challenges to implementation of UHC in Enugu state - Perceptions of PHC workers by Chinonye Orji
- Knowledge and attitude of religious leaders in Ilorin metropolis towards encouraging pre-marital haemoglobin genotype screening among their congregants by Ameen H. A.
- Knowledge, attitude and menstrual hygiene practices among adolescent secondary school girls in Kosofe local government area, Lagos State, by Tolulope Soyannwo
- Determinants of treatment failure among HIV -infected by …
- Adolescents on first-line ART in Abakaliki, Ebonyi State, South-east Nigeria, by Maria-Lauretta Orji
- Prevalence and factors affecting exclusive breastfeeding practice among nursing mothers accessing routine immunisation in a tertiary hospital by N. C. Ekeleme
- Effect of knowledge on dietary choices and practices of pregnant women attending antenatal care at a primary health centre in Aba, Nigeria, by N. C. Ekeleme
- Demand for health cooperatives and willingness to join health insurance schemes in Akwa Ibom State, Nigeria, by Christie Divine Akwaowo.

Poster Session 2

Venue: Physical - Gallery and Virtual Room 2
Date: 26th March 2021
Time: 11 a.m.–12.30 p.m.
Rapporteurs: Dr Olugbemide Abimbola (physical), Dr Alatishe-Muhammad B. W. (virtual)

Background/Introduction

The poster session started 30 min behind schedule having waited so long for a moderator; the rapporteurs

took up the responsibility of being moderators. The session was a poster presentation of 12 presenters; however, one presenter was not included in the abridged programme. The rapporteurs welcomed presenters to the session and apologised for starting late. It was also explained that each presenter had 5 min because the session was already 30 min behind schedule while questions and answers were duly addressed after all presentations were made.

Technical presentation/topics covered during the session

- Female participation in medical politics in Nigeria
- Assessment of common dental problems and provision of care among institutionalised hearing impaired student in South-west Nigeria
- Well-being of doctors during the COVID-19 pandemic, the Nigerian doctors' study
- Handwashing techniques and oral hygiene practices among children in selected primary schools in Ibadan, Nigeria
- Attitude and practice of authorship criteria among some selected specialist doctors in Nigeria
- Breast cancer in young women: A study in a private setting
- Factors influencing north western member participation in the activities of the MWAN: A cross-sectional pilot survey
- Knowledge and attitude of religious leaders in Ilorin metropolis towards encouraging pre-marital haemoglobin genotype screening among their congregants
- Breast cancer in young women: A study in a private setting
- Is there a gender disparity in infection prevention and control procedures with regard to the COVID-19 among medical doctors?
- Self-risk perception and predictive factors of women delivery site preference in Ile Ife.

Highlights of some of the presentations made during this session were:

- Assessment of common dental problems and provision of care among institutionalised hearing impaired student in Southwest Nigeria by Odofin Adesola D.

Deafness comes with challenges in communication which affects social, emotional and general well-being of the affected individual. This disability may be a deterrent to assessing oral care as communication will be difficult between the healthcare personnel and the patient without the knowledge of sign language or availability of a sign interpreter. Poor oral hygiene was the most common dental problem observed, making scaling and polishing the most prevalent treatment in this study, followed by grossly carious teeth, and the least is asymptomatic dental caries.

Question: Was the study able to find out the most prevalent cause of poor dental hygiene?

Answer: The students did not have adequate information on good oral hygiene practice. By improving their knowledge, their oral hygiene will be improved.

Question: How did you get ethical approval for the children studied?

Answer: The study was done and presented on behalf of MWAN Oyo. The questionnaires were distributed to the students in public primary schools to be filled at home by their parents. Ethical approval was obtained from the Ministry of Health, Oyo

- Handwashing techniques and oral hygiene practices among children in selected primary schools in Ibadan, Nigeria, by Hannah Dada-Adegbola

Handwashing is an essential tool in the public health sector necessary for combating diseases and infection, thereby significantly reducing global morbidity and mortality. The promotion of handwashing for disease prevention remains a challenge, particularly in resource-limited settings. We therefore assessed the knowledge of handwashing practices among selected public primary schools in Ibadan metropolis. The study revealed that revealed that even though the school pupils have some idea of personal hygiene, there is still need to teach them the effective handwashing techniques. There is also a need for provision of adequate water supply to aid the hygienic practices of our pupils, especially in public schools.

- Breast cancer in young women: A study in a private setting by Olarinoye-Alegbejo M. I.

Breast cancer is rare among the young; this study highlighted the clinical stage of presentation and histological subtypes among women below 45. More than half of the total cases of breast cancer seen during the study were young women who presented with late stage of the diseases majority as triple negative. Following this presentation, a participant commented that the presenter should acknowledge MWAN, for what she has done so far as regards breast cancer and the WORTHI Project such as enlightening the public in health facilities and SOPD and distribution of fliers.

- Self-risk perception and predictive factors of women delivery site preference in Ile Ife by…

Maternal death is decreasing globally but increasing in Nigeria. Maternal mortality ratio was 917 deaths/100,000 live births in 2017. Health facility delivery reduces maternal death by 16%–33% and averts intra-partum stillbirth by 75%. In 2019, 81%, 60%, and 43% of births

were attended by skilled births attendants globally, in SSA and Nigeria, respectively. Several factors in the literature said to predict women's delivery site preferences; few had considered their maternal death self-risk perception. Proportion of women who eventually delivered at public primary and secondary health facilities were fewer than those who had intended to deliver there. Proportion who eventually delivered in non-health facilities were higher than those who intended to deliver there

- Well-being of doctors during the COVID-19 pandemic, the Nigerian doctors study by Ogechukwu Mary-Anne Isokariari

No health worker had a total percentage WHO well-being (WBI) less than 13% (cut-off) for major depression. 10.3% of health workers had WHO WBI scores less than 50% (cut-off) for depression. The questions asked on this topic were as follows:

Questions: (1) Was there a correlation between doctors during residency and those in private hospitals? (2) Are there tables on correlation?

Answers: No relationship between being a residency doctor and having a lower score. The females however had a lower score than males.

- Is there gender disparity in infection prevention and control procedures with regard to the COVID-19 among medical doctors? By Kemisola Agoyi

Nigerian medical doctors have sufficient knowledge of infection control and prevention measures. The importance of continual use of personal protective equipment should be emphasised to both male and female doctors.

- Female participation in medical politics in Nigeria

The presenter was applauded for recommending the need to encourage more YDF members into MWAN.

Question: Were there questions on religion and marital status as it may influence the female participation in politics?

Answer: Religion was excluded from the study; however, marital status was considered. Detailed analysis was not available at time of presentation.

Total Attendance = 31 (virtual – 21, physical – 10)

g. Closing ceremony, dinner and awards

The Congress came to a close on Friday following a highly interactive 3-day period that was packed-full of activities and interesting sessions. Key personalities among the medical women were recognised for their outstanding contributions to the association at the national and/or international levels at a dinner organised in the evening of the final day to finally mark the end of the Congress.

References

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4. Kiani MA, Ghazanfarpour M, Saeidi M.Adolescent Pregnancy: A Health Challenge.Int J Pediatr 2019; 7: 9749-52. DOI:10.22038/ijp.2019.40834.3444.