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Equitable access
Research challenges for health in developing countries

Book of Abstracts

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The collection is intended for the use of participants in Forum 11. Full texts of presentations will be made available on CD-ROM after the meeting.
Tuesday 30 October
Are health interventions being implemented where they are most needed? Lessons from the Integrated Management of Childhood Illness strategy and from the literature

L Huicho, Professor of Paediatrics, Universidad Nacional Mayor de San Marcos, Peru with JJ Amaral, J Armstrong-Schellenberg, F Manzi, E Mason, R Scherpbier and CG Victora

This paper describes geographical implementation patterns of the Integrated Management of Childhood Illness (IMCI) strategy in three countries and explores whether it was implemented in areas with the greatest child health needs. We complement this information with additional findings of the Multi-Country Evaluation of IMCI (MCE of IMCI) and with a literature review on innovative implementation strategies for reducing equity gaps in child health.

The district uptake of IMCI was assessed through a desk review of governmental documents and databases, complemented by interviews with key informants in Brazil, Peru, and the United Republic of Tanzania.

Early IMCI implementation districts were close to the capital and had suitable training sites, motivated health managers and a functioning health system. In the expansion phase, IMCI tended to be adopted by other districts with similar characteristics. In Brazil, uptake by poor and small municipalities and those further away from the state capital was significantly lower. In Peru, there was no association with distance from Lima, and there was a non-significant trend for IMCI adoption by poor departments. In Tanzania, the only significant finding was lower uptake by remote districts. Implementation was not associated with baseline mortality levels in any of the three countries.

Whereas clear and reasonable guidelines are provided for selection of ‘early use’ districts, no guidance was provided to countries regarding IMCI expansion, and high-risk areas were not prioritized. Equity analyses based on the geographical deployment of new programmes and strategies can contribute to assessing whether they are reaching those who need them most.

These findings are not unique to IMCI. Innovative implementation strategies aimed at reducing equity gaps need to be promoted and evaluated. A recent systematic review shows that programmes relying on training of lay health workers at primary and community level are encouraging. The literature also shows that comprehensive plans for primary health care interventions with active community involvement, conditional cash transfer initiatives, and pre-payment mechanisms for avoiding catastrophic out-of-pocket spending, seem promising for reducing child health inequities. However, further research is needed to conclude whether social health insurance systems offer better or worse protection than tax-based systems.
Tuesday 30 October  10.45–12.15

**Parallel session: Child health equity**

**Trends and determinants of parental care-seeking for sick children: implications for Viet Nam’s pro-poor health policies**

Bussarawan Teerawichitchainan, Postdoctoral Fellow, Population Council, Viet Nam with James F Phillips

Viet Nam’s sustained investment in primary health care ever since the introduction of socialism has lowered infant and child mortality rates and improved life expectancy, exceeding progress achieved in other poor countries with comparable levels of income per capita. The recent introduction of user fees for primary health-care services created considerable concern because it could adversely affect health-seeking behaviour and introduce an unprecedented era of health inequality.

This paper examines this controversy by assessing parental care-seeking for sick children under five years of age in the context of Viet Nam’s changing health policies. Based on the 2001–2 Viet Nam National Health Survey, the study examines the determinants of parental recalls of the incidence of illnesses among their children under five years of age and assesses the patterns of parental health-seeking once parents reported that their children were sick.

We found that ethnic minority parents were significantly less likely than non-minority parents to report that their children were sick. When they recognize that their children are sick, they are less likely to seek care. Ethnic differentials remain in remote areas and at most income levels. Regression estimates of net ethnicity and educational attainment effects are more pronounced than poverty effects. Findings suggest that social equity may be under-emphasized in Viet Nam’s health equity policy deliberations. Policies extending free health care to poor communes affect parental decisions to seek professional care or self-prescribed care among prosperous parents without affecting parental decision-making among the poor. Policies may therefore be failing to offset equity problems among impoverished families of ethnic minorities. The underlying causes of persisting inequity merit further investigation.
Improving access to care for indigent children: increasing enrolment in the PhilHealth Indigent Program

Stella Quimbo, Associate Professor, Economics, University of the Philippines School of Economics, Philippines
with Kimberly Yee, Orville Solon and John Peabody

Studies have shown that access to care is one factor that can lead to improvement in health. However, in developing countries such as the Philippines, access to health care is often restricted, leading to policy efforts focusing on expanding access to health care.

With funding from the National Institutes of Health (NIH), USA, a collaboration of researchers from the University of the Philippines School of Economics and University of San Francisco’s Institute for Global Health partnered with the Philippine National Health Insurance Program and the Department of Health to start the Quality Improvement Demonstration Study (QIDS). The purpose of QIDS is to evaluate the impact of policy reforms on the long-term health status of children under the age of five, including their cognitive health status.

Using an experimental design, QIDS randomly assigned expanded coverage in 10 districts of the Visayas region of the Philippines for indigent patients. Expanded insurance coverage in this setting offers a zero co-payment benefit package for all children under five years old. We designated another 10 sites as control sites, in which enrolment was done by usual means through local media sources and word of mouth.

To operationalize the policy change and expand coverage in the 10 intervention sites, we used a simple approach that has proven quite effective. Three members of the QIDS team made regular visits to speak directly with mayors of the local government units. Visits were made in person on a biweekly basis and lasted between 20 and 40 minutes. During each visit dedicated staff discussed enrolment procedures, provided updates, analysed enrolment figures, and presented data related to the benefits of expanded coverage.

We compared the enrolment data between the intervention sites versus the control sites. We found a difference of 29% in enrolment increases from the third quarter of 2005 to the third quarter of 2006 in intervention sites compared to control sites.

In conclusion, QIDS has shown that a simple, individualized marketing effort is an effective approach to increasing enrolment and ultimately, access to care. Moreover, this approach is relatively inexpensive and costs a mere US$ 0.50 for a household of 5 members.
Benchmarking the fairness of health sector reform in the Philippines

Dale Huntington, Technical Officer, Reproductive Health and Research, World Health Organization, Geneva
with Mike Tan, Theresa Batangan and Raul Ting

The history of health sector reform in the Philippines presents a mixed record: sustained consensus on the need for reform, yet an uneven track record on introducing change. Reducing inequities in access is clearly a priority for the Department of Health, as demonstrated by the improved performance of the national health insurance programme PhilHealth in reaching the poor with coverage of basic health services. However indicators of success in reducing inequalities are narrowly defined around targets such as the number of enrolled indigents or the newly accredited health facilities. Broader questions of how well equity is being achieved throughout the health system are infrequently articulated in policy dialogue and indicator frameworks used for reporting on the health sector reform programme.

In 2006–2007, the World Health Organization (WHO) worked with the University of Philippines and the Department of Health to adapt an analytic framework termed the ‘Benchmarks of Fairness’ to assess the overall fairness of women’s health care in one province of Mindanao, Philippines. The results from the study are being used as one of the baseline measures of equity for measuring the impact of a World Bank-supported women’s health and safe motherhood project.

Fairness is a broad ethical term that has much to do with social justice and is conceptualized by this method through three dimensions: equity, accountability and efficiency. Nine benchmarks are specified, each covering a main goal of fairness in health system performance and design related to one of the three dimensions.

Five benchmarks capture different aspects of equity, two focus on clinical and administrative efficiency, and two examine accountability and autonomy.

This paper reviews the developmental process for adapting the Benchmarks of Fairness to the evaluation of the women’s health project, presents key findings for each of the nine benchmarks and discusses the policy and programmatic implications of the results.
The equity gauge approach to enhancing equity of access to public health services: research challenges for health in developing countries from the African Gauges experience

Thabale Jack Ngulube, Executive Director, Health, Science and Social Research, Health Research and Training, Centre for Health, Science and Social Research (CHESSORE), Zambia
with Thando Ngomane, Itai Rusike, Fredrick Mugisha and Banza Baya

Since 2001, the Global Equity Gauge Alliance (GEGA) has implemented an equity gauge approach as a way to promote greater equity of access to public health system benefits in developing countries. The alliance started with ten gauges and has since expanded to include more countries and reorganized to comprise four groupings as follows: 1) the GEGA headquarters; 2) the African Gauges; 3) the Latin American Gauges; and 4) the Asian Gauges.

The African Gauges have met to distil lessons learnt from the diverse approaches used in addressing equity issues in the public health systems in Burkina Faso, Kenya, South Africa, Zambia and Zimbabwe. The equity gauge approach in these African Gauges was undertaken by people with different attributes, whether as university academics, nongovernment organizations, research institutions, or in other capacities.

Taken together, the experiences from these equity gauge initiatives shed some unique light on research challenges for equitable access to health in developing countries and more effective knowledge translation.

The key findings from the African Gauges initiative will be presented as an opportunity for sharing perspectives, joint learning and possible consensus on the way forward. Our experiences of this approach have also persuaded us to advocate for deliberate approaches to adapting research skills in order to deal with identified health challenges for greater access to health services, particularly in the severely constrained public health systems commonly found in developing countries.
Tuesday 30 October  10.45–12.15
PARALLEL SESSION: HEALTH INFORMATION FOR DECISION-MAKING

Qualitative and quantitative research to assess vital registration and compile vital statistics in Viet Nam

Chalapati Rao, Lecturer, International Health, School of Population Health, University of Queensland, Australia
with NTK Chuc and Tran That

Where civil registration systems are weak or non-functional, research is needed to find ways of strengthening them that are appropriate to different historical, cultural and socioeconomic circumstances. Inevitably, building such systems will take time and resources. In the interim, alternate methods to estimate mortality are needed for populations that do not have adequate statistics systems. This research in Viet Nam provides information on these two aspects of mortality data collection and estimation.

The following questions guided research: 1) What are the existing practices for registering deaths in the vital registration system in Viet Nam? 2) Who are the key stakeholders in this system, and what are their roles and responsibilities? 3) What are the key modifications required to adapt the current systems to include the reporting of cause of death at the time of registering deaths? 4) What is the best process to compile statistics on population and vital events at local (commune) levels on a periodic basis, and transmit the same to provincial and national authorities? 5) What are the current levels and differentials in mortality in the Vietnamese population, as derived from vital statistics? Are they plausible? 6) What are the strengths and limitations of the Vietnamese vital registration system?

Both qualitative and quantitative methods of data collection were used.

Expected outputs are as follows: 1) Qualitative report: The qualitative research will document the steps and process of vital registration in Viet Nam, the roles and responsibilities of different stakeholders, and the mechanisms to include the reporting of cause of death as part of the civil registration process. The report will highlight the strengths and limitations of the Vietnamese system, and strategies to strengthen it.
2) Vital statistics report: The research will generate the following statistics at national and regional level: a) age-specific death rates; b) life expectancy at birth; c) under-five mortality rates; d) risks of adult mortality (between ages 15 and 60); and e) completeness of registration.

These reports on vital statistics in Viet Nam will be used as empirical evidence to assess the health situation in the country, as well as inform on the operational status of an integral element of health information systems in Viet Nam.
Verifying causes of death: activities to strengthen vital registration in Thailand

Yawarat Porapakkham, Co-Principal Investigator, Setting Priorities Using Information on Cost Effectiveness (SPICE), Ministry of Public Health, Thailand with Chalapati Rao, Narumol Sawanpanyalert and Warangkana Polprasert

The utility of vital statistics compiled from civil registers in Thailand is limited due to weak determination of cause of death, with over a third of all deaths assigned vague or ill-defined causes. Even for deaths with specific diagnoses, there is no empirical evidence as to the validity of cause attribution. This study aims to verify the registered causes of death in a stratified cluster sample of roughly 10 000 deaths from the vital registration data, using verbal autopsy (VA) procedures.

The specific objectives of the study are as follows: 1) to measure the validity of registered causes of death in Thailand; 2) to understand the patterns of misclassifications in registration data by cause, especially for ill-defined causes; 3) to use these results to adjust the vital registration data, in order to derive a ‘best’ estimate of cause-specific mortality in Thailand; 4) to test the design of verbal autopsy questionnaires, and the feasibility of implementing verbal autopsy interviews in a range of community settings in Thailand.

The study is currently underway in 27 districts located in 9 provinces of Thailand, representative of the five regions of the country. For each death recruited into the study, the availability of medical records will be explored, either through the occurrence of the death in a health facility or from hospitalization during the illness preceding death. Where available, medical records will be analysed to ascertain the cause of death and these reference diagnoses will be used to measure the validity of registered causes, as well as the validity of verbal autopsy diagnoses. The misclassification patterns will be used to correct vital registration data.

The paper will present the ‘best’ estimates of cause-specific mortality in Thailand in 2005. The paper will also discuss the experience in developing standardized VA methodology, and key issues in their implementation for routine use in the country.
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PARALLEL SESSION: HEALTH INFORMATION FOR DECISION-MAKING

Which questions best identify adult AIDS deaths using verbal autopsy tools?

Ben Lopman, Research Associate, Department of Infectious Disease Epidemiology, Imperial College London, United Kingdom
with Mark Urassa, Raphael Isingo, Basia Zaba, Simon Gregson, Adrian Cook, Godwin Chawira, Jennifer Smith and Ties Boerma

Verbal autopsy (VA), in which next of kin to the deceased report information on signs and symptoms preceding death, is currently the only option to obtain cause of death information in populations lacking death registration with medical certification. The World Health Organization (WHO) is currently coordinating an effort to develop a common tool for verbal autopsy. The research meets two urgent needs: to validate VA questions designed to identify AIDS-related deaths in different populations and settings; and to demonstrate the performance of a standardized algorithm developed to monitor AIDS mortality in generalized epidemics.

A statistical algorithm based on verbal autopsy data from Zimbabwe has been developed for estimating AIDS mortality in the community. This research: 1) evaluates the accuracy of the algorithm (in place: Zimbabwe and Tanzania) in identifying AIDS deaths and allow a proper validation of the statistical and computer methods; 2) evaluates the accuracy of the algorithm (in time) by testing it against data from a subsequent period following the period when the algorithm was developed; 3) investigates the feasibility of developing a similar algorithm based on questions to be included in the WHO/Health Metrics Network standardized VA tool.

The research will enable us to: 1) determine if data-driven algorithms produce a consistent set of criteria to categorize AIDS deaths using VA; 2) report whether data-driven algorithms perform consistently in terms of sensitivity and specificity in different times and places; 3) recommend whether such algorithms should be used for monitoring AIDS mortality using VA and, if so, whether a single algorithm is reliable for all settings, or a specifically adapted algorithm is required for each application; 4) suggest what modifications are needed to the general purpose INDEPTH VA tool to allow AIDS deaths to be identified with greater accuracy in high HIV prevalence countries.
Vaccines are among the most effective tools for fighting infectious diseases, and an HIV vaccine should be considered one of the best hopes to end the spread of HIV. However, the impact that first generation preventive HIV vaccines may have is uncertain, particularly if they only provide partial protection against HIV. In order to determine how effective HIV vaccines may be, the International AIDS Vaccine Initiative (IAVI) developed an epidemiological transmission model that estimates the impact of HIV vaccines on incidence of HIV infection, mortality and related treatment costs. This model examines the effects of different delivery scenarios and illustrates how even modestly effective vaccines could have a major impact in halting the HIV epidemic. The model was previously used to estimate the impact of HIV vaccines on all low- and middle-income countries.

The model is currently being used to simulate HIV prevention and treatment scenarios in Uganda. The model captures three possible effects of HIV vaccines (reduced susceptibility to infection, reduced infectiousness of infected individuals, and increase in average survival time following infection). To model the impact of HIV vaccines, we projected the course of the HIV epidemic to 2030 in Uganda based on national surveillance data. We convened a group of high-level policy-makers, public health specialists, and HIV researchers to inform the assumptions behind model inputs. We are also conducting secondary data collection to refine model inputs and generate specific results for indicators of vaccine impact (prevalence, incidence and deaths averted).

Although HIV prevention programmes have expanded in recent years, our global analysis shows that even a dramatic expansion of prevention and treatment services will not stop the HIV epidemic. In these circumstances, even a partially effective vaccine with modest levels of coverage and uptake could make a significant contribution to lowering the number of new infections, slowing the epidemic, and saving millions of lives and hundreds of millions of dollars in treatment costs for HIV-related illnesses and anti-retroviral therapy. This work can help national policy-makers develop different vaccine delivery scenarios (targeting different risk-associated groups), analyse the cost-effectiveness of various tools to combat HIV, and explore the impact of HIV vaccines with a range of characteristics.
Parallel session: Incentives for equitable product development

Progress on a new paradigm for financing research and development

James Love, Director, Knowledge Ecology International, USA
with Tim Hubbard, Michelle Childs, Judit Rius Sanjuan, Benjamin Krohmal,
Thirukumaran Balasubramaniam and Spring Gombe

Policy-makers at the global, regional and national levels are seeking ways to create a financially sustainable basis for needs-driven, essential health research and development (R&D) that balances innovation and access.

The current system, which relies upon high prices to bolster medical R&D investments, anticipates and accepts the rationing of new medical innovations, does nothing to address the global need for public sector R&D investments, is ineffective at driving investments into important priority research projects, and when taken to extremes, is subject to a number of well-known anticompetitive practices and abuses.

High prices for medicines can no longer be seen as the primary instrument to stimulate R&D. It is abundantly clear that this does not work when basic or translational research are needed, or when patients are poor. R&D is expensive. No one wants to pay, and not everyone can pay. But someone has to pay. Our work elaborates new mechanisms for making sure that those who can pay, do.

There are several proposals for new mechanisms for stimulating R&D that do not depend upon high drug prices – such as prizes, open source approaches – which could be implemented in combination with a treaty on R&D, or soft norms for support of R&D. The unifying theme in all of these ideas is the separation of financing of innovation from paying for it, and a shift in the trade framework from high drug prices to sustainable support for R&D.

Knowledge Ecology International will discuss strategic and substantive progress in this regard.
Medical progress: must the poor be excluded?

Thomas Pogge, Professor, Political Science, Columbia University, USA

This paper will present and discuss a current team effort toward developing a feasible and politically realistic pharmaceutical patent reform plan. Its central idea is to create a second type of pharmaceutical patent that rewards inventors not with monopoly pricing powers but in proportion to the invention's impact on the global burden of disease (GBD). Any inventor firm would be free to choose either the conventional patent or the new ‘Patent-2’. If it chooses the latter, its patented knowledge is treated as a public good, making the new medicine available for generic production worldwide.

Patent-2 would create incentives for research and development of drugs for poverty-related diseases that remain neglected under the current patent regime. Moreover, while traditional patents make it far more lucrative to develop treatments rather than vaccines, Patent-2 entails no such bias and focuses potential inventors solely on developing interventions that reduce the GBD in the most cost-effective way.

Patent-2 holders would have incentives: to make their drug accessible to even very poor people, by selling it below marginal cost or by giving technical and financial support to generic producers; to ensure that patients are fully instructed, so that their drugs have maximum public health impact; to collaborate toward improving health systems of poor countries to enhance the impact of their inventions there.

The reform thus aligns the interests of Patent-2 holders with those of patients and generic drug producers – interests that the current regime brings into sharp opposition. The reform also harmonizes the moral and prudential interests of inventors who now must often choose between recouping their research investments and preventing avoidable suffering and deaths.

Rewards are to be secured by a treaty in which willing countries commit to contributing a certain monetary amount per unit of GBD reduction. This amount can be proportioned to gross national product (GNP) – with some variability according to per capita GNP so as to exempt the poorest countries. The scheme would cost money only if and insofar as it actually leads to GBD reductions. Its introduction would be supported by the pharmaceutical/biotech industry, which gains new opportunities for profitable and morally urgent research without losing any of the profit opportunities it now enjoys.
Tuesday 30 October  10.45–12.15

PARALLEL SESSION: NATIONAL HEALTH RESEARCH: Developing a Policy Framework

National health research systems: developing the policy framework

Andrew Kennedy, Senior Research Officer, Council on Health Research for Development (COHRED), Switzerland

Many countries lack a formal national health research system (NHRS), instead health research is commissioned, managed, produced and utilized in an \textit{ad hoc} manner by a range of actors, often from different sectors with varying aims. Many of these actors and institutions do not consider themselves part of the NHRS, but rather part of health, education, science and technology or development systems, or indeed part of foreign or international systems.

In such a context, an important part of the transition from an informal to a formal NHRS is the development and implementation of a national health research policy. The policy development process can facilitate dialogue between the full range of stakeholders that need to be engaged to ensure that the NHRS delivers on its aims to improve health, health systems and health equity.

In a review of existing policies, we have found that the questions countries face are remarkably similar, whether the country falls within low-, middle- or high-income groups. Where they differ is in their response to these issues and the national context within which the NHRS functions. An output from this work, and an input to the session, will be a paper on best practices in policy formulation and a template policy and development process that countries can use and adapt to their own needs. This template is currently being used in Cameroon, building on experience from South Africa.

This is part of an ongoing programme of research and consultation being conducted by the Council on Health Research for Development (COHRED) and partners in the lead up to the Ministerial Forum on Research for Health in Bamako (2008). The aims are to develop an approach that countries can use to guide policy development and ensure that a commitment to establish a national policy framework for health research be formally adopted at the 2008 meeting.

This session will bring together a panel of experts with practical experience of developing and implementing health research policies. The aim is to provide a forum where participants and panel members can highlight best practices, discuss the template policy and process, and share experiences.
Strengthening capacity for research on patient safety: overcoming the challenges in developing countries

Itziar Larizgoitia, Research Secretariat Lead, Research Programme, World Alliance for Patient Safety, World Health Organization (WHO), Geneva

Research on patient safety reveals the downfalls of health care and proposes solutions for them. Studies indicate that significant levels of error occur frequently and that a significant fraction results in injury to patients. For example, some data suggest that developing countries account for 77% of all reported cases of substandard drugs, and that at least half of all medical equipment in these countries is unusable or only partly usable. It is suspected that unsafe care disproportionately affects the poor. However, there has been little research in developing and emergent countries. Moreover, there is a dearth of applied research aiming to develop locally effective solutions. Research is needed to illuminate the causes of unsafe care and to find solutions.

Developing countries face important challenges in undertaking patient safety research, such as the discrepancy between the allocation of research funding and the problems that account for the highest disease burden, and the fact that many national research programmes lack direction and appropriate governance and management structures. These are aggravated by the general scarcity of resources and the human resource crisis of many developing countries. Research on patient safety is also about translating knowledge into practice. This is also hampered in developing countries.

The World Health Organization (WHO) World Alliance for Patient Safety intends to propose recommendations leading to strengthening the capacity for patient safety research worldwide and to mainstream it into health systems. With this purpose, it has set up an advisory expert working group that includes representatives from major health research networks such as the Council on Health Research for Development (COHRED), African Medical Research Foundation (AMREF), International Clinical Epidemiology Network (INCLEN) and others.

The WHO World Alliance for Patient Safety proposes to bring the current deliberations of the expert group to Forum 11, to learn from the views of the larger audience.
Health journalists: mistrusted and sensationalist, or important allies for researchers? Examining the barriers to effective health journalism

Robin Vincent, Senior Advisor, Panos Institute, United Kingdom

This paper examines factors that impact the ability of health journalists to report accurately, effectively and to support informed debate on health.

Many researchers are wary of media misreporting and sensationalism, and thus shy away from engagement with the media. At the same time, the lack of accessible and accurate information and research from sources in national health ministries and government in some countries, drives journalists to seek information from alternative sources, including pharmaceutical companies. In still other settings, political pressures and even direct intimidation are used to discourage investigative reporting on particular government health policies or the health impacts of particular industries.

The paper draws on data gathered for the Health Journalism Partnership (HJP)\(^1\), including a global survey questionnaire of over 450 organizations engaged in health media support, key informant interviews in 15 countries, and four in-depth case studies of the part played by media in particular national health responses, such as the role of the Jamaican media in tackling stigma and discrimination around HIV.

The paper outlines a range of barriers to effective health journalism, such as: many journalists lack basic skills and understanding of science and health issues; health reporting tends to have low status and few rewards; many countries restrict access to health statistics and information; many journalists lack time, equipment, travel expenses and access to communication options; relationships between journalists and a range of health actors need to be strengthened.

Where the media has played a constructive role in providing sensitive and informed coverage of health issues, this is often underpinned by engagement between journalists and those most affected by a health condition, and good ongoing relationships with health ministries. Drawing on the HJP research and existing studies on the agenda-setting role of the media, the paper outlines priorities for improved support to health journalists. In addition, it highlights areas for further research and policy action, not least various ways to promote greater engagement between journalists and researchers that would enhance the potential role of the media in effective health responses.

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\(^1\) The Health Journalism Partnership was a one year study by the Panos Institute, International Centre for Journalists and Internews.
Health research system analysis in Kazakhstan

Aikan Akanov, Director, Institute of Public Health, Kazakhstan
with Sh Abdrakhmanova and K Nurmanov

As part of the World Health Organization (WHO) Health Research System Analysis (HRSA) initiative, Kazakhstan has conducted a survey of the health research system, including an individual survey, a mass media survey, focus group discussions and an institutional survey (ongoing).

For the individual survey 340 people participated, among them 210 researchers, 80 policy-makers and 50 health-care providers. The survey sample reflected the diversity of actors in health research from various research and teaching institutions, government agencies, and primary health-care providers. The survey defined aspects of health research that require strengthening and improvement, as well as strategies for decision-making. Top priority areas for improvement in the health research environment, as ranked by respondents were: transparency of health research funding, wages, work facilities, range and breadth of health research networks, and training in health research. Top priorities for improvement of the health research system were identified as: securing research funds, articulating a vision for health research, and identifying health research priorities.

Focus group discussions on four themes concerning health research were conducted within groups of researchers, policy-makers and research users. Participants highlighted strengths and weaknesses of the health research system in Kazakhstan. The main constraints of effective functioning of the health research system, as identified by participants, were: translating research into policy, insufficient coordination of health research activities, limited funding for research, poor dissemination and utilization of research findings, insufficient incentives for researchers, lack of training in health research, and, limited access to the Internet and other international information sources.

The involvement in the survey of young researchers, health-care providers and other research users as stakeholders was innovative for an assessment of health research systems and policy-making in Kazakhstan. In 2006, the Kazakhstan Ministry of Health developed and approved health research reforms that contribute to changes in: priority-setting, research relevance to health needs, and production and utilization of health research. Application of HRSA results has enabled crucial changes in the health research process.
Strengthening equity-based health research systems at the local level: the Brazilian experience

Marcia Luz da Motta, Manager, Department of Science and Technology, Secretariat of Science, Technology and Strategic Inputs, Ministry of Health, Brazil with Suzanne Serruya, Priscila Almeida Andrade, Margarete Oliveira, Ludmila Neves, Cristianne Haraki and Rita de Cassia Martins

The importance of health research in Brazil is widely recognized, and the institutes of health research have been ranked among the major research institutions in the country since the nineteenth century. Although the number of studies relevant to health is relatively high compared to other areas, making up 30% of the scientific research output in Brazil, there is a concentration of health research capacity (researchers and research institutes – public and private) in the most developed regions of the country, i.e. the south and south-east. Therefore, investments in the field of science, technology and innovation in health are mostly oriented to those regions. That brings about deep inequities in health research.

In 2000, in an attempt to change this scenario, the Ministry of Health, through the Department of Science and Technology and based on the equity principle, created a strategy to decentralize the resources for health research, foster the development of research capacity in other Brazilian regions, and involve local health systems and services in knowledge production and use. This initiative has ensured a specific budget for all regions. Furthermore, investments in health research are more relevant to the local health agenda. This paper aims to present the results of the early stages of that strategy, its conceptual basis and how its implementation has successfully promoted research for health and reduced inequities in that field.
Systematic literature review on vulnerable groups in Mexico

Miguel Angel Gonzalez Block, Executive Director, Centre for Health Systems Research, National Institute for Public Health, Mexico
with Victor Becerril, Leticia Robles, John Scott, Maria Beatriz Duarte and Nelly Salgado

A systematic literature review on the problems of health systems in addressing the needs of four vulnerable groups in Mexico: indians, the poor, the elderly and migrants, was the starting point of an effort to identify and develop local capacities to produce, adapt and use health policy and systems research in the Mexico health system.

Four experts, one per vulnerable group, conducted what can be considered a pioneering research synthesis in a developing country. Two steps were followed: an initial broad-based review of the literature and a synthesis of a subset of papers. Various search engines were used to identify 1940 papers. Independent selection by two researchers assured objective paper selection. Further research permitted identification, classification and review of the literature best suited to the Latin America and Mexico contexts.

The initial review showed that most of the literature refers to North America (excluding Mexico), Europe and Central Asia (80.6%) and is published in English (90.3%). Literature on the poor accounts for 51.8% of all the references, the elderly 18.8%, indigenous populations 17.8%, and migrants 11.6%.

Literature on poverty and health is abundant, so a selective rather than exhaustive review was undertaken. A broad gap has been recognized between the ambitions of international projects to promote health equity and the practicality of the literature produced to this aim.

Successful long-term health interventions for the elderly imply a strong engagement on the part of governments to respond to the needs of this group. Interventions must be led by multidisciplinary teams on a communitarian basis.

Theoretical papers, as well as those dealing with successful interventions targeting indigenous populations, point to the importance of this group’s autonomy in planning and evaluating all actions related to their health care.

Literature on migrants in Mexico is scarce, particularly for the southern border. The lack of literature points to the fact that, while systematic reviews may inform on certain topics, health policies and programmes must also consider the points of view of migrant groups in addressing their needs.
HIV research and the BIAS FREE Framework (Building an Integrative Analytical System For Recognizing and Eliminating inEquities)

Garance Upham, General Secretary, Safe Observer International, Switzerland
with Aimée Mwadi Kadi

A review of research on HIV in Africa, as in other low-income populations, shows a decontextualised approach to the HIV epidemic, which focuses essentially on individual behaviour. This approach may foster attitudes, among others, of victim-blaming, stigma and exclusion both on the local and on the global level.

To what extent can research assist in devising a better, more equitable and more efficient approach to understanding and preventing the spread of HIV in Africa?

The BIAS FREE Framework (Building an Integrative Analytical System For Recognizing and Eliminating inEquities) is a research tool that aims at examining and eliminating biases that derive from any and all social hierarchies. We have sought to use the tool to examine inequities and inequalities in HIV research.

Populations are not equitably and equally situated when faced with epidemics of infectious diseases. As the World Health Organization (WHO) Commission on the Social and Economic Determinants of Health is demonstrating: the environment, the climate, the social and economic circumstances and concomitant presence of many epidemics place the individual, the specific community or population in a situation of advantage or disadvantage vis-à-vis a specific pathogen.

The case of tuberculosis is well known. But how is this relevant to facing HIV?

If built-in inequalities exist relative to the environment, the socioeconomic conditions and other factors, and these are not taken into account, African populations might be un-equally situated and left defenceless in the face of HIV, as the enormous burden of HIV would seem to indicate.

Official publications state that, after malnutrition, unsafe sex is the cause for the largest burden of disease in Africa. Is this evidence-based?

A recent review of sexual behaviour in 56 countries – published in The Lancet – failed to show differences in behaviour that would explain the difference between a galloping epidemic in southern Africa and a largely contained epidemic in Europe, quite the contrary. It was found that people had sex at a younger age and with more partners in OECD (Organisation for Economic Co-operation and Development) countries than in sub-Saharan Africa, or in low-income countries in general. That finding in itself shows the need to re-examine assumptions about HIV transmission.

We reviewed the social and epidemiological research on HIV spread and prevention and were able to identify many inequities, hierarchical biases, failures to examine differences, decontextualization, use of double standards and insensitivity to apparent differences.

We will present our findings in a comprehensive way with an extensive bibliography from the 20 years of the epidemic.

The authors have been involved in the field of HIV in various capacities for the past two decades.
Health-care financing is once again prominent on the global health policy agenda. The difficulty that low- and middle-income countries have in providing for the health-care needs of their populations remains a major problem. At the same time, the current focus on poverty reduction, as reflected in the Millennium Development Goals (MDGs) and other international initiatives, has spurred a growing emphasis on the need for health-care financing mechanisms that protect the populations of these countries from the potentially impoverishing effects of health-care costs.

This paper reviews health-care financing in low- and middle-income countries as it relates to three main functions: 1) Revenue collection, which concerns the sources of funds, their structure and the means by which they are collected. 2) Pooling of funds, which addresses: the unpredictability of illness, particularly at the individual level; the inability of individuals to mobilize sufficient resources to cover unexpected health care costs; and, consequently, the need to spread health risks over as broad a population group and period of time as possible. 3) Purchasing, which transfers pooled resources to health-service providers so that appropriate and efficient services are available to the population.

Enormous challenges face low- and middle-income countries confronted with the need to improve or replace their existing health-care financing system. Yet, several countries with limited financial resources have managed to improve the health of their populations by introducing innovative health-care financing mechanisms and health-care provision, as well as by encouraging health-fostering interventions that take place, or stem from, outside the health system. By improving revenue collection, risk-pooling and purchasing and by learning from the experience of other low- and middle-income countries and adapting it to their own circumstances, all resource-poor countries can improve their health-care financing systems and make them more equitable, efficient and sustainable.

There is still a paucity of success stories, and therefore real scope for future research to document how the three health-care financing functions actually operate in countries, as well as identifying factors that have contributed to success.
Equity versus efficiency in reducing child mortality in the developing world

Margaret Elizabeth Kruk, Assistant Research Scientist, Health Management and Policy, University of Michigan School of Public Health, USA
with Marta Prescott, Helen de Pinho and Sandro Galea

In developing countries poor children have less access to health services than their better-off peers, despite higher mortality rates and greater health needs. Little is known about the impact of pro-poor health policies on reducing inequities as health sector spending rises. Furthermore, it is unclear whether such redistributive policies hasten or slow countries’ progress on overall targets such as the child mortality Millennium Development Goal (MDG 4).

This study used multivariate analyses to assess how health-care expenditure, provision of basic health services (such as immunization), and distribution of basic health services influence the mortality among poor versus better-off children in 47 developing countries.

In fully-adjusted models, rise in health expenditures resulted in greater reduction in child mortality in countries where basic health care was highly skewed to the rich than it did in countries where it was less pro-rich. However, countries with a more pro-rich distribution of health services had greater inequities in child mortality compared to countries with less pro-rich distributions.

Health policies that promote equitable distribution of basic health services mitigate the rise in inequity that accompanies higher health spending. However, such policies may slow the pace of overall child mortality reduction in developing countries, possibly because of lower efficiency of the dollars spent to reach the poor. There is an apparent trade-off between equity and efficiency in reaching global targets that requires frank discussion in the global community and in countries committed to achieving MDG 4.
Impact of poverty reduction policy on commune-level health care in Thai Nguyen Province, Viet Nam

Tung Quoc Mai, Doctor, Department of Ophthalmology, Thai Nguyen Medical College, Viet Nam
with Phuong Nguyen, Quang Nguyen, Duong Bich Hanh, James F Phillips and Jane Hughes

Although Viet Nam leads the developing world in providing universal coverage of essential health services, economic restructuring and privatization of health services has been associated with emerging social and economic health care inequity. In response, the Government of Viet Nam has promulgated ‘People’s Decree 135’ providing resources to poor communes for cost-free Commune Health Centre (CHC) services.

This analysis aims to examine the service utilization and equity of access achieved by this policy and its interaction with health service investments in Thai Nguyen Province.

Quarterly health management information system reports from all 180 communes of Thai Nguyen province were analysed for the period from January 1, 2004 to March 31, 2006. Generalized regression methods were used to explain caseload variance, with commune exposure to poverty policies and CHC service benchmarks, controlling for poverty level, remoteness and ethnic composition.

Fixed effect regression results show that resource poor and remote CHC have higher utilization rates than CHC located in communes that are less poor and less remote and that this effect that is amplified by Policy 135 exposure. The effects of the policy are also more pronounced if service quality standards are met at ‘benchmark’ service input levels. Investments in staff, equipment and facilities directly affect overall and under-five caseloads in all communes, irrespective of commune poverty status. In Policy 135 non-benchmark communes, caseloads increase directly with levels of commune poverty, suggesting that prosperous families abandon CHC care if quality is low. Achieving benchmarks elevates caseloads in all exposed communes, reducing inequity by accelerating demand for CHC services among all segments of society.

Findings suggest that poverty policies promote utilization, particularly in poor communes. However, if quality is low, the poor are left behind as the less poor seek services elsewhere. Combining Policy 135 with high quality investments reduces the gap between CHC caseloads in poor communes versus those that are less poor. Findings lend support to the hypothesis that Viet Nam’s CHC policies differentially benefit the relatively poor, but corresponding prioritization of investment in quality benchmark standards would further reduce inequity in health care services.
Research to decrease inequities for mothers, neonates and children

Andrés de Francisco, Deputy Executive Director, Research and Programmes, Global Forum for Health Research, Switzerland

One of the most striking expressions of health and development inequities is reflected in the different rates of mortality and morbidity of mothers and children between countries. There are currently reportedly about ten million deaths in children under five years old every year, four million neonatal deaths, and half a million pregnant women, mostly occurring in poor populations of low- and middle-income countries. Studies indicate that the Millennium Development Goals will not be achieved unless action is taken on this front.

Research has contributed to the design of programmes to reduce mortality and improve maternal and child health. Programmes benefiting from such research results, in particular those aiming at improving child survival, can be quite effective. In low- and middle-income countries in which child mortality has been reduced, neonatal and maternal mortality have often remained high. It has been pointed out that unless mothers and children are targeted with joint sets of interventions and health promotion strategies, such mortality will not be reduced. The problem is that the knowledge to create such ‘joint’ interventions on the so-called ‘continuum of health’ does not really exist.

This paper reviews research required to facilitate the essential linkages of maternal, neonatal and child health programmes. Using a spectrum of research, the presentation will highlight points where innovation can yield specific recommendations to improve programme effectiveness.

Research elements will be presented in the following groups: 1) research on health systems for programme development, including how to overcome obstacles within health systems; 2) research to develop appropriate preventive and curative tools, including medicines, vaccines and diagnostic methods; 3) research for and by communities, including information sharing and the interactions between health, health promotion and related risk factors.
Building consensus to improve care for sexually transmitted infections: engaging with the private sector in Botswana, Namibia and Zambia

Oluseyi Oyedele, Senior Researcher, South African Development Community (SADC) STI Initiative, Initiative for Sub-District Support (ISDS), Health Systems Trust, South Africa
with AG Elgoni, SN Iipinge, C Mulenga, M Rahman, F Hussein and N Chabikuli

The public health significance of providing early and appropriate treatment for sexually-transmitted infections (STI) has been underscored by the evidence that many STIs are co-factors in the sexual transmission of HIV. Controlling STIs is therefore a priority strategy for the ongoing control of the HIV epidemic. Providing first-time clients with high quality STI treatment needs to be an issue involving both the public and private health-care sector.

A programme of appropriate participatory action research was carried out in Botswana, Zambia and Namibia: 1) to assess quality of STI care in the private health-care sector; 2) to develop a public-private partnership framework for STI care; 3) to engage relevant stakeholders for improved STI services.

A rapid situation analysis approach was taken including: 1) a review of literature; 2) structured in-depth interviews with stakeholders; 3) assessment of a purposeful sample of private general practitioners (GPs); 4) client exit interviews; and 5) focus group discussions.

Findings showed that the private sector is considered important in the provision of STI services in the three countries and by all stakeholders. STI patients prefer to utilize the private sector for STI care despite the provision of free STI services in the public sector. Confidentiality in the private clinic setting, the perception that being treated by a doctor was better, extended working hours and fast services were some of the reasons given. Assessment of the quality of STI care by private GPs showed a generally poor compliance with national guidelines. There was little evidence of public-private partnership activities for STIs. STI data are not collected from the private sector making the information unavailable for use in planning and coordinating national responses.

Consensus-building workshops were held in each country during which findings from the studies were presented and issues of partnerships between the sectors were discussed. Consensus was reached on the need for the public and private sectors to work more closely together for improved STI services. STI working groups were established with representatives from both sectors. A public-private partnership framework document has been developed based on lessons learned and plans are underway to implement it in the countries.
Equitable access to sexual and reproductive health for marginalized adolescents in Argentina

Gabriela Perrotta, Counsellor, National Ministry of Health, National Program of Sexual Health and Responsible Procreation, Argentina

In Argentina there are equity gaps in access to health care among different regions of the country. This inequality relates to different factors: economic and social, but also cultural and of gender-related. The aim of this paper is to show the difficulties faced by adolescents of low resource sectors in accessing sexual and reproductive health care (SRHC). The paper combines the results of a study performed in a low resource neighbourhood in Buenos Aires with the findings obtained from other studies in different Argentine provinces.

Results show that gender autonomy, which is usually a challenge for young girls of poor neighbourhoods, is an important issue at the moment of considering health care access options. This approach gives a broader perspective to the traditional concept of access to health, especially SRHC, including cultural characteristics of the population and gender inequities.

Studies performed in different implementation stages of the Reproductive Health Program of Buenos Aires City, verify a change in the orientation of the programme over the past five years. This change has tended to prioritize an approach associated with gender and sexual and reproductive rights, facilitating the construction of a new reproductive health paradigm. Its implementation has changed the attitude of health professionals, improving the access of adolescents to sexual and reproductive health care. In conclusion, shaping public policies based on gender and reproductive health rights, facilitated by training health professionals and generating space for discussion among them, constitutes a valid strategy to improve accessibility and reducing gender inequity.
China’s health system reform has been underway for more than two decades. Recently, the Government of China has focused on the development of new rural cooperative medical scheme (RCMS) and urban community health services, as well as the improvement and strengthening of the urban social health scheme. This presentation describes the overall structure of health insurance schemes in China, with special reference to eligibility and beneficiaries, organization and management, fund allocation and payment arrangements, service benefit packages of mainstream health insurance schemes, as well as medical financial schemes for the poor.

The presentation synthesizes available evidence, mainly using secondary data from a literature review. It analyses and discusses key issues and problems associated with these schemes; from equity, efficiency and quality perspectives.

Key findings include: 1) The mainstream urban social health insurance schemes have limited population coverage, leaving many people in the informal sector, children and other vulnerable groups without any financial protection. 2) The new RCMS cannot ensure the access of their beneficiaries to essential health care, since most of them focus only on catastrophic disease-related services, according to the design of service benefit packages. This has implications for cost-effectiveness. 3) Low-income beneficiaries of urban employee health insurance and the new RCMS have been in a disadvantaged position in seeking services, simply because they are less able to afford to pay the deductible and co-insurance payments required. 4) The efficiency of resource allocation and use is not optional in all the schemes, due largely to a lack of effective purchasing functions, and distorted incentives created by the provider-payment method (i.e. fee-for-services).

The proportion of the Chinese population covered by both RCMS and urban social health insurance schemes has increased significantly in recent years and it will continue to rise due largely to new government policy initiatives. However, the financial protection offered to beneficiaries by these schemes is limited because of the substantial co-payment required. Rapid escalation of medical care costs, owing to a lack of effective cost control measures and weak service purchasing by the schemes, is threatening the sustainable development of the schemes and jeopardising equity in health care in China.
A national essential health services package

Jing Wu, Researcher, Center for Health Statistics and Information, Ministry of Health, People's Republic of China
with Keqin Rao and Wenxiu Yang

This research aims to define and to cost a package of essential health services that is appropriate for the current social and economic situation, and to establish a sustainable mechanism that enables the package to be enlarged along with economic development. By doing this, we hope to support the development of an efficient, equitable and high quality health system in China.

We will define a comprehensive package of essential health services, from which services can be selected as prioritized. A national package that will be funded by the central government shall include most public health interventions and some treatments for severe infectious diseases. Local government should extend the national package in consideration of local situations, with financial support from the central government. A case study in Tianjin shall serve as an example for the local essential health service package.

It is estimated that 161.5 billion yuan (5.1% of the government revenue) will be needed to cover all the essential health services in the package. Of which, 21.7 billion yuan (less than 20 yuan per capita) might be sufficient to cover all the special institutions that provide public health services for the whole population. Extending the contents of the package further will take the capacity and willingness of the government, and the cost of interventions, into account.

The contents of the package, as defined by this study, are intended to cover those interventions that are most important to the health of poor people. So, equitable access to health services should be improved by the implementation of the package. Significant additional work is required in order to ensure the implementation of a feasible package and to sustain its development. In time, a set of policies and measures will be recommended, such as a referral system, supervision and evaluation of the service quality, sustainable financing and the adjustment of the contents and level of the package.
Effect evaluation of the Urban Health and Poverty Project medical assistance Scheme

Qingyue Meng, Director, Center for Health Management and Policy, Shandong University, People's Republic of China
with Lan Yao

The objectives of this study were to evaluate the effect and efficiency of the China/United Kingdom Urban Health and Poverty Project (UHPP) Medical Assistance (MA) Scheme, identify effective technical measures and recommend them to the government.

The evaluation looked at: 1) Change in the utilization of medical services by poor people. 2) Effectiveness of different ways of improving poor people's use of medical services, including: dissemination of MA policies by media, street committees or dissemination days in the community; improvement of poor people's use of Community Health Services (CHS); development of CHS services attitude; improvement of the quality of services. 3) Implementation of CHS as a gatekeeper of MA and the two-tier service delivery system. 4) Indicators of evaluation including: satisfaction of poor people with financial aid; quality and attitudes of CHS services; and satisfaction of government managers about the MA project.

Evaluation was based on: 1) interviews with 2148 poor people, 2209 residents and 80 managers; 2) focus group discussions; 3) a survey of 40 institutes, 4) the MA scheme in four cities.

The evaluation revealed: 1) The MA scheme improved the use of medical services by poor people. The use of outpatient services by the poor increased from 14.25% in 2004 to 39.22% in 2006; inpatient utilization rose from 3.23% in 2004 to 4.95% in 2006. 2) There was a dramatic increase in the level of awareness of MA by poor people. The most effective method of awareness-raising was dissemination by street committees, but this needs to be improved further. 3) CHS's role as the gatekeeper of MA has a high reported satisfaction rate among poor people. 4) MA reduced the disease burden of poor people, but the financial aid is inadequate as compared to people's income. 5) The two-tier service delivery system is not in good condition.

The participants in this research included managers from central and regional departments of civil affairs. It provides a good model of government use of research results. The project cities have adopted many recommendations from this research.
WEDNESDAY 31 OCTOBER
Plenary: Innovation in research for equitable access

The Noordwijk Medicines Agenda

Susanne Huttner, Director, Directorate for Science, Technology and Industry, Directors Office, Organisation for Economic Co-operation and Development (OECD), France

The Organisation for Economic Co-operation and Development (OECD) held a High Level Forum in June 2007, at Noordwijk-aan-Zee in the Netherlands, on ‘Medicines for Neglected and Emerging Infectious Diseases: Policy Coherence to Enhance their Availability’. Participants at the forum, which included Ministers from OECD and non-OECD countries, agreed a Noordwijk Medicines Agenda (NMA), a consensus document identifying promising actions governments could take to improve the availability of vaccines and diagnostics for neglected and emerging infectious diseases.

Participants agreed that there is a need to improve the efficiency of the innovation system, which at present is failing to deliver a robust pipeline of new medicines, vaccines and diagnostics for the neglected diseases of the developing world. The NMA includes several actions that focus on making the health innovation system for infectious diseases more open, encouraging more collaborative research, broadening the involvement of researchers, academic institutions, laboratories and companies globally in order to increase the efficiency and lower the costs of developing new, safe and effective medicines, vaccines and diagnostics. The NMA called on governments to show political leadership and to join with a wide variety of stakeholders in multiple sectors to intensify collaborative efforts and promote coherent policies.

The OECD will report on the High Level Forum discussion themes and summarise the main points of the Noordwijk Medicines Agenda. It will identify where economic analyses and accountability would help improve policy-making in this area. And it will suggest how to capitalise on growing political momentum in support of policy actions to stimulate research and development, and encourage a translational research environment. Finally it will identify what work OECD countries are interested in taking forward to enhance the availability of new medicines, vaccines and diagnostics for diseases that primarily affect developing countries.
An innovative approach to improving public communication skills among researchers

Mary Woolley, President and Chief Executive Officer, Research!America, USA

The Paul G Rogers Society for Global Health Research is an innovative approach to enhancing public understanding of support for, participation in planning for, prioritizing, and assuring equitable access to research for global health, by improving public communication skills among global health researchers. Its design and execution draws on a rich recent history. In the 1980s, the success of communication-aware advocates in obtaining strong policy and funding support for HIV research, forever altered the landscape of public involvement in priority agenda-setting and equitable access to medical research. Patient and family advocates for other diseases soon followed suit, with breast cancer advocates notably demonstrating the value of non-scientist participation in peer review programmes.

The Institute of Medicine of the National Academies of Science called for more as it issued an influential report, which led to the establishment of a Council of Public Representatives at the National Institutes of Health (NIH). The Council has made a number of important contributions, including emphasizing the importance of improved communication skills by researchers and research institutions.

The most recent innovative contribution to the important movement toward enhanced public outreach and communication by health researchers is the Paul G Rogers Society for Global Health Research, undertaken in the USA by Research!America with primary funding support from the Bill and Melinda Gates Foundation. The inaugural cadre of Rogers Society ‘Ambassadors’ was identified in late 2006 by a prestigious selection committee including several Nobel Laureates, and is presently engaged in a variety of activities designed to enhance public awareness and support for global health research. The author will discuss the training component of the Rogers Society and related Research!America researcher communication training initiatives, and will provide an evaluation of experience to date. The author will include discussion of recent public opinion research demonstrating the support of the American public for eliminating disparities in health outcomes; showing support for ensuring broad public participation in policy-making for, and the conduct of, research; and for assuring strong capacity for the conduct of research, for the benefit of the global population.
Recent studies have highlighted the challenges associated with the communication of health research, and have identified a number of key prerequisites to effective and equitable access to health information. It is essential to target different audiences with tailored communication and dissemination strategies and to close the gap between all research stakeholders, including prospective beneficiaries. Strong networks and capacity development are crucial to strengthening and sustaining meaningful linkages between research and practice. Locally-originated evidence, disseminated via locally-produced communication tools, add to the credibility and relevance of research studies, which are better placed to support local people and to inform the decisions that affect their health.

*Aizi Ni Wo Tan*, a new publication jointly produced by Healthlink Worldwide and China HIV/AIDS Information Network (CHAIN), is targeted at front-line health workers and community groups involved in HIV work. Designed as an accessible and engaging tool for a comprehensive communication strategy, which includes but goes beyond mere dissemination activities, it aims to: 1) initiate research and generate topically and locally-relevant evidence; 2) promote dialogue and experience sharing through the establishment of networks; 3) provide a forum for practical suggestions and information to assist readers in planning and carrying out community-based prevention and care.

The project started in June 2006 and has concentrated on communicating research on access to treatment and care with articles such as ‘Improving access to voluntary counselling and testing for men who have sex with men’, ‘Barriers to accessing treatment’, and ‘Why start a support group?’ The dialogues during project development bring together stakeholders from government and nongovernment sectors, academics, social scientists and community groups. Published in Chinese, it features a mix of both local and relevant international content, and is guided by an experienced editorial advisory group consisting of both Chinese and overseas members.

A current focus is on stigma and discrimination, reflecting on and sharing the findings of a survey administered through the newsletter. This relates directly to the Joint United Nations Programme on HIV/AIDS (UNAIDS) protocol for the identification of discrimination against people living with HIV and results will be able to be fed back to both readers and policy-makers.
Parallel session: Access to information: research capacity strengthening

The Cochrane Developing Countries Network: an initiative to improve equitable access to knowledge and information and to its management

Zulma Ortiz, Chief, Training and Research, Epidemiological Research Institute, National Academy of Medicine, Argentina
with Mona Nasser, Li Wang, Youping Li, Jordi Pardo and Xavier Bonfill

There is a wide consensus in the Cochrane Collaboration that more needs to be done to extend the activities and outputs of the collaboration to developing countries. Although some Cochrane centres and branches are based in these countries, and some review groups, methods and fields have very active members who live there, globally, less than 10% of the Cochrane reviews are authored by people based in a developing country. Furthermore, many topics relevant to the developing world and addressing problems that affect large populations remain neglected. Moreover, there is a low awareness of the Cochrane Collaboration and the Cochrane activities in many developing countries.

During the past five years, a number of debates and proposals to address the above issues have been made. To channel the existing ideas and make appropriate proposals for translating the prevailing general willingness into practice, the Steering Group promoted a Developing Country Initiative (DCI) in 2001. Five years later, the group was officially registered as the Cochrane Developing Countries Network (CDCN). CDCN has a co-ordinating group, consisting of people living in a low- or middle-income countries and representing different developing regions in the world.

The objectives are: 1) to describe the needs of people living in developing countries that may be addressed by the Cochrane Collaboration and promote the participation of people living in developing counties; 2) to analyse the mechanisms for networking in developing countries and actively promoting synergies from current entities devoted to health research; 3) to establish strategic alliances with other organizations whose activities are devoted to developing countries; and 4) to promote knowledge translation and dissemination in developing countries.

CDCN attempts to promote greater participation and inclusiveness within the Cochrane Collaboration for people living in developing countries, to become the information and resource point for health research activities related to evidence-based health care for developing countries, and to reduce the inequity of access to systematic reviews.

CDCN promotes the preparation of Cochrane reviews relevant to health-care problems in low- and middle-income countries and encourage authors to address priorities in the developing world.
The formulation of national health research agendas and research networks in developing and developed countries: state-of-the-art and possibilities

Eduardo Martins, Coordinator of Health Information, Center for Technological Development in Health, Science and Technology Information, Oswaldo Cruz Foundation, Brazil

The health research agenda of poorer developing countries in general follows the established priorities of richer developed countries for diseases that affect the wealthier populations of the poorer countries. International cooperation between rich and poor countries only functions when it is in the interest of the rich ones. This fact is confirmed and evidenced in the proceedings of the 7th Framework Programme – FP7 (2007–2013) – of the European Community that has a total budget of € 6 billion for funding health over the duration of FP7. The document says: “The objective of health research under FP7 is to improve the health of European citizens and boost the competitiveness of health-related industries and businesses, while addressing global health issues such as anti-microbial resistance, HIV, malaria, tuberculosis and emerging pandemics.”

This paper analyses the cooperation between researchers in the study of diseases that afflict poor populations in poor countries and demonstrates that the health research agendas of rich countries have almost nothing to do with “priorities formulated by international bodies such as the United Nations Millennium Development Goals.” It also verifies that diseases that do not affect rich countries are not the object of health research funding policies or of any interest to the majority of research institutions and groups in these countries.

Taking into consideration the results of this study, which clearly shows the low level of participation of the developed nations in research of these diseases, the creation of a new agenda is proposed for multilateral programmes, such as the EC’s FP7, which would dedicate some financial resources for collaborative research with developing countries into diseases and health issues that afflict poor people in poor countries.
Wednesday 31 October    10.45–12.15

PARALLEL SESSION: AID AS A DETERMINANT OF HEALTH

Aid effectiveness: a case study of health services for the poor and remote populations of Viet Nam

Lokky Wai, Programme Management Officer, World Health Organization, Hanoi
with Hans Troedsson and Nguyen Thuc Anh

The objective of this paper is to examine whether the current modes of support provided by donors/development partners are effective in resolving the health care problems of the people who reside in poor and remote areas of Viet Nam.

Viet Nam is inhabited by over 54 ethnic groups. The Kinh is the largest ethnic group, constituting about 84% of the total population. Most of the remaining ethnic minorities are poor and live in the vast but difficult-to-access northern uplands and the central mountainous areas, far from cities and economic centres. These areas are sparsely populated with few public amenities and services, including health services, available to the local inhabitants.

As a decentralized country, Viet Nam’s health services are managed by the local People’s Committees, while supervision and technical support to health services are provided by health departments at the higher level.

From a health care perspective, poor and remote areas usually suffer from certain deficiencies, namely: lack of adequate staff, poor infrastructure and facilities, poor quality of services, inadequate support from larger institutions, and insufficient resources. The local populations tend to be illiterate or have very little education, particularly health education. Public resources tend to be self-generated although the central government provides substantial amounts of direct budget support to local governments.

There are currently three dominant aid modalities used by the development partners and international financiers to support the Government of Viet Nam to improve health services in the poor, remote and mountainous areas: 1) the Poverty Reduction Strategy Paper (PRSP) approach advocated by the World Bank and a few large development partners in the form of budget support to the provinces; 2) the national programme approach carried out typically by the United Nations agencies; and 3) the project approach dealing specifically with certain programmes in selected areas following the government’s national guidelines.

Initial data analyses indicate that none of these three approaches are adequate in substantially improving the health care situation in these areas. Although some improvement has been observed in a few areas, the Kinh majority tend to be the largest beneficiaries, thus creating a widening health gap between the majority and the minority ethnic populations.

As well as presenting the findings from the data analyses, this paper raises a number of issues concerning the use of development aid in achieving equitable health goals in Viet Nam.
In 2002, Ukraine submitted a country proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) applying for funding for a programme aimed at countering the HIV epidemic and providing medical care for people living with HIV. The GFATM provided Ukraine with US$ 92 million for the term of five years.

Despite significant international interventions, the number of newly registered HIV cases is still increasing in Ukraine, as is AIDS-related mortality. There has been a rapid increase in HIV prevalence nationally, on average rising 16% annually (since 1995). The most at-risk population groups include injecting drug users, sex workers and prisoners.

This paper presents results of two complementary studies: research on the political factors influencing HIV policy in Ukraine; and early results of a study on the impacts of global health initiatives on the health system of Ukraine. Research conclusions include the following: 1) Both studies suggest that despite substantial additional funding received from the GFATM, weaknesses within the national health system have limited the scale-up of prevention, care and support services. 2) The response to HIV is, in practice, uncoordinated at national and regional levels, and fails to take into account epidemiological and behavioural evidence of patterns of HIV transmission. 3) There is also strong opposition to programmes supporting groups vulnerable to HIV infection and people living with HIV due to widespread discrimination among much of the general population, including health and social care service providers. This has undermined the development of HIV control programmes. 4) There have been some positive changes in public attitudes towards HIV-positive people since information on HIV has increasingly been made available.

This paper draws out recommendations for policy-makers and practitioners by highlighting factors inhibiting and supporting the HIV policy in Ukraine. It argues that it is necessary to pay close attention to structural, political, institutional and sociocultural factors that undermine the development of equitable access to HIV services.

The lessons from implementation of the GFATM programme will be discussed, including: 1) the change of balance between prevention and care interventions; 2) strengthening capacities of the national health system.
Gender and health equity interventions in poor regions of China and India: a comparison

Fang Jing, Board Member, Yunnan Reproductive Health Research Association, People's Republic of China
with Gita Sen

The Gender and Health Equity Network (GHEN), an international partnership of individuals and institutions, has been working over the last six years to demonstrate through applied research the importance of taking gender equity into account in health policy and programming. Two of its major case studies are in very poor districts in China and India.

The objectives of these action-research studies are to use research to: 1) improve policy implementation with respect to gender and health equity in contexts of high or persisting poverty and inequality; and 2) enable communities, and particularly poor women and adolescents, to exercise their rights to good health. The projects are being implemented in contexts where policy commitments to health equity exist, but also where there are difficulties in translating those macro-level commitments into programmes of work at lower levels of government, or practical action on the ground. In particular, using research to support awareness building or capacity strengthening provides both opportunities and challenges within the contexts of poverty and inequality in which the project is working in the two countries. These have significant implications for policy learning and programming scale-up.

This presentation will explore the lessons being learnt through comparison of the tangible, on-the-ground experiences of working on these issues in China and India. Similarities in levels of poverty and inequality are counterposed with differences in the political, policy and knowledge generation/research contexts of health interventions. Comparative analysis of research and implementation lessons in two such similar, yet very different, locales provides a rich basis for mining the lessons learnt from working in such contexts.
The purpose of this study was to examine physicians’ screening practices for female partner abuse during prenatal visits and epidemiological observation of pregnant women to reveal the impact of violence on health.

A self-administered questionnaire was developed to collect data on physicians’ screening practices. The survey contacted obstetricians/gynaecologists practicing in Georgia. The response rate was 79.2% (420/530). Routine screening was carried out among 297 pregnant women.

More than half of respondents estimated that 23% or more of their patients had experienced abuse. Only 2% of respondents had recent training on partner abuse. Only 17% of respondents routinely screened for partner abuse at the first prenatal visit and 5% at follow-up visits. Screening revealed violence in 134 cases (45%). Of these, sexual violence was experienced in 25% of cases, and domestic violence in 75%. Among women who experienced abuse there was a higher relative risk of: impending abortion (27%), hypertensive syndrome (44%), urinary tract infection (60%), and intrauterine growth retardation (16%). Newborns were of lower weight (38%), and size (35%), and four cases of stillbirths and one case of mother-to-child transmission of HIV were recorded.

Violence is associated with hypertension during pregnancy and intrauterine growth retardation. Most physicians do not routinely screen for abuse during prenatal visits.

The Women’s Center has used research results to influence public health policies, laws and interventions, develop advocacy materials and publish the books Medical Aspects of Domestic Violence and Reproductive Rights and Health. The centre has also created and implemented a certificate programme for postgraduate training doctors: ‘Impact of Violence on Reproductive Health’, which supports the creation of policies for improved identification, documentation, surveillance, professional education and forensic examination. The centre has implemented violence indicators, raised awareness at community level (training 560 women and creating a network of 56 volunteers at regional level in 12 regions), and trained 340 law enforcement officers and doctors. Nine hundred and twenty-one pregnant women have had routine HIV testing and 123 face-to-face consultations. We have also lobbied the government for health-care subsidies for women who are victims of violence and other forms of abuse.
There is a growing body of literature that establishes the link between social position (class, race, caste, gender, ethnicity and religion), physical location (rural, urban and mountainous regions etc.), and physical attributes/conditions (disability, age and HIV status), with access to health care services. Over and above the current focus on articulating how these mediations occur and how they can be circumvented through sound public policy initiatives, it is also important to consider emergent issues that challenge the understanding of ‘equity’ and ‘access’.

Women face intangible barriers in accessing health care services that go beyond ‘demand’ – social, economic and cultural constraints, or ‘supply’ – availability of services. These barriers can be classified as: 1) gaps in access – due to inadequate accommodation of women's needs and therefore inadequate and inappropriate services and/or; 2) misguided access – where the commercial medical sector drives an artificial choice and access to medical technologies leading to an ‘over-medicalization’ of women's bodies. In both cases, gender and equity issues are compromised, alienating women from the health care system and from their own bodies.

In both scenarios mentioned above, women and households emerge poorer because they spend precious resources looking for medical solutions. Based on research evidence, innovative interventions and advocacy initiatives, the panel presenters will throw light on mapping new ways of engendering health research and health-care services; and regulating and engendering safety standards in medical technologies.
How can the concept of ‘access’ be researched in a policy-relevant way?

Stephen Birch, Professor, Department of Clinical Epidemiology and Biostatistics, Centre for Health Economics and Policy Analysis, McMaster University, Canada with Diane McIntyre and Michael Thiede

The objective of this paper is to outline a useful conceptualization of ‘access’, how it may be used for empirical investigation of access, and how this may inform policy initiatives to promote equitable access. In order to develop appropriate policies, there needs to be greater clarity on what access means and barriers to access need to be identified through detailed research.

While there is consensus in the literature that access is a multi-dimensional concept, there is little agreement on what dimensions constitute access. In addition, there is frequently an exclusive focus on ‘supply-side’ issues when considering access.

We argue, first, that access has both health system (supply-side) and household or individual (demand-side) aspects. Access is fundamentally about the interaction, or ‘degree of fit’, between the health system and the individual or household. Second, given the multitude of factors influencing access, it is necessary to identify key dimensions of access to act as ‘entry points’ for empirical investigation in a specific country context. The dimensions suggested by Penchansky in the late-1970s are a useful starting point, but we suggest modifying them into three key dimensions: 1) availability – i.e. whether or not the appropriate health services are available in the right place and at the time that they are needed; 2) affordability – i.e. the ‘degree of fit’ between health care costs and individuals’ ability to pay; and 3) acceptability – i.e. the relationships between providers and patients, which are influenced by their attitudes towards and expectations of one another.

While there are considerable interrelationships between these dimensions, they are sufficiently distinct to allow their use as separate entry points into a comprehensive empirical consideration of access. Such an evaluation would require both quantitative measures and qualitative assessment.

We believe that in order to avoid the prevalent tendency to (inappropriately) adopt utilization as a proxy for access, a structured set of entry-points is needed to facilitate the direct evaluation of access and in order to inform the development of appropriate policy.
Wednesday 31 October    10.45–12.15

Parallel session: Framework for measuring access

Community-managed pharmacies: an alternative to improving access to essential drugs for the rural poor in southeastern Mexico?

Rosario García, Research Assistant, Health, Society, Culture and Health, El Colegio de la Frontera Sur, Mexico
with Annette Hartmann and Hector Ochoa

The rural population in Chiapas, in south-eastern Mexico, has limited access to health care services because of geographical, cultural, economic and organizational barriers. Many essential drugs are often unavailable at health facilities. Most prescribed drugs have to be bought in private pharmacies in the larger towns. Special trips have to be made, resulting in heavy expenses for transportation, food and accommodation. Among the possible options to improve the availability, distribution and use of essential drugs, a system of community-managed pharmacies might constitute an effective way of improving equity of access to essential drugs among marginalized populations in rural south Mexico.

In this paper we present the findings of a study that was aimed at generating information for decision-makers regarding the acceptability, feasibility and economic impact of developing a scheme based on community-managed pharmacies. The hypothesis was that the improvement in the accessibility and availability of essential drugs could help poor rural households financially and reduce health inequities.

The study focused on researching health care-seeking practices, the main sources of essential drugs and the costs for households of four marginalized rural communities of Chiapas in south-eastern Mexico. The information was gathered through a household survey (480 interviews), a follow-up study of family health during a one-month period, and interviews with 190 pharmacy users, pharmacy owners and drug vendors of a sample of private pharmacies, and health staff at local health facilities situated in larger towns. Two participatory workshops were held with community members and leaders to review results, and two workshops were held with academic and health staff of the main public health institutions. Focus group discussions for men and women in the communities were held separately to study attitudes and opinions regarding a potential community-managed system of pharmacies.

The results showed that the communities were very interested in the idea of developing community pharmacies with 24-hour access. Findings from the focus groups and participatory workshops supported this view and it was apparent that the communities were capable of managing such a scheme themselves as long as they had support from the government. Based on the findings, it is recommended that the main health institutions should: strengthen the drug supply system, develop mass training for community health workers on the standard treatments for the most frequently reported illnesses, and undertake a pilot implementation of a scheme of pharmacies managed by trained community workers in marginalized and dispersed rural localities.
The United Nations Children's Fund's (UNICEF) ‘Zone de Convergence’ programme in Northern Cameroon is an innovative example of an integrated health approach designed to maximize access to essential health, nutrition, sanitation and other social services for families living in extreme poverty. Agencies of the government, civil society and the private sector provide these services. Through close programme collaboration, they also become ‘partners with parents’. Together, they provide a rich array of services that help ensure vulnerable children become healthy, well nourished, well developed, safe and protected.

When family members in participating communities enter any one of five ‘ports of entry’, they are referred to the other four key services. The five ports of entry to services are: 1) health and nutrition; 2) HIV prevention; 3) water and sanitation; 4) education; and 5) protective services.

The programme has developed a rich evaluation system that is managed by the communities in collaboration with the array of local services. This evaluation system includes: child and family assessments; follow-up tracking of the child or family through each service and across all services; parent education to help achieve parent involvement and continuous service utilization; and, community self-assessment, including overall basic demographic and health statistics as well as information on the frequency of service provision and utilization. Community members are taught how to gather, manage, analyse and interpret data for the benefit of their entire community as well as for the ‘Zone de Convergence’ programme as a whole.
Parallel session: Mobility and health

Mobility and health: using networked research to build capacity in developing countries

Marinke van Riet, Executive Secretary, Secretariat, International Forum for Rural Transport and Development (IFRTD), United Kingdom

At Forum 10 in Cairo, the International Forum for Rural Transport and Development (IFRTD) participated in a panel on ‘Transport and Health’. In this panel we introduced IFRTD’s Networked Research Programme on Mobility and Health. This programme is critical as the development sector is yet to fully acknowledge and understand the role of transport in improving poor people’s health. A literature review has shown that there has been little research done in this area, particularly in low- and middle-income country settings. In addition, the issue of mobility and access to health services has been on the periphery of the development agenda and is only mentioned occasionally in relation to health. In the context of the need to increase development activity to meet the Millennium Development Goals, a better understanding of this relationship is a priority.

The programme has three objectives: 1) to increase understanding of mobility constraint impacts on overall health and well-being of the rural poor; 2) to develop tools that will enable transport professionals to include health impact assessments and mitigation measures in planning, design and implementation; and 3) to develop an advocacy programme to sensitize the health and transport sector. Twenty-five case studies from Africa, Asia and Latin America are currently being carried out across a wide range of issues, such as transport and health in mountainous areas, water transport and access constraints for fistula patients.

By July 2007 researchers will have finished a draft report of the results. A three-day international symposium prior to Forum 11 in Beijing will bring together the transport and health sectors to debate these findings in general and access in particular (in line with this year’s theme). These sectors often talk in isolation and this shall be a unique opportunity for a cross-sectoral debate and brainstorming about future collaboration among health and transport professionals from Africa, Asia and Latin America.
Research organizations in low- and middle-income countries can make better use of research communication to increase the overall relevance of their work, its impact on improving peoples’ lives, and to encourage increased investments in research from the donor and development communities.

While the level of use of strategic research communication is generally low in developing country research organizations, there are a number of ‘bright spots’ – organizations that have developed effective strategies, or have recently taken management decisions to invest in professionalizing their research communication activities.

In this session, three health research organizations from developing countries will present their approaches to organizing and delivering health research communication. Two of these organizations will explain programmes and strategies in progress. The third will present a strategy and consultative process currently in development – internally and with external stakeholders – to professionalize its approach to managing and communicating research.

In part one of this learning session, representatives of the three organizations will present their strategy and approach, then comment on lessons learnt, obstacles experienced and offer advice to others interested in improving communication of their research. The audience will be invited to comment and ask questions on these approaches.

Part two of the meeting will feature comments by several senior users and potential users of health research, who will respond to the research institutes’ presentations, addressing the question: what do we need from health research organizations; and how can their work serve us better? These panel members will include senior policy-makers from a developing country, a member of the media; and members of a community or interest group that is involved in a research process or feels it can contribute.

The results of this consultation will feed into the ongoing Council on Health Research for Development (COHRED) research communication initiative, which is creating and testing a set of generic guidelines and an approach that research institutes can apply. This session will also be a preparatory meeting for the Bamako 2008 Ministerial Forum on Research for Health to ensure that country-level science communication is specifically addressed.
International health research spending by the United States National Institutes of Health

Temina Madon, Science Policy Researcher, Division of International Science Policy, Planning and Evaluation, Fogarty International Center, National Institutes of Health, USA
with Karen Hofman, Brian Zuckerman and Roger I Glass

The United States National Institutes of Health (NIH) supports and advances research relating to the causes, diagnosis, treatment and prevention of human diseases. In 2003, spending by the NIH constituted nearly 50% of worldwide public sector funding for basic health sciences research. Between 2000 and 2005, the agency’s direct support for research conducted at foreign institutions quadrupled from US$ 70 million to US$ 285 million. Support has also increased for collaborations between American and foreign researchers. Because the NIH plays a key role in funding global health research, it is valuable to characterize its investment portfolio, to help inform the decision-making and priority setting of other research agencies and donors.

This study will estimate the total NIH investment in international research from 2004 to 2006. In particular, we will examine the share of spending directed to research and research training priorities of low- and middle-income countries (LMICs). Levels of NIH funding will be presented by country and geographic region, scientific discipline, and disease area. Information generated will show how NIH allocations are aligned with global health research priorities within different regions of the world. Given changing demographic trends, including aging populations and future shifts in the global burden of disease, we will also demonstrate how NIH investment in LMICs is distributed with respect to infectious and noncommunicable disease, as well as acute and chronic disorders.

This study represents a minimal data set, focused on research and training in collaboration with and by researchers in LMICs; therefore, it is likely that total investment in research relevant to populations in these settings will be underestimated.

Overall, the analysis will provide a snapshot of current NIH investment globally, demonstrating the agency’s commitment to international health research. Having this information may enable other national governments and the private sector to leverage existing research investments in global health and potentially develop new partnerships. This study is timely given the African Union decision to designate 2007 as the ‘year for scientific innovations’. It is also responsive to recent calls for national governments to increase funding for global health research and make investments in this area more transparent.
THURSDAY 1 NOVEMBER
Social responsibility and health

Adolfo Martínez-Palomo, Coordinador General, Consejo Consultivo de Ciencias, Mexico

Global health conditions at the beginning of the new century are marked by growing inequities related mostly to poverty and lack of access to health-care services. Health policy has recently become considered to be more than the provision and funding of medical care, taking into consideration that for the health of the population as a whole the social and economic conditions that make people ill are clearly of utmost importance. These include, among others, the life-long importance of health determinants in early childhood, and the effects of poverty, unemployment, malnutrition, working conditions, drugs, social support, adequate food, and socioeconomic status. In contrast, the influence of biological and physical factors on health has been estimated to be less than 15% and 10%, respectively.

It is an accepted fact that more than one billion people – one sixth of the total population of the world – live in extreme poverty, lacking the safe water, proper nutrition, basic health care, and social services needed to survive. Poverty is reflected in various aspects of the life of individuals and populations living under deprived conditions in developing countries, but also in some regions of industrialized countries. The development of new technologies has improved life expectancy and quality of life for many people around the world, especially in developed countries. But paradoxically, while technology grows, ethical problems and inequalities are also growing, in even greater proportions.

The new technical advances, which have been so useful in improving our quality of life, have been inefficient in solving this problem. Almost 60 years have passed since the Universal Declaration of Human Rights was approved by the United Nations, but serious inequities persist all around the world.

The guiding principles of many governments have been those of equality of access to health care and solidarity in sharing the financial burden proportionate to income. However, pressures on health-care systems are already imposed by financial and demographic determinants. These factors were recognized almost 30 years ago in the development of international strategies for health promotion, such as the World Health Organization (WHO) commitment to a global strategy for ‘Health for All’, the principles of primary health care and the 1978 Declaration of Alma Ata. Today, having failed to achieve ‘Health for All’ by the Year 2000, health promotion is still a crucial topic of debate.

Subsequent international health policy guidelines have promoted health as a basic human right, essential for social and economic development. Health promotion, through investment and action, is considered to have a marked impact on the determinants of health so as to create the greatest health gain, to contribute significantly to the reduction of inequities in health, to further human rights, and to build social capital. The ultimate goal is to increase health expectancy, and to narrow the gap in health expectancy between countries and groups.
A research roadmap to address chronic diseases risk factors across multiple countries

Jun Lv, Assistant Professor, Department of Epidemiology and Biostatistics, Peking University Health Science Center, People's Republic of China

Around the world, lifestyles are changing. It is increasingly difficult to make healthy choices: access, availability and affordability of healthy foods are decreasing; whereas unhealthy foods have become readily available and cheap. As a result, chronic diseases are rising at alarming rates in both developed and developing countries.

Decades of research based in developed countries has identified a collection of evidence-based or promising practices for prevention of chronic diseases, but this has not yet been applied to developing country settings in a comprehensive and self-sustaining way.

Community Interventions for Health (CIH) draws upon the knowledge and skills of global researchers, addressing the three main risk factors for chronic disease (physical inactivity, tobacco use and unhealthy diet) and the barriers to change through comprehensive community interventions.

CIH uses four strategies for change: 1) structural changes, such as environmental change, policy and economic changes; 2) community coalition-building; 3) health education; and 4) media – which will be implemented in four settings: schools, workplaces, health centres and neighbourhoods.

Some examples of strategies that will be implemented include, but are not limited to: creating opportunities for physical activity (environmental change); creating and/or implementing smoke-free environmental policy (policy change); creating and/or implementing competitive food standards for healthy food options (economic change); building community coalitions to drive and sustain the changes in the community; using social marketing campaigns to drive behaviour change; and using public will campaigns to mobilize communities to advocate for structural changes.

The aim of CIH is to develop and showcase sustainable interventions. CIH provides the opportunity to build: 1) a best practice ‘roadmap’ of guidance to address chronic disease risk factors; and 2) a comprehensive international database of intervention processes and outcomes. In other words, CIH will provide evidence and practical advice on what does, or does not, work in chronic disease prevention.
Global research priorities in noncommunicable diseases

Sania Nishtar, President and Chief Executive Officer, Heartfile, Pakistan

The need to reorient public health priorities worldwide is evidenced by the current prevailing global burden of disease, 56% of which can be attributable to noncommunicable diseases (NCDs). Despite this, NCDs have remained on the sidelines of mainstream public health action.

There are some indications of the beginnings of change in this arena with recent shifts in multilateral policies and allocation of seed resources, particularly in the area of tobacco control. This change creates a number of policy, legislative and institutional imperatives for countries, as well as the need for a global mechanism to pool resources and technical expertise.

Within countries, reorienting health systems, building the capacity of health professionals, upgrading infrastructure and ensuring availability of and access to essential drugs will have to be evidence-based, which underscores the need to determine priorities for research to support the envisaged public health transition. Most developing countries currently have a focus on risk factor and etiological research in relation to NCDs. There is, therefore, a need to move towards other areas in generating evidence relevant to the structuring of NCD public health programmes, such as surveillance and intervention research, in order to facilitate an assessment of the effectiveness of policies, disease trends and future health needs.

For epidemiological purposes, population-based NCD risk factor surveillance systems and registries for surveillance of cancers and stroke need to be established and maintained; management information systems need to be reconfigured and morbidity surveillance systems need to be re-cast. Epidemiological research to determine causal associations for risk factors that have implications for setting targets for preventive interventions also needs to be promoted. Depending on the stage at which public health action is being initiated, policy and operational research on risk mitigation in the diet, physical activity, tobacco and environmental pollution arena; and operational research in demonstration settings and/or programme evaluations’ also need to be strengthened.

In addition, health policy and systems research of relevance to developing integrated models of service delivery are also a priority, as is research to address institutional impediments to the integration of NCDs – across diseases, and in relation to other public health programmes. Integration of NCDs in public health must be leveraged as an opportunity to strengthen health systems and obviate some of the inadvertent weaknesses created in health systems as a result of the single disease vertical programmes of the past.
The risk of night-time motorcycle crash among motorcyclists using rear-end reflectors in Malaysia

Nhan Tran, PhD Candidate, International Health, Health Systems, Johns Hopkins University Bloomberg School of Public Health, USA
with Adnan Hyder, S Kulanthayan and Radin Umar

Motorcycle crashes constitute over half of all road traffic-related fatalities and injuries in Malaysia and are one of the leading killers of young adults aged 15–44 years. Between March and September 2005, an intervention using adhesive rear-end reflectors was initiated in the district of Klang, Selangor State, Malaysia. The aim of the intervention was to reduce the incidence of night-time motorcycle crashes and subsequent injuries.

Following an intervention programme, in which rear-end reflectors were distributed and installed onto motorcycles, information about a sample of 837 crashes was collected over a period of 12 months by the traffic police bureau of Klang. For each crash within the sample, data on reflector usage and the time of crash was obtained. To measure the impact that reflector usage had on the likelihood of night-time crashes, logistic regression analyses were conducted with night-time crashes as the dependent variable and reflector usage as the independent variable.

Overall, the reduction in risk among motorcyclists with reflectors was not significant, OR=0.773, p-value=0.155 (CI=0.542-1.1). However, stratified analyses carried out for those months where reflector usage was above 35% showed that there was a significant reduction in the likelihood of crash among those motorcyclists using rear-end reflectors, OR=0.547, p-value=0.052 (CI=0.298-1).

Visibility enhancement materials such as rear-end reflectors can reduce the risk of night-time crashes among motorcyclists. The use of adhesive reflectors is an innovative and effective means of ensuring reflector coverage among motorcyclists in low- and middle-income countries since the reflectors are effective on both new and older motorcycles.
The aim of this session is to increase our understanding of how national health research systems can ensure that equity issues are addressed adequately through research. Research for health aims to achieve better health and development for the entire population. To achieve equity in health there is a need to understand how inequity is generated, and what can be done to reverse inequitable situations. There is a considerable amount of research focusing on questions such as the impact of health services on equity, the impact of social differences on health, or the impact of interventions on health. There is, however, very little information available on how national health research systems can be set up and operationalized in such a way that equity in health becomes a key concern and operating principle of these research systems.

This session will address equity from the national health research system perspective. It will look at how an equity focus in research can be promoted through priority-setting for health research, in health research policy development, and in resource allocation and development. It will also address how the system can measure its impact on equity through its monitoring and evaluation function, and adjust its strategies accordingly.

A consultative meeting, to be held prior to Forum 11 and organized by the Council on Health Research for Development (COHRED), will inform the session. The session itself will take a format that encourages and facilitates debate and discussion. After a short introduction to the topic, panel members will provide brief inputs from their own national or institutional perspective. The consultative meeting and the session will identify challenges, strategies and approaches for national health research systems to ensure an equity focus. The outcomes will be used to guide further work on this topic in preparation for the Bamako 2008 Ministerial Forum on Research for Health, and to obtain the commitment of governments during that meeting to retain or re-establish an equity focus in health research.
Equity in the National Health Research and Technology Development System, Costa Rica

Xinia Gómez Sarmiento, Chief, Health Research Unit, Health Research and Technology Development, Health Stewardship Technical Division, Ministry of Health, Costa Rica

Increasing inequalities between and within countries have grown along with globalization, and have brought many countries’ health disparities – and the macro-determinants of health equity – to the forefront. On a worldwide level, advocacy is being conducted so that knowledge generation and use are oriented towards improving health systems and towards reducing inequalities, within the framework of national health research systems (NHRS). Disparities are still a major challenge in the Costa Rica health arena, and there is a real need to focus efforts on research in order to identify the determinants of inequality and improve knowledge about the needs of the health system. Ultimately, this research aims to establish policies that minimize the effects of social inequity and improve health system administration and governance in general.

The Costa Rica Ministry of Health, as health sector steward, has oriented its efforts towards construction of a vision of ‘stewardship of health research and technology development’ that has the ability to respond to the country’s needs and strengthen the national health system. This vision has allowed it to direct, conduct and articulate the components of this system and to establish, along with its members and stakeholders, policies and plans of action geared towards generating effective responses to the main health problems the country faces. The Ministry of Health has coordinated efforts with researchers, academics, financiers, decision-makers and knowledge users, among others, to establish policy instruments that include strategies, projects and specific actions intended to improve the quality of life of the population in general, with an emphasis towards vulnerable and marginalized social groups.

Among these efforts, two instruments have been key: 1) the National Health Research and Technology Development Agenda (2005–2010), which establishes specific strategies to strengthen research that contribute to reducing inequities and social exclusion in health, and to improve access and quality of health services; and 2) the National Health Research and Technology Development Plan (2007–2015), which identifies specific actions and projects, for example: studies on the determinants of health in priority areas and social groups; studies on equity and governance with a gender, intercultural and disability perspective; studies on access (economic, geographic, cultural, functional, generational, etc.); studies on the quality of health services for the unemployed and members of the informal economy; and studies on the modes of insurance and the need for focused programmes for the inclusion of vulnerable groups.

In order to guarantee the completion of these projects, various networks have been set up composed of experts from each priority area. These members, who come from key institutions and key organizations within the system, will not only monitor the Plan’s development and execution, but will also strengthen and articulate the National Health Research and Technology Development System.
Putting equity issues on the research agenda in east and southern Africa: civil society roles and action

Itai Rusike, Steering Committee Member, Regional Network for Equity in Health in East and Southern Africa (EQUINET), Zimbabwe

Analysis of the current health conditions in east and southern Africa (ESA) set out in the Regional Network for Equity in Health in East and Southern Africa (EQUINET) Regional Equity Analysis point to three major areas of action to improve health equity: 1) for poor people to claim a fairer share of national resources to improve their health; 2) for a more just return for countries in ESA from the global economy to increase resources for health; and 3) for a larger share of global and national resources to be invested in redistributive health systems to overcome the impoverishing effects of ill-health.

Health systems can make a difference in these areas, by providing leadership, shaping wider social norms and values, demonstrating health impacts and promoting work across sectors. Evidence shows that this calls for comprehensive, primary health care-oriented, people-centred and publicly led health systems, especially to reach the most disadvantaged people with greatest health needs. These approaches are not without challenges, whether from local elites, competing approaches or global trade pressures.

These challenges meet two strong counter-forces for health equity: the universal human right to health and the international conventions that protect this right, and the social pressure, resources, networks and capabilities that exist to achieve equity-oriented goals. The paper identifies the ways health systems and civil society in ESA can and do act to empower people, stimulate social action and create powerful constituencies to advance public interests in health, including through the use of research.

Civil society has an important role to play in strengthening the collective capability of people to assert their own needs and interests, in influencing, monitoring and holding systems accountable for the allocation of resources towards health needs and in challenging inequity in power and resources. In the research sector, this is done by influencing and setting research agendas, collecting of evidence and active engagement in the use of evidence. Engagement is most effective when health systems adequately resource community roles, invest in and recognize their communication and facilitation functions, and provide functional mechanisms for dialogue and interaction with communities.
The need for translational research to generate the evidence for rational and efficient introduction of new vaccines: the success story of the International Vaccine Institute in Asia

John Clemens, Director of the International Vaccine Institute, Republic of Korea with Viveka Persson

Currently, a large number of countries, international agencies and philanthropies make large investments into private-public partnerships that focus on product development and increasing children’s access to vaccines. A recent initiative is the Advanced Market Commitment (AMC) that was launched in Rome this year. It is an instrument that provides financial incentives to harness the creativity and resources of private-sector research and development to provide access to new vaccines to combat diseases that affect poor countries. While these initiatives are vertical and focus on the production, procurement and distribution of vaccines, there is a great need for translational research (studies on disease burden, cost-effectiveness, safety and feasibility) that generates the evidence needed for rationale and efficient introduction of new vaccines. In addition, activities aiming at strengthening the national regulatory authorities and local vaccine production capacity are needed to ensure that suitable vaccine technologies are transferred to manufacturers in developing countries and that they follow appropriate national regulatory standards.

The International Vaccine Institute (IVI) has a mission to contribute to the reduction of vaccine-preventable diseases in developing countries through research that generates the evidence needed for rationale introduction of new vaccines. IVI was established a decade ago in the Republic of Korea, as part of a larger public sector process of change where several organizations are acting in mobilizing resources for procurement and distribution of vaccines in developing countries. Projects within IVI’s translational research programme are conducted through existing infrastructures (Ministries of Health or other local partners). The analysis and cost reports of disease burden are communicated to policy-makers and planners. They are cooperating with developers and producers of vaccines in developing countries (e.g. Viet Nam, Indonesia and India) as well as industrialized countries (e.g. Australia, Canada, France, Sweden, the United Kingdom and the United States of America). The programme is strongly supported by relevant training (e.g. good clinical practice, demography and laboratory methods) and capacity-building (vaccine production according to good manufacturing practice and regulatory issues).

A recent evaluation of IVI concludes that the programme has had a major impact on policy decisions about vaccine development and introduction for a number of diseases, such as cholera, typhoid and rotavirus. It further affirms the role of IVI as unique and an excellent complement to activities undertaken by the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization) and others in this area. IVI has shown during its first 10 years that it is filling major gaps that exist in translational research, technical support, training and capacity-building for vaccines of priority to developing countries. Finally, the evaluation recommends an expansion of IVI’s translational research programme to Africa.
Lymphatic Filariasis: exemplifying the research, policy, practice continuum in a global programme

David H Molyneux, Director, Lymphatic Filariasis Support Centre, Liverpool School of Tropical Medicine, United Kingdom

Many disease control programmes have long time horizons and require adjustment of strategies during implementation. Programmes to control, eliminate or eradicate filarial infections have been particularly successful, yet have often changed strategies over time as problems emerged or new research findings offered more appropriate or cost effective approaches.

The Global Programme to Eliminate Lymphatic Filariasis (GPELF) was initiated following a World Health Assembly resolution in 1997. The programme commenced in 2000 and now over half the endemic countries have national programmes. In 2005 some 351 million people were treated. The GPELF strategy is based on annual treatment with two drugs (albendazole and ivermectin in Africa, where onchocerciasis is co-endemic; albendazole and diethylcarbamazine (DEC) elsewhere) for at least 4–6 years.

The research that drove the establishment of the programme, as well as the more recent research questions that will assist in defining programme end-points, will be described. These include: when to stop mass drug distribution to ensure there will be no resurgence; the role of vector control in reducing duration of annual treatments cost effectively; the role of increased drug dosages and frequency of use of antibiotics against Wolbachia endosymbionts. The role of preventive chemotherapy strategies in integrated neglected disease initiatives, given the broad anthelminthic impact of the drugs used in the GPELF, will be discussed.
Establishing the Chinese Clinical Trial Registration and Publishing Collaboration

Youping Li, Director, Chinese Evidence-Based Medicine Centre, West China Hospital, Sichuan University, People’s Republic of China with Taixiang Wu, Guanjian Liu and Jing Li

The global clinical trial registration system has been established by the World Health Organization but most Chinese clinical trials are conducted with poor methodology and reporting. This situation reflects the need to establish a special system to improve trial registration in the country.

The establishment of the Chinese Clinical Trial Registration and Publishing Collaboration (ChiCTRPC) has been initiated. The collaboration consists of three functional groups: 1) Chinese Clinical Trial Register (ChiCTR): registers trials, gives advice on writing trial protocols and articles, trains editors of medical journals, performs centre randomization, and acts as a quality controller for design and methodology at the beginning of trials; 2) Chinese Evidence-Based Medicine Centre/Chinese Cochrane Centre/INCLLEN CERTC Local Centre: offers a technical support platform, and acts as an expert resource; 3) Medical journals: publish only registered trials, publish articles according to their actual design and performance quality, act as quality controller for reports, to reflect the real situation at the end of trials.

The latest outcomes of these combined initiatives are as follows: 1) ChiCTRPC was established (April, 2006) by the following members: 48 medical journals, ChiCTR and the Chinese Cochrane Centre, the Chinese Evidence-Based Medicine Centre, and INCLLEN CERTC Local Centre. Four more journals have since joined the journal group (currently 52 key Chinese journals); 2) A Joint Statement on Establishing the Chinese Clinical Trial Registration and Publishing System (Chengdu Statement) has been published; 3) The Chengdu Statement includes a declaration that from 1 January 2007, member journals of ChiCTRPC shall preferentially publish registered trials, and will gradually phase out publication of non-registered trials.
Equitable access to diagnostics: promises and challenges of translating research on use of rapid syphilis tests into policy and practice

Rosanna Peeling, Manager, Special Programme for Research and Training in Tropical Diseases (TDR), Diagnostics Research and Development, World Health Organization, Geneva with Adele Benzaken, John Changalucha, Xiang-Sheng Chen and Jean Pape

The objective of this session is to explore the promises and challenges in health research that will lead to equitable access and improvement in maternal and child health.

Although many high-quality diagnostic tests for infectious diseases are available in the developed world, they are neither affordable nor accessible to patients in developing countries due to the lack of appropriate facilities and resources. Most of these infectious diseases are treatable, but without the tools to diagnose infections, many of those infected cannot benefit from therapy. An estimated 500,000 babies die in sub-Saharan Africa every year from congenital syphilis simply because many women lack access to a screening test for syphilis in pregnancy. Research to evaluate the performance and utility of rapid syphilis tests has shown that tests with acceptable performance can be used in primary health care settings to guide treatment and avert stillbirths and congenital syphilis. The translation of this research evidence into policy and practice to ensure equitable access offers many promises and challenges.

During the session, presentations will address the following: 1) Introducing syphilis screening into control programmes for ethnic minority populations and high-risk individuals present many challenges but may help avert a major HIV epidemic. 2) Currently 30% of pregnant women in Haiti have access to syphilis screening. Rapid tests can reach rural populations through the use of mobile clinics and village health workers, the challenge is to monitor access and evaluate the quality of testing performed in remote settings. 3) Lessons have been learnt in implementation research to make syphilis screening available for villages along the Amazon river and in the municipalities in the Upper Solimões region. 4) The challenge is how to introduce new tools into district and village levels, where there are already multiple vertical donor programmes and a scarcity of trained personnel.

The translation of research evidence on new tools into policy and practice to ensure equitable access must involve community engagement and integrated approaches.
The role of health systems in addressing health equity

Lucy Gilson, Professor, London School of Hygiene and Tropical Medicine/Centre for Health Policy, University of Witwatersrand, South Africa with Jane Doherty and Rene Loewenson

The Knowledge Network on Health Systems of the Commission on the Social Determinants of Health explored the role of health systems in promoting health equity. The final report of this network, prepared by the authors with background contributions and peer review by network members, provides the basis for this paper. It aims to: 1) analyse the pathways through which health systems impact on health (in)equity; 2) highlight the key policy implications of this analysis; 3) identify the priorities for further research in this field.

In addressing objective 1, the paper highlights the potential for health systems to: lever intersectoral action for health, promote social empowerment, provide health care that is accessible to socially-disadvantaged population groups, including low-income women, protect poorer groups from the impoverishing effects of ill-health, enable re-distribution and contribute to wider well-being. The key policy implications (objective 2) focus on the actions and approaches that ministries of health, civil society organizations and donors must take in differing contexts to initiate and institutionalize equity-promoting changes within health systems.

Reflecting on the difficulties experienced in assembling the knowledge base in this field, the paper concludes that the research needs in this field are many. Priorities (objective 3) include context-specific and cross-national analysis to understand the health equity impacts of different approaches to: social empowerment; strengthening public health-care financing and provision; changing the organizational culture of public sector health systems; as well as the strategies of political action and international actions needed to bring about these changes. Overall, the paper concludes that health systems are themselves a social determinant of health and that, currently, most health systems work to promote health inequity. This critical weakness demands political and social action to operationalize a primary health care and population health approach across health systems. Health equity must once again become the pre-eminent goal for health systems development. To support action, researchers must develop the knowledge base in this field.
The politics of health worker migration in the Commonwealth

Ann Keeling, Director, Social Transformation Programmes Division, Commonwealth Secretariat, United Kingdom
with Peggy Vidot

The Commonwealth is a voluntary association of 53 states from five continents. Commonwealth countries include 1.8 billion people, or around 30% of the global population but have 60% of global maternal deaths and HIV cases. Strengthening health systems and enabling all member states to attain the health-related Millennium Development Goals (MDGs) by the target date of 2015 is therefore a major priority for the Commonwealth.

The World Health Organization estimates that there is a global shortage of 4.2 million trained health workers and cites 17 Commonwealth countries as having acute health worker shortages. Shortages of trained health workers in parts of Commonwealth sub-Saharan Africa and south Asia are having a negative impact upon health service delivery and health indicators. The common heritage of English language, education systems and networks within the Commonwealth has facilitated migration of health professionals. In response in 2003, Commonwealth member states agreed a Commonwealth Code of Practice on the International Recruitment of Health Workers, the first multilateral political agreement of its kind; setting ethical standards for the recruitment of health professionals and safeguarding the rights of those who do migrate.

The code contains a set of recommended policy measures for both source and destination countries. Governments (source and receiving) make political decisions that encourage or discourage health worker migration. These include investing in planning human resources for health and health worker training; facilitating inward migration into the public and private sector through immigration regimes/targeted recruitment; and strategies to retain staff/facilitate return. The Commonwealth Secretariat has commissioned research into the migration of nurses within the Commonwealth to determine the factors facilitating migration and the policy measures needed to protect the most vulnerable health systems from unmanaged migration. The secretariat has also evaluated the effectiveness of multilateral codes of conduct, such as the Commonwealth code, to determine whether such political agreements between states can contribute to better health outcomes in the poorest countries. This paper will focus on the political determinants of health worker migration and policy measures at national, Commonwealth and global levels.
‘Up to our ears in …’: political factors determining water and solid waste management issues in Karachi, Pakistan

Gregory Pappas, Professor and Chairman, Department of Community Health Sciences, Aga Khan University, Pakistan

Infectious diseases caused by inadequate clean water supply and solid waste management continue to be major problems in less developed countries. Indeed health problems caused by unsanitary conditions may be growing as mega-cities spiral out of control.

This paper presents two brief case studies of political determinants of health in Karachi, Pakistan. The first addresses the issue of water and solid waste management at the city policy level. Rapid population growth, competition for land, poor planning and corruption have exacerbated the spread of infectious diseases caused by poor sanitation in this mega-city of over 17 million people. The second case analyses one slum neighborhood’s struggle for construction of a sewage line. This poor neighborhood was able to improve their sewage problems through community action in which a public health agency played a catalytic role. The two cases are linked and demonstrate both the obstacles and potential for positive change through community empowerment.
Enhancing capacity to use health policy and systems research evidence in policy-making

Sam Adjei, Deputy Director of Health Services (retired), Ghana Health Service, Ghana

This presentation draws upon the Alliance for Health Policy and Systems Research (HPSR) Biennial Review and describes the primary organizational capacity constraints upon the use of research evidence in policy-making.

Five aspects of organizational capacity were conceptualized: 1) governance and managerial capacity; 2) human resources; 3) finance; 4) communication capacity; and 5) functional technical capacity. Consultations with organizations active in the HPSR field were undertaken, country case studies and a review of previous capacity-enhancing initiatives in health research were conducted.

Policy-making is not a linear process but is likely to be fluid and messy. Furthermore evidence is only one factor that influences policy. Multiple actors are involved in policy development: advocacy organizations, media and other civil society organizations pick up on research findings and amplify research messages, multiple branches of government (ministries, executive offices and parliament) may receive and act upon research findings.

Very few initiatives have focused on developing capacity to promote the use of evidence in policy-making. Often there is no culture of evidence-based policy. Regulatory mechanisms (such as requiring the publication of the evidence base for policy decisions) hold promise as a way to engender such a culture. There are self-assessment mechanisms that enable policy-makers to assess their own ability to acquire, assess, adapt and apply evidence in policy. But the evidence base in terms of what is effective in promoting evidence-informed policy-making is weak. Networks between policy-makers and research organizations are often fragile, and policy-makers sometimes lack skills to commission and interpret evidence and manage partnerships with researchers.

There are particular challenges to enhancing the capacity of civil society organizations to participate in evidence-informed advocacy, in a way that does not compromise their independence, yet maintains legitimacy and accountability.

Civil society is a critical component of open government and democratic decision-making, but its role in evidence-informed policy has previously been extremely neglected. Policy-makers’ capacity to commission and use evidence has also been neglected. More evidence is needed about effective interventions in this area.
Strengthening capacity for health policy and systems research: an agenda for progress

Sara Bennett, Manager, Alliance for Health Policy and Systems Research, Switzerland
with Andrew Green

National capacity for health policy and systems research (HPSR) is critical given the context-specificity of much HPSR. This presentation draws upon the Alliance for Health Policy and Systems Research Biennial Review. The presentation draws conclusions from the various papers prepared for the review and presents priorities for action.

The conceptual framework used focuses upon the organizational dimensions of capacity. In undertaking the review, multiple consultative meetings were held, country case studies and a review of previous capacity enhancing initiatives in health and development research were conducted.

This abstract indicates five priority areas for action that are emerging from the review: 1) Improving the definition and rigor of the field of HPSR: including strengthening, standardizing and disseminating methodologies for common types of HPSR studies, and strengthening and standardizing the curriculum used to teach HPSR in northern and southern institutions. 2) Addressing common practices that distort incentives for health policy and systems researchers and contribute to them leaving the field. This includes shifting investment of national and international agencies away from short-term consultancies towards longer-term, more rigorous research that builds knowledge and capacity, and ensuring that a greater share of total HPSR spending goes to southern organizations. 3) Increasing the volume and predictability of financing for HPSR through measures such as promoting in investment in HPSR (particularly operational research and evaluation) as part of health systems strengthening investments and working with partners to create basic core funding packages for research organizations in the south. 4) Bringing a much stronger focus to capacity development among the users of HPSR (policy-makers and civil society), including: (i) demonstrating how taking account of evidence can lead to better policy; (ii) developing specific skills and capacities (such as for research commissioning); and (iii) using prospective evaluation to build knowledge in this area. 5) Focusing on organizational systems and structures in research organizations, such as governance, financing, human resource management etc. that help create appealing and functional work places and thus help retain staff, as well as enabling efficient operations.
Enhancing capacity for generating health policy and systems research knowledge in developing countries

Ravindra Rannan-Eliya, Director, Institute for Health Policy, Sri Lanka

National capacity for health policy and systems research (HPSR) is critical, given the context-specificity of much related research. This presentation draws upon the Alliance for Health Policy and Systems Research Biennial Review. The paper describes the primary organizational constraints upon capacity and discusses strengths and weakness of strategies to enhance capacity.

Five different aspects of organizational capacity for HPSR were conceptualized: governance and managerial capacity; human resources; finance; communication capacity; and functional technical capacity. Consultations with organizations active in HPSR were undertaken, country case studies and a review of previous capacity-enhancing initiatives in health and development research were conducted.

Strong leadership is critical to the success of many HPSR institutions, and further attention needs to be paid to providing mid-career opportunities, and motivating and creating incentives for senior researchers to stay in-country. ‘Brain drain’ (both internally to donor organizations that offer higher pay, and externally to international organizations) is a major problem that afflicts HPSR organizations. Many HPSR organizations struggle to survive financially and are dependent upon multiple small grants. Greater predictability and reduced volatility of HPSR financing is needed including a better balance between core and project funding. Policies of funders, which prevent the payment of overheads to research organizations, should be revisited. Little attention has previously been paid to how to strengthen research organizations’ ability to communicate with policy-makers and civil society. In addition, the possibilities for shadowing and job swapping to improve mutual understanding between organizations should be explored. Communication with other southern research centres or partners in the north is also important, and enhanced capacity is needed to be able to negotiate and maintain equitable relationships with northern partners.

Finally, HPSR remains a poorly understood field and more should be done to standardize, strengthen and disseminate HPSR methodologies.

Capacity enhancement strategies need to focus more on the organizational context. Research producers need to recognize the links to policy processes and develop new skills for taking the opportunities such links present. New strategies are needed to attract and retain HPSR researchers.
Thursday 1 November  10.45–12.15

**PARALLEL SESSION: RESEARCH PRIORITIES**

**Priorities and interactions of a health research system in a developing country: a Cameroon experience**

Peter Mbondji Ebongue, Public Health Expert and Researcher, Military Health Research Centre (CRESAR), Cameroon
with Okalla Abodo Raphaël, Pierre Ongolo Zogo, Rose Leke, Ritu Sadana, Shook Pui Lee Martin, and members of the World Health Organization (WHO) Health Research System Analysis (HRSA) Initiative

The primary aim of this study was to develop an approach to analyse and improve the health research system by requesting, from a nationally representative sample of individuals, their vision of the national health research system. This qualitative study was part of a wage analysis, and requested the views of people involved in the research process (health researchers; policy-makers within the health and health-related sectors; publishers or journalists who communicate health research studies or findings; and others who make use of health research results, such as within patient or other advocacy groups, industry and the private sector).

A self-reported survey, with re-test reliability estimates, was conducted in 2004 among 195 individuals in the country. Questionnaires covering many topics were distributed; but the study focused on open-ended questions. These questions concerned the opinion of researchers with regards to what they consider the priorities, goals and usefulness of health research; what they think has been done up to now and how they think it could be improved.

Our findings were discussed within a national research team and shared with World Health Organization (WHO)/Health Research System Analysis (HRSA) Initiative members. Data analysis is still in progress and final results will be presented.

However, current trends show that this new approach developed by WHO seems to give relevant indications for the orientation of health research policy to better translate health research into action. The varied social level of respondents produced a global view of the priorities and interactions of the health research system. This approach permits an identification of health research challenges for improving health and related policies in many countries.
This paper discusses the latest priority-setting and advocacy efforts of the Philippine National Health Research System. Using bottom-up and top-down approaches, the Philippines identified research priorities at the sub-national and national levels for 2006–2010 addressing global concerns (like the Millennium Development Goals), national and local initiatives (like the health reform agenda, gender and development and other developments) that influence the health sector. The priority-setting process involved various stakeholders from academia, government and nongovernment organizations including civil society at the sub-national and national levels. The priority-setting process was novel because it involved a validation process among national agencies with oversight responsibility for programme and activity implementation, and the identification of sources of both financial and logistic support for the implementation of the recommended priorities.

Advocacy initiatives were also pursued by the country’s health research system to promote the use of, and adherence to, the country’s health research agenda. National and sub-national dissemination activities were initially pursued, involving major players who were also involved in the priority-setting activities. Workshops were convened to identify strategies to best advocate for the newly-formed research agenda so that national and sub-national priorities were disseminated and promoted.

What makes this approach different is the involvement of major partners (who were responsible for the priority-setting exercises at the sub-national levels) in the crafting of strategies to improve adherence to the agenda and their involvement in the dissemination process so that advocacy flows back to where priority setting all began, particularly at the sub-national levels.

This paper not only describes the experience of the recent priority setting process and advocacy initiatives but also identifies the lessons learnt in pursuing these activities. The paper concludes with some recommendations on how to further improve the priority-setting process and advocacy initiatives in resource-limited countries such as the Philippines.
Health research priorities in Argentina: how to get them funded

Silvina Ramos, Director, Área Salud, Economía y Sociedad, Centro de Estudios de Estado y Sociedad (CEDES), Argentina
with Zulma Ortiz, Martin Olmos and Silvia Kochen

The methodology for facilitating research priority setting must be understood as a constantly reviewed, recurrent, long-term process, which must be explicit and transparent. Stakeholders with diverse interests and expertise must be involved in the process, thus ensuring the participation of the community, either directly or through representative organizations. Following Global Forum for Health Research methodology, we have used the Combined Approach Matrix (CAM) as a strategy to set research priorities. CAM is a process encompassing eight steps, is as evidence-based as possible and incorporates the view of a wide set of policy-makers who often operate in a non rational context. The last step described by the CAM consists of allocating priority research projects among the research institutions in the country, based on their comparative advantages.

Given that setting of a research agenda through a process of consultation and consensus-building helps funding organizations to make informed choices between competing research options, the second phase of our project aims to build a consensus-based tool for achieving a national public health research agenda.

A participatory action research (PAR) approach will be applied. PAR differs from most other approaches to public health research because it is based on reflection, data collection, and action that aim to improve health and reduce health inequities through involving the people who, in turn, take actions to improve their own health. PAR allows decision-making criteria to be defined and weighted in an explicit manner. The approach will be organized in four phases: 1) forming a collaborative inquiry group among the stakeholders of the health research priority-setting process; 2) creating the conditions for debate with the funding organizations; 3) acting on responses regarding how to get funding for the priorities; and 4) creating meaning (capturing and interpreting the group's experiences). This process will be a continuous cycle that reconsiders the group perspectives, and recreates the conditions for group learning, etc.

Pooling of funds between public funding bodies is one way of enhancing the likelihood of implementing national priorities. Achieving this goal will strengthen our health research system.
Thursday 1 November  10.45–12.15
PARALLEL SESSION: RESEARCH STRATEGIES FOR NEGLECTED DISEASES

The Wellcome Trust: strategic partnerships

Pat Goodwin, Head, Pathogens, Immunology and Population Studies, Science Funding, The Wellcome Trust, United Kingdom

The mission of the Wellcome Trust is to foster and promote research with the aim of improving human and animal health. Strategic partnerships are one of the mechanisms we use to take forward activities that will help us fulfil our mission and specific examples will be given, including partnerships with government, industry and other funders.
Thursday 1 November 10.45–12.15

Parallel session: Research strategies for neglected diseases

Research, technological development and innovation in neglected diseases: new strategies adopted by Brazilian funding agencies

Suzanne Jacob Serruya, Director, Department of Science and Technology, Secretariat of Science, Technology and Strategic Inputs, Ministry of Health, Brazil with Carlos Morel and Moisés Goldbaum

The Brazilian Government, through the Ministries of Health, Science and Technology, and Education, organized the 1st National Conference on Science and Technology for Health in 1994 and in 2004 the 2nd National Conference on Science, Technology and Innovation for Health. These conferences led to the creation of the Department of Science and Technology and soon after the Science, Technology and Strategic Inputs Secretariat with the mission to fund and implement strategic actions in science and technology to feed the needs of the Brazilian National Health System (SUS).

In 2006, it was decided to launch the Neglected Diseases Research and Development Program. Consequently, US$ 10 million was allocated from the Ministry of Health budget for a two-year programme to be implemented and managed in partnership with the National Council for Scientific and Technological Development, including the Oswaldo Cruz Foundation.

A call for applications of letters of intent (LoI) was discussed and approved in a 3-day meeting in Rio de Janeiro in May 2006, involving 60 participants from the research and development, public health and decision-making areas. From the 320 LoI received by August 2006, 180 were requested to submit full proposals. All LoI and final proposals were peer-reviewed through regular National Council procedures and 76 proposals were approved in December for funding during the 2007–2008 biennium.

The Neglected Diseases Program represented significant changes from the classical funding mechanisms: (1) health research and development priorities discussed and set in advance by scientists, public health experts and decision-makers following the guidelines and recommendations of the 2nd National Conference; (2) peer review based on health needs and scientific merit; (3) a clear focus on neglected diseases and network formation; (4) budgets of up to US$ 200 000 per project; (5) 30% of the total budget allocated to the three geographical regions of Brazil most afflicted by neglected diseases.

The final evaluation of the programme is expected in 2009. However, the programme has already been successful in planning, launching and implementing the decisions from the national conferences. This will contribute to the enhancement of the Ministry of Health’s active role strengthening research and development activities and innovation in health.
Towards equitable access to drugs for diseases of the poor: some new research and development initiatives from India

Sadhana Srivastava, Senior Research Officer, Intellectual Property Rights Unit, Indian Council of Medical Research, India
with K Satyanarayana

With a population of over 1.2 billion, India also accounts for a fifth of global communicable disease burden, with the majority not having access to drugs and other health products. Access to health products depends on many factors, such as successful innovation of new technologies, global and national public-private product development partnerships (PDPs) on high-priority diseases, effective technology management etc. A new thrust and focus is being given in India to addressing this issue by both the public and private sectors with increasing support for research and development (R&D) and also innovative partnerships.

Some such new initiatives include: 1) the New Millennium Indian Technology Leadership Initiative (NMITLI); 2) the Pharmaceutical Research and Development Support Fund (PRDSF); 3) the National Jai Vigyan Science and Technology Mission; 4) the Technology Development Board (TDB); 5) the Clinical Trial Initiative.

The NMITLI aims to forge innovative public-private partnerships to catalyze innovation to develop products for diseases of the poor, with a budget of Rs 3000 million (about US$ 65 million). A new molecule for tuberculosis (TB) treatment is undergoing clinical trials. The PRDSF, with Rs 1500 million (about US$ 33 million), is another major initiative for drug development. The National Jai Vigyan Science and Technology Mission has a special focus on the integrated development of new vaccines and diagnostics for cholera, rabies, Japanese encephalitis, TB, malaria and HIV using novel strategies. The TDB supports R&D and also scaling-up of new drug development; a major success being the development of a hepatitis B vaccine. The Indian Council of Medical Research, New Delhi is currently conducting clinical trials of 10 vaccines and has just set up a Clinical Trial Registry in India to ensure all trials are conducted with complete transparency and comply with all the statutory ethical and regulatory requirements. The Government of India is also promoting R&D for drug development through several incentives, such as increased R&D tax benefits and subsidies to support industry-university partnerships.

The impact of these new initiatives to improve access to new health products will be discussed.
Sexual violence violates multiple fundamental human rights. It is diametrically opposed to attaining the highest standards of physical and mental health. As such, research needs to be undertaken to: 1) identify strategies for stopping sexual violence, and 2) identify the appropriateness and effectiveness of services provided to survivors of sexual violence.

This round table session focuses on research aimed at ensuring that women and girl survivors of sexual violence gain equitable access to the basic preconditions for health, and in particular on the research required to provide a greater understanding of priorities for services for survivors/victims of sexual violence. These include survivors/victims, family members and communities, and an assessment of which interventions are effective in responding to sexual violence in different settings. Globally, responses are very diverse with differences influenced by the level of resources, status of women and girls, and a range of other factors.

The Sexual Violence Research Initiative (SVRI) has commissioned a desk review on women’s responses to sexual violence along with an appraisal of sexual violence in China. The SVRI has also developed a sexual violence research agenda that highlights appropriateness and effectiveness of sexual violence services as a key focus area.

Guided by these studies and the Sexual Violence Research Agenda, the SVRI will facilitate the round table on sexual violence with a particular emphasis on women’s and girls’ responses and a general overview of sexual violence in China, with a view to identifying ways in which research can be used to strengthen services for women survivors of sexual violence.

Key areas for discussion are as follows:

- To what extent do current services meet the identified needs of women and girl survivors of sexual violence?
- What areas of service provision must be prioritized to strengthen services for women and girl survivors of sexual violence in different settings?
- How can research be used to strengthen services for women and girl sexual violence survivors?
An overview of sexual violence against women and children in China

Edward Ko Ling Chan, Assistant Professor, Social Work and Social Administration, The University of Hong Kong, People's Republic of China

This paper provides an overview of research on sexual violence in China. It is based on a review of literature in the form of journal articles and book chapters located in databases. The prevalence of and risk factors for various types of sexual violence is reviewed, and community knowledge and perceptions about sexual violence are discussed to demonstrate how cultural beliefs influence reporting and help-seeking behaviour by sexual violence survivors/victims.

Existing intervention and prevention strategies are examined and new services are suggested in the context of Chinese societies.

Five interrelated prevention strategies are proposed for the prevention of sexual violence in mainland China and Hong Kong: (1) legal reform; (2) anti-violence policy; (3) development of professional and specialized services; (4) training for professionals; and (5) research. Recommendations for future research on sexual violence in China are made.

The findings of this paper will inform discussions on how research can be used to strengthen policies and services to better respond to and prevent sexual violence in China.
Lessons from 15 countries: Global HIV/AIDS Initiatives Research Network

Ruairi Brugha, Head of Department, Epidemiology and Public Health Medicine, Population Health Sciences, Royal College of Surgeons in Ireland, Ireland with Aisling Walsh, Neil Spicer and Gill Walt

The Global HIV/AIDS Initiatives Research Network (GHIN), 2006–09, is a network of 17 research groups in 15 countries across Africa, Eastern Europe, Asia (including China) and Latin America, supported by researchers in six northern countries (see www.ghin.lshtm.ac.uk for membership). Studies are assessing the effects of global initiatives on country systems, with most studies focusing on equity of access to HIV-related services at the sub-national level. The network, funded by two donors, is supported by coordinators based in Dublin and London. Five other donors are funding the country studies.

The objectives of GHIN are to: 1) Promote comparability of approaches, methods and research tools across studies with similar objectives; 2) Share expertise across country study teams, build research capacity and promote best research practice; 3) Generate multi-country comparisons and context-specific policy lessons; and 4) Coordinate dissemination of findings and communication with global stakeholders.

Thus far, the results of GHIN are: 1) In response to members’ requests, the network funded regional workshops in Ukraine and Malawi to promote common research approaches in concentrated and generalized HIV epidemics. 2) Members agreed standardized approaches and methods, and country teams have adapted from common research instruments to facilitate comparability. Most studies are independently funded, which has created a new network dynamic, enabling ‘southern’ researchers to decide how they address country-specific contexts. 3) Lesson sharing has occurred across countries, because some country researchers have moved more quickly to implement sub-national level studies. The network has funded south-south capacity-building, utilizing the experience of ‘early starters’. 4) Coordination with other studies is being facilitated, which will be crucial if Global Fund five-year evaluations take place in countries that are implementing GHIN studies. 5) Equitable access to research findings on the country-level effects of global initiatives is a network function, making these available to government and nongovernment knowledge users at global, national and sub-national levels.

Other lessons (February to October 2007) will be shared.

This systematic network approach to collating research into common issues of global and cross-country importance, provides a middle ground between multi-country self-evaluations, funded by global initiatives, and a multiplicity of uncoordinated independent studies of variable quality and focus.
Centres, peripheries, academic colonization
and ‘national science’: the case of Peru

Carlos F Caceres, Professor, Unit of Health, Sexuality and Human Development,
School of Public Health, Cayetano Heredia University, Peru
with Walter Mendoza

The globalization process has raised new concerns regarding global health, among
which are those related to the asymmetries of the north-south research relationship;
particularly in relation to their distinct rationales, approaches and the social values
attached to the research agenda implemented. Such discussions, particularly their
ethical and political implications, constitute a new framework for analysis, from
which new issues and evidence could be raised in order to advocate for health as a key
development variable.

This presentation departs from a discussion of research in public health as a field
with a rationale and specific goals, actors and roles (the state, academia). Subsequently,
it reviews information on the characteristics of health research sponsored and
implemented by the state and its agencies, and also by Peruvian academia. Particular
attention is paid to funding sources, public-private cooperation mechanisms, the type
of research conducted (basic or applied), including their relevance to national health
priorities and policy-making, and the diffusion and use of publications. It continues
to seek explanations for the particular status of health research in each setting, and to
draw conclusions relating to the debate about centres and peripheries, and on locality
vs. globalized research; including ethical review, ethical standards, and its relevance to
addressing neglected diseases and the ‘10/90’ research gap.

Finally, the presentation suggests specific avenues for change, stemming from new
experiences of participatory, and public-private research collaboration, as well as the
strengthening of regional health cooperation agreements involving Latin American
countries. While most attention is given to the case of Peru, a significant part of the
discussion applies to most of Latin America and more generally to countries in the
global south.
Women of colour in the United States of America experience health disparities in research agendas. We suffer from under-researched reproductive health-related illnesses such as fibroids and infertility, while experiencing over-medicalization of our bodies, such as unnecessary caesarian births after normal vaginal deliveries. In addition to the missing research data we face, in terms of understanding and responding to the above-named medical conditions, we also confront the conflation of limited available research data in aggregations that are less than useful. For example, data on black women in the USA conflates data on African American women, African immigrant women, Spanish-speaking black women from Latin America, and Caribbean immigrant women. Similarly, data on Asian American women subsumes specific information needed on Pacific Islander women and other Asian immigrant women.

This presentation will address these research gaps and propose a research agenda to meet this unmet need. This research gap has been identified and studied by the SisterSong Women of Color Reproductive Health Collective, a coalition of 80 women of colour reproductive health advocacy and service delivery groups. The collective is composed of local, regional and national grassroots organizations and individuals who represent the five primary ethnic populations/indigenous nations in the USA: Native American/Indigenous, Black/African American, Latina/Puerto Rican, Arab American/Middle Eastern, and Asian/Pacific Islander.

Founded in 1997, SisterSong is committed to educating women of colour on reproductive and sexual health and rights, and working towards access to health services, information and resources that are culturally and linguistically appropriate through the integration of the disciplines of community organizing, self-help and human rights education. As advocates and service providers, SisterSong has identified some of these research gaps for prominent health research institutions in the USA such as the Centers for Disease Control, the USA Government Office of Women’s Health, and the National Institutes of Health.

This presentation will explore variables of race, class and ethnicity that determine research priorities in the USA and also discuss our progress as women of colour in getting these research needs met.
Control policy optimization for SARS and other emerging infections (SARSTRANS)

Roy Anderson, Professor of Epidemiology, Department of Infectious Disease Epidemiology, Imperial College London, United Kingdom
with CA Donnelly, BX Fan, AJ Hedley, H Heesterbeek, CA Hsiung, GM Leung, AJ Valleron and the SARSTRANS research teams

The evolution, spread and persistence of infectious diseases are facilitated by aspects of contemporary society, for example through more frequent air travel, the growing world population and the increasing number of densely crowded urban areas. Under these conditions, epidemic outbreaks of novel infectious agents are likely to become ever more common. Policy-makers and health workers, therefore, need to be prepared, and the experience with severe acute respiratory syndrome (SARS) has provided important lessons for the future.

The European Union (EU)-funded SARSTRANS project brings together existing knowledge about the SARS virus and its mode of transmission to develop models and analytical methods to inform policy-makers on how to achieve more effective control of infectious diseases. The SARSTRANS consortium has outlined recommendations on the construction and real-time analysis of databases, integrating epidemiological, clinical and treatment information, for the monitoring and evaluation of epidemic outbreaks of infectious diseases. The recommendations cover guidelines for pre-outbreak data collection and analysis, followed by guidelines for outbreak analysis and epidemiological investigations once a new emerging epidemic has been recognized. The effectiveness of control measures is evaluated most effectively through real-time unbiased estimation of the effective reproductive number.

Key epidemiological parameters have been estimated in a comparative epidemiological analysis using the most comprehensive dataset to date, including SARS patients from Hong Kong, Taiwan and Beijing. Demographic and clinical variables were analysed to explain observed differences between the three regions. Although the research was motivated by the SARS epidemic, the mathematical and statistical frameworks developed will facilitate assessment of how best to control the spread of infectious agents depending on various factors, including: the time from infection until symptom onset (the incubation period); the timing on infectiousness relative to the onset of symptoms; the short- and long-distance travel patterns of the population; and any age- or gender-dependence on the susceptibility or severity of the disease.
Country reports on health and poverty

Davidson R Gwatkin, Consultant, USA

The World Bank, in collaboration with the Demographic and Health Survey Program and the Governments of the Netherlands and Sweden, has recently completed a series of country sourcebooks on health and poverty. These present basic data about health inequalities in 56 low- and middle-income countries. The data come from 95 Department of Health Services (DHS) household surveys undertaken in these countries between 1990 and 2005.

Each of the 56 country volumes features estimates for each economically-defined 20% (quintile) of the population, determined by assessing household assets. The assets cover up to approximately 120 indicators of health status, service use, behaviour and related social development. In addition, each country report contains separate estimates for economic quintiles of females and males, and of rural and urban residents; a presentation and discussion of the methods used in preparing the tables; links to other sources of health inequality data; and guidance on using material in the report to monitor how well health projects reach disadvantaged population groups.

An overview report is also available. Each of its principal tables presents data for a single indicator from all countries. Additional contents will include a summary of the principal finding of the country volumes.

The Global Forum for Health Research presentation will provide a brief introduction to the contents of these volumes, to their principal findings, and to ways the data contained in them can be used to inform policy and programme design. Complimentary copies of the overview report will be made available.
Mental health (MH) has been historically neglected in terms of service delivery, research productivity and impact, policy-making and implementation of administrative measures and norms. This results in the inaccessibility of MH care for significant segments of populations, particularly in low- and middle-income countries (LMICs). This report aims at identifying proposals from key MH actors in LMICs, and factors they associate with successful initiatives, implemented in attempts to overcome this iniquitous situation.

Our study is part of a larger initiative of the Global Forum for Health Research, directed to map MH actors and their research agendas in LMICs. The results presented here have been extracted from interviews of 31 informants (i.e. MH professionals, researchers and other stakeholders) in 15 countries in the Latin America and Caribbean (LAC) region.

Most informants agreed that research is a basic step towards achieving better MH; but for this to occur, MH should firstly be perceived as a priority. MH professionals and researchers are aware they should act as dynamic, central agents in sensitizing stakeholders and the general public about MH. On this basis, governments and research institutions will be motivated to allocate resources for infrastructure and professional training to improve research and translation capacities on MH. Stakeholders reporting successful cases, where research findings were followed by implementation of the results into policies or programmes, identified the following factors as pivotal: 1) participation of stakeholders in the generation of research; 2) interest of governmental institutions (e.g. Ministry of Health) in specific MH issues (e.g. drug use, violence); 3) international support (e.g. Pan American Health Organization (PAHO), World Health Organization (WHO), US Government); 4) academic recognition and economic reward to the different MH professionals involved in every step of the process; and 5) the dissemination of research results, in particular through the media.

Due to the scarce resources in LAC countries, support of research efforts is a crucial step in making a rational plan to improve the quality and accessibility of MH care. Several local factors are identified as possible facilitators in building a successful research-translation engine. These factors could provide a solid background for contextualized models aimed at a genuine improvement of MH care in the region.
The biomedical psychiatric model of post-traumatic stress disorder has been criticized in addressing health development needs. This is especially true in situations where mental distress represents a natural response to conditions of protracted conflict and violence, yet does not meet the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for mental health illness.

Diagnosis and treatment of mental health problems in the Occupied Palestinian Territory (OPT) are generally driven by international agencies, focus on acute ailments, and lack an overall strategy based on local need and context. Narrow medicalization and a focus on the individual obscure the social, political and other contextual causes of mental distress and undermine communal responses in addressing these problems.

The Palestinian Adolescents Coping with Trauma Project (PACT) was a research survey of 3500 youth aged 14 to 18 years in the district of Ramallah in 2003. The findings identified a strong relationship between individual and collective trauma that youth experienced and various psychosocial and mental health problems such as depressive-like states, anxiety and poor coping styles.

The goal of PACT is to establish a paradigm shift in policy and interventions – away from narrow clinical programmes towards a network of communal support and services. A social and community approach to addressing the psychosocial and mental health problems among Palestinian youth utilizes existing community structures – community-based rehabilitation projects (CBR) – and involves youth in decision-making. It expands these activities to include culturally appropriate community actions in psychosocial-mental health among youth.

A participatory research-to-action model is being employed to establish initiatives that empower members of the community, and rebuild the social fabric through: 1) using the knowledge, culture, traditions and resources of the community to understand psychosocial health problems and to design interventions; 2) connecting these groups directly with the research process and action model building by putting research knowledge in the hands of those who need to make changes; 3) reconstructing a social-web and sense of community that helps people act together to improve their lives; 4) reinforcing the capacities of youth groups, school health committees, and community agencies to work together in formulating policies, designing programmes, and implementing interventions.
A collaborative research project for mental health human resources improves care and outcomes for depression in clinical sites in Cuba

Martha Fors, Project Manager, International Cooperation, National Center of Clinical Trials, Cuba
with Maria Amparo Pascual, Yudexi Mendoza, Yamile Cachimaille, Roselin Valle, Colleen Cash and Stan Kutcher

The National Center of Clinical Trials of Cuba (CENCEC) engages in drug research and health professional training that result in enhanced services delivery and increased knowledge about the management of various disorders through clinical trials. We have been working with Dalhousie University, Canada for almost five years on a capacity-building project for conducting clinical trials of psychopharmacological drugs. One of the unexpected results of this project was that mental health-care delivery, especially in patients with depression, was also improved in those services where a training programme was delivered.

A questionnaire was designed to take into account different variables, such as the knowledge of physicians about new available medications, disease management, diagnostic tools in use, and service organization.

A total of 10 service recipients, who were trained by researchers, provided feedback via a brief questionnaire; overall participation rates were excellent (more than 90%). The most common treatment for depressive illness was tricyclic antidepressants, even though 100% of the psychiatrists know how to use other treatments appropriately. 95% of the providers adhered to the recommended guidelines for care.

Clinical researchers and site coordinators are able to design, implement and evaluate projects for assessment of new drugs, as well as disseminate their findings. They improve diagnosis and management of depression, and implement effective strategies that can bridge the gap between research and medical care. Researchers identified promising quality improvement strategies to strengthen the ability of primary care providers to diagnose and treat depression in their patients. Research capacity is also a way to improve health care delivery.
National health research system analysis in Viet Nam

Anh Le, Dean, Hanoi School of Public Health, Viet Nam
with Tran H Bich, Le T Ha, Nguyen M Hang, Nguyen H Oanh and Nguyen L Hien

In 2006, Viet Nam embarked on a process of national health research system (NHRS) analysis as part of a five-country Western Pacific collaboration. The NHRS analysis aimed to describe the structure of the NHRS in Viet Nam and provide information that decision-makers could use to strengthen the system.

The analysis used quota sampling to ensure a diversity of research producers, funders, and users across the whole country. The study selected 50 institutions with 94 questionnaires in total. Researchers from Hanoi School of Public Health sent questionnaires to the selected institutions as official Ministry of Health documents. The total number of successfully recruited institutions was 48 (96%). Of the 94 questionnaires distributed, 89 were completed (94.68%). An NHRS mapping exercise identified institutions with roles in research as funders (17), producers (34) and users (38).

The study found that the Viet Nam health research system has many disadvantages: 1) Participation of users in setting priorities is insignificant. 2) Policies and mechanisms that enable the research demands of users to be developed into research proposals are insufficient. 3) Agreement among funders, producers, and users on proposal evaluation criteria and concrete mechanisms in using these proposals is deficient. 4) Ethical and equity considerations are not among the main issues for evaluating a proposal. 5) The NHRS has limited financial resources, health research networks, and collaboration with other researchers and institutions. 6) Researchers have poor or inadequate salaries, benefits, and workspaces or equipment. 7) The national budget for health research is low. 8) Appropriate dissemination of health research results is lacking. 9) Researchers skills are limited. 10) The role of libraries has not been pertinently considered.

NHRS analysis, supported both technically and financially by the World Health Organization Western Pacific Regional Office (WHO-WPRO), provided concrete directions for improving the strategic plan for the long-term, as well as for strengthening the NHRS in Viet Nam in the near future.
National health research systems analysis in Mongolia

Burmaa Badrakhyn, Senior Officer-in-charge of Health Research Policy and Coordination, Scientific Secretary of the Mongolian Academy of Medical Sciences, Health Policy and Planning Department, Ministry of Health, Mongolia with E Erdenechimeg, V Khadkhuu, P Otgonbayar, G Narantsetseg, I Bolormaa and S Enkhbold

In 2006 the Ministry of Health of Mongolia embarked on a process of national health research system (NHRS) analysis as part of a five-country Western Pacific collaboration. The purpose is to improve NHRS in Mongolia based on results from the current evaluation, using internationally recognised methods.

The aims of this initiative are to describe the structure of the NHRS in Mongolia and to provide information that decision-makers can use to strengthen the system.

A review of approaches to research evaluation and NHRS analysis informed the decision to focus on an NHRS mapping exercise and on an institution-level survey of research commissioners, producers and users. A range of potential indicators was assessed and those deemed most useful for the national context were incorporated into the institutional questionnaires. This study built on the works of WHO Health Research Systems Analysis and the Council on Health Research for Development’s (COHRED) framework on NHRS.

To ensure engagement of national stakeholders, an official meeting was organized including representatives from the Ministry of Health, Ministry of Education, Culture and Sciences, Mongolian Academy of Sciences, Science and Technology Foundation, Science and Technology Board and research institutions. Also unofficial meetings were organized with researchers. The research team was approved by the Health Minister. Questionnaires were translated into Mongolian. The study methodology was discussed at a Ministry of Health Science and Technology meeting.

The NHRS mapping exercise identified institutions with roles in commissioning (10), producing (14) and using (267) research. A total of 291 institutions were surveyed and 260 responded (89.3%). Mongolia faces similar constraints to other developing countries in developing its NHRS, such as limited funding allocated to the research area, lack of equipment, limited access to internet communication, inadequate library facilities and researchers lacking skills in survey methods.

The consumers for this survey included public and private health institutions from both urban and rural areas, and researchers from different levels, in order to allow evaluation of accessibility, utilization and the importance of research. Furthermore, it provided evidence for future improvement of NHRS in a broader context including planning, identifying priority areas, involvement of consumers in the research, motivation for conducting research, and creating opportunities for researchers.

The key results/recommendations from this survey should be presented to policymakers at all levels for further consideration, to broaden and strengthen collaboration between research institutions (locally and internationally), as well as encouraging partnership between researchers and consumers.
Health research systems analysis in Shanghai, China

Jie Chen, Professor, Key Laboratory of Health Technology Assessment, Fudan University, People's Republic of China

In 2006, Fudan University embarked on a process of health research system (HRS) analysis as part of a five-country Western Pacific collaboration. China has made significant advances in health research activities, especially in Shanghai, but we do not know if the research is related to the health demand, how research is managed, how funds are allocated, or the status of the research environment.

The aims of this work were to provide evidence to describe the structure of the HRS in Shanghai and provide information that decision-makers could use to strengthen the system.

A review of approaches to research evaluation and HRS analysis informed the decision to focus on a HRS mapping exercise and an institution-level survey of research commissioners, producers and users. A range of potential indicators was assessed and those deemed most useful for the national context incorporated into the institutional questionnaires. This study built on the work of World Health Organization’s Health Research Systems Analysis and the Council on Health Research for Development’s (COHRED) framework on national health research systems (NHRS).

HRS analysis cannot be undertaken as a ‘purely technical’ exercise and for the evidence to be used for sustainable impact, parallel process activities are crucial. To ensure engagement of national stakeholders, the research team invited some related government leaders, such as the directors of the Education Commission, Science and Technology Commission, and the Health Bureau of Shanghai, to constitute a steering group. A workshop was then held with participants invited in the name of the Health Bureau of Shanghai.

The HRS mapping exercise identified institutions with roles in commissioning (4 institutions), producing (20 institutions) and using (26 institutions) research. A total of 60 institutions were surveyed and 50 responded (83.3%).

Governance of the health research system is complicated. There are several funders and several government institutions involved. But there is no integrated information collection system and there is no formal ethical review system. The results of the institutional survey show that most of the resources are allocated to basic and clinical medicine. The number of projects related to national priorities is smaller than the number related to other topics. Most of the funds are allocated to high-technology medicine. Many of the results of research projects are not applicable.

Health policies need to be made according to health priorities. Similarly, research priorities need to match health needs. Resources must be allocated to research priorities, policy-makers must consider inequities, and the management of research projects must be optimized.
National health research systems analysis in the Philippines

Merlita Opeña, Division Chief, Research Information, Communication and Utilization Division, Philippine Council for Health Research and Development, Department of Science and Technology, Philippines
with Jaime C Montoya

In 2006, the Philippine Council for Health Research and Development, the lead coordinator of the Philippine National Health Research System (PNHRS), embarked on a process of national health research system analysis as part of a five-country Western Pacific collaboration. This analysis follows on from the earlier situation, which resulted from the work of the different PNHRS committees in 2004, based on focus group discussions and analysis of secondary documents. The primary data, which will be obtained through the complementary World Health Organization (WHO) and Philippine Council for Health Research and Development (PCHRD) survey questionnaires, will enable the PNHRS to assess the use of health research resources for 2001–2005. This project builds on the work of WHO on health research system analysis and mapping of NHRS conducted by the Council on Health Research for Development (COHRED).

The aims of this work are to provide evidence to describe the structure of the NHRS in the Philippines and provide information that decision-makers could use to strengthen the system.

A review of approaches to research evaluation and NHRS analysis informed the decision to focus on an NHRS mapping exercise and an institution level survey of research commissioners, producers and users. A range of potential indicators was assessed and those deemed most useful for the national context incorporated into the institutional questionnaires.

To engage stakeholders, the assessment was undertaken in selected institutions which manifested active research activities in a purposive manner. A cross-section of the stakeholders within respondent institutions, representing their multi-dimensional roles as producers, users and funders, were invited to attend the briefing/consultation.

The NHRS mapping exercise identified institutions that perform the three roles of producer, user and funder; mainly universities and research organizations. A team from the PCHRD visited and surveyed 153 institutions nationwide and in some of these visits, partners from the Department of Health joined. To date, 37 institutions have returned their questionnaires. Follow-up work to increase survey returns is currently being undertaken, together with parallel fielding of questionnaires to users and funders.

Bringing together a multidisciplinary group from within a respondent institution, as observed, has already stimulated a mindset that intra-institutional networking is a good approach to capacitating institutions to be active in the PNHRS.

Difficulty in retrieving the questionnaires may be attributed to the intensive data requirement needed for the financial portion of the WHO questionnaire.
plus the PCHRD supplemental questionnaire, which needs a thorough review of interdepartmental data. This difficulty is exacerbated if the institution’s research information system is not in place.

The results of the WHO and PCHRD integrated survey are expected to guide the PCHRD and the PNHRS in planning health research activities for the next five years.
National health research systems: analyses from the Western Pacific

Andrew Kennedy, Senior Research Officer, Council on Health Research for Development (COHRED), Switzerland
with Le Vu Anh, Tran Huu Bich, Badrakh Burmaa, Jaime Montoya, Merlita Opena and Vonthanak Saphonn

In 2006, five countries in the Western Pacific: Cambodia, China (Shanghai), Mongolia, the Philippines, and Viet Nam embarked on a process of national health research system (NHRS) analysis. The aims of this work were to provide evidence to inform NHRS development in these countries and develop methods and processes that could be used by other countries in the region.

A project development workshop, jointly sponsored by the World Health Organization Regional Office for the Western Pacific and the Council on Health Research for Development (COHRED), and hosted by the Institute for Health Systems Research, Malaysia, was used to review approaches to research evaluation and NHRS analysis, and identify information needs from the country perspectives. The workshop was conducted in a format to facilitate learning between countries, and previous experience of NHRS analysis from China, Laos, Malaysia, and the Philippines were found to be particularly useful.

Based on the review and country experiences, it was decided that the multi-country collaboration would focus activities on a NHRS mapping exercise and an institution-level assessment of research commissioners, producers and users. These activities build on the work of the World Health Organization’s Health Research Systems Analysis and COHRED’s NHRS framework. In China, the focus was extended to provide information on the extent to which the NHRS conducted research that could be used to address issues of inequity.

It was also acknowledged that NHRS analysis cannot be undertaken as a ‘purely technical’ exercise and for the evidence to be used for sustainable impact, parallel process activities are crucial. In adapting the design of the project to each country’s context, identification of the key stakeholders and strategies for engaging them were carefully considered.

Researchers from the five country teams will present the results of these studies reflecting on the methods used and the process undertaken to engage national stakeholders; and highlighting key findings and implications for NHRS decision-makers.
Thursday 1 November 13.30–15.00
PARALLEL SESSION: POLICY COHERENCE FOR PRODUCT DEVELOPMENT AND ACCESS

Introducing human papillomavirus (HPV) vaccines in the developing world: bridging reproductive health and the global response to HIV

Robert Hecht, Senior Vice-President, Public Policy, International AIDS Vaccine Initiative, USA
with Julie Becker and Gabrielle Lamourelle

The commercial debut of two highly promising vaccines against the human papillomavirus (HPV) presents the HIV vaccine community with a unique opportunity to contribute to the rapid introduction and uptake of HPV vaccines in low- and middle-income countries, and to transmit the valuable knowledge gained to the HIV vaccine field. HPV pilot projects currently underway to develop and evaluate HPV vaccine delivery strategies for adolescent girls and associated policy efforts, will be instrumental in developing tools to aid decision-making and planning processes for HPV vaccine introduction. These introduction efforts can serve as a platform to accelerate future HIV vaccine introduction and access in both industrialized and developing countries.

The presentation will discuss the range of factors and issues common to HPV and HIV vaccines, and areas in which the reproductive health and HIV fields may gain most by working collaboratively. These include, for example: the social and logistical challenges of prioritizing pre-adolescents or adolescents for immunization; developing approaches to communicating complex concepts such as partial efficacy; approaches to garnering community and political support; addressing concerns about sexuality and stigma in a vaccination programme; and the importance of women, as users of vaccines and facilitators of access. The presentation will also describe a new project of the International AIDS Vaccine Initiative to ensure a continual exchange of learning between the HPV operational research/pilot introduction efforts and the HIV vaccine field, and will discuss the areas in which the HPV vaccine field can take advantage of HIV vaccine experience in policy research and analysis, global advocacy and vaccine preparedness.

Operational research and pilot interventions to test approaches to HPV vaccine introduction will produce important lessons about facilitators of and barriers to access, which will be applied to the scale-up of HPV vaccination programmes. These lessons will also inform delivery and introduction strategies for other interventions facing similar social, economic, political and/or logistical challenges. As such, evaluating effective delivery strategies for HPV vaccines offers the international health community a special opportunity to support equitable access to recently developed tools, as well as prevention technologies still in development, such as HIV vaccines and microbicides.
Ensuring access to new tuberculosis drugs: results from a global analysis

Heather Ignatius, Policy Officer, Policy, Global Alliance for TB Drug Development, USA
with Nina Schwalbe

Over the past five years there has been a dramatic increase in investment by foundations and donor countries in developing new drugs, diagnostics and vaccines for diseases of poverty. A critical component of this investment has been a commitment by donors that these products, once developed, will be accessible to those most in need.

With funding from the Government of the Netherlands, the Global Alliance for TB Drug Development, a product development partnership focused on shortening and simplifying tuberculosis (TB) treatment, carried out a study to analyse drug procurement and distribution systems in 10 countries. The study also quantified the market value for TB drugs in these countries and globally. Brazil, China, India, Indonesia, South Africa and the Philippines were selected for in-depth analysis because they account for over 50 percent of the global TB burden and have a perceived high value of drug sales. The United States of America (USA), the United Kingdom (UK), France and Japan were also analysed. Although these countries have a relatively low TB burden, they account for a majority of the total global market for all pharmaceuticals and represent a significant value in terms of the global TB market because of higher cost of medicines in these countries. Research methods included both qualitative and quantitative analyses. Primary and secondary data were used to map the flow of TB medicines from the supplier to the end-user, the selection process for suppliers, and the role of public and private payers for first- and second-line TB medicines.

With regard to procurement and distribution, the findings varied dramatically by country, suggesting that drug developers will need to engage in country-specific as well as global launch plans to enable adoption of new drugs and regimens as they become available. With regard to the TB drug market, the global market for first-line TB drugs is approximately US$ 285 million per year and highly fragmented in terms of both purchasers and suppliers. Given that drugs are provided in combinations, the market for any of the individual agents is a fraction of this amount and is split among a large number of suppliers. Local production and procurement play a strong role relative to global pooled procurement.
New malaria products: addressing the bottlenecks

Mary Moran, Director, Pharmaceutical Research and Development Policy Project, Health Policy Division, The George Institute for International Health, Australia with Javier Guzman, Anne-Laure Ropars, Margaret Jorgenson, Alina McDonald, Sarah Potter and Hiwot Haile-Selassie

Over the past two decades, and particularly in the last 5–6 years, there have been efforts to find more effective malaria drugs and a potent malaria vaccine that could dramatically reduce malaria mortality, particularly among the children and pregnant women of Africa. In the field of malaria drugs, this goal has been partially reached with the advent of artemisinin combinations, while new therapies now in clinical development promise to deliver even more cost-effective products by 2010. A partially effective malaria vaccine is also in advanced trials and work is continuing to find a more immunogenic and long-lasting vaccine.

In an effort to bring these new products to fruition, public and private funders have invested considerable sums in different approaches, including grants and intramural funding to public and institutional groups, direct funding to product development partnerships, and creation of public purchase ‘markets’ to stimulate private companies. Additionally, some funders have focused on building African trial infrastructure, which is often seen as a major bottleneck in malaria vaccine development.

This study analyses current malaria drug and vaccine product research and development (R&D), including by private pharmaceutical firms, public and academic groups, and product development partnerships; and identifies the likely donor funding needed to support clinical development of this portfolio, and the most efficient way of allocating this funding.

Research outcomes include an empirical review of current malaria vaccine and drug R&D; analysis of key R&D gaps and bottlenecks; identification of the global funding needed for clinical development of the current portfolio; and recommendations for how and where this funding could most efficiently be allocated. Using a pipeline simulation model, we have projected the likely cost of different scientific, regulatory and policy approaches to clinical development of the current malaria product portfolio, and the associated demands these impose on trial sites in terms of both trial size and trial numbers. We hope that this combination of up-to-date empirical information, in-depth analysis and pragmatic modeling will assist donors in making rational future funding and policy choices.
Links between poverty and major illness in poor rural areas of China

Henry Lucas, Research Fellow, Institute of Development Studies, University of Sussex, United Kingdom
with Ding Shijun

Major illness has become an important cause of rural household impoverishment in China as it manages the transition to a market economy. This is related to the rising cost of health care and the relatively low levels of government subsidy. The recently introduced risk-pooling scheme known as the ‘new CMS’ (Cooperative Medical Scheme) was intended to address this issue.

This paper reports the initial findings of research intended to contribute to knowledge about the most effective ways to help households cope with major illness. A limited number of geographical case studies were undertaken, based on purposely selected counties in China. In each of these areas a rapid, large-scale household survey was undertaken, with the objective of identifying households substantially affected by different categories of serious health problems. In-depth studies of a stratified sample of these households were then used to explore the detailed impact of ill-health on: household and individual well-being; health care-seeking behaviour; coping strategies; health care-related costs; and the extent and effectiveness of the support provided by formal assistance schemes or other sources.
The role of demographic sites in designing evidence-based health interventions: experiences from Bangladesh

Abbas Bhuiya, Senior Social Scientist, International Centre for Diarrhoeal Disease Research (ICDDR,B), Bangladesh

National health and demographic information systems are deficient in almost all developing countries. Bangladesh, however, is fortunate to have a 40-year-old demographic site in one of its sub-districts known as Matlab. There are also three other sites that were started much later. All these sites were established and have been run by the International Centre for Diarrhoeal Disease Research (ICDDR), an international health and population research centre based in Dhaka, Bangladesh. The sites have been generating valuable information on mortality, morbidity and their socioeconomic differentials on the one hand, and have enabled evaluation of the impact of health and population interventions on the other.

Community trials of the efficacy of oral rehydration therapy, tetanus toxoid, and various cholera vaccines, and an evaluation of the impact of interventions on maternal and child health and family planning, poverty alleviation, and community-led primary health care were made possible using these sites.

Evidence generated from these sites has influenced national and international policies and programmes significantly. The paper will explore possible future site uses that focus more directly on health-poverty linkages and the impact of social protection measures.
Institutions and the implementation of pro-poor interventions in rural China

Xiaomei Pei, Professor, Department of Sociology, Tsinghua University, People’s Republic of China
with Gerald Bloom and Bruno Meesen

This paper argues that institutional arrangements strongly influence the capacity of governments to implement pro-poor health interventions. Policies that do not take the role of institutions and their development into account are unlikely to have the intended impact. This is particularly important in countries experiencing rapid economic, social and institutional change. The paper illustrates this with the case of China, where the health system is adapting to the transition to a market economy and associated changes in the relationship between levels of government and between the government and health-service providers. It presents findings from studies of institutional influences on the performance of rural hospitals in two Chinese provinces and concludes with a discussion of how governments can use this kind of evidence in designing policies and implementation strategies.
Two phenomena, one of which relates to the area of human reproduction and the other to the frequency, distribution and control of disease in a population have emerged in the previous century and continue to develop intensively. Both these phenomena are directly related to the changes that are occurring in the incidence and prevalence of malignant tumours, as well as to mortality from them and to the opportunities for cancer control. The first of these phenomena has been denominated as demographic, and the second as an epidemiological transition.

The commonly accepted definition of a demographic transition is currently applied to designate a sustainable change in the type of population reproduction, when an initial and abrupt acceleration of population growth is replaced by its rapid deceleration with a subsequent stabilization of a population and a sharp change in its age structure. Demographic transition develops in a brief historical space of time and has the character of a global process. Population aging and disequilibrium between the younger and older generations are the most important consequences of the demographic transition, and must inevitably influence the strategy and implementation of national cancer control programmes.

As life expectancy increases, so does the certainty that people will become more and more prone to diseases that are more common among older age groups, i.e. noncommunicable diseases and cancer in particular, rather than being affected by epidemics of infectious diseases. This situation is known as the epidemiological transition and reflects spectacular shifts in the pattern and causes of death and morbidity that have taken place in the vast majority of countries over the previous century. Epidemiological transition results in accession by poor countries to the problems of the rich, and leads to the ‘double burden’ of disease in countries whose economies are undergoing transition, because of the still continuing heavy burden of endemic infectious diseases.

The majority of developing countries, with their fluctuating economies and low level of population income, are entering the final stages, both of the demographic and the epidemiological transition, a period when increasing demands on the systems of social protection and public health are inevitable. According to recent global estimates the number of new cancer cases in the year 2006 exceeded 12 million, and the number of deaths from cancer reached almost 7 million. The annual growth rate of global cancer incidence during the last 30–35 years was higher than the global population growth rate.

Analysis of data available from several reliable population-based and personalized cancer registries in different regions of the world confirms the conclusion that cancer is mainly the fate of people belonging to the older age groups. Given the levels of exposure to specific carcinogens and genetic predisposition factors, the incidence of cancer should be considered an exponential function of age.
The unfeasibility of attempts to change, in the foreseeable future, the rate and trend of demographic transition and population ageing, in particular, is obvious. It would therefore be more rational to envisage their probable consequences and to adapt the limited resources of national health and social support services to the needs of cancer control, which will significantly increase in the very near future.
Urban poverty and social exclusion: challenges ahead

Sabina Faiz Rashid, Assistant Professor, School of Public Health, James P Grant School of Public Health, BRAC University, Bangladesh

Urban slum populations around the world provide important case studies of the impact of systemic, structural and social inequalities, which exclude them and critically shape their lives and health experiences.

Let me begin with the story of Farida, an adolescent mother who a few weeks after giving birth to her second child in a Dhaka slum, was forcibly evicted overnight by the government, leaving them homeless and without access to health services. This is typical for the 4 million slum dwellers residing in Bangladesh's capital, Dhaka city.

Farida's story will also resonate among 1.9 poor urban dwellers living in low- and middle-income nations in Africa, Asia and Latin America and the Caribbean who represent two-thirds of the world's urban population. At least 600 million of these have income and asset bases too low to cover the costs of essentials, and live in homes that are congested, have poor sanitation and overflowing sewage, face rampant crime, extortion and violence and inadequate basic services (e.g. education, health), placing them at constant vulnerability and risk.

This presentation draws on primary ethnographic research in Bangladesh and case studies from around the world to demonstrate how living in such dismal conditions, together with the larger external forces of national policies, result in urban poor populations bearing the brunt of social, political and economic exclusion and its multiple consequences on their lives, bodies and health.

Urban poverty is one of the most significant issues and challenges facing many countries in the world, and urbanization and its effects on health remain poorly understood and overlooked. To improve the lives of people who live in slums and to work towards achieving the Millennium Development Goals requires community empowerment, good local governance, dialogues among all stakeholders (development agencies, donors and other local actors) and political commitment from the state.
In recognition of emerging and re-emerging environmental health issues and the special vulnerability of children to environmental hazards, the World Health Organization (WHO) and its partners have, with support from the National Institute of Environmental Health Research (NIEHS), significantly strengthened and integrated its activities related to children’s health and the environment.

In addition to forming a multistakeholder global alliance to implement worldwide action on reducing environmental risks to children, WHO promotes research collaboration in children’s environmental health among scientists in developing and developed countries. Such research collaborations are critical to addressing health problems in their national and local contexts, and must involve local communities.

Cooperative research activities started through the twinning of scientists from industrialized and developing countries, and the promotion of harmonized core research protocols. The strategy adopted combines a regional approach with a stepwise process that includes: 1) establishing expert advisory groups; 2) identifying key concerns, assessing issues and data gaps; 3) promoting and following-up collaborative research activities.

Ongoing international collaboration on issues such as asthma in children, arsenic exposure during pregnancy/early childhood, biomonitoring of persistent toxic substances, biomarkers of benzene exposure and longitudinal cohort studies are presented. The results of these research studies will be used to recommend specific prevention and remediation strategies, and other interventions, and also to promote evidence-based public health policies at the community level. These collaborative activities also result in technology transfer and capacity-building, and in the build up of a network of trained scientific collaborators throughout the developing world.
Globalization and health equity: innovation for an interconnected world

Ronald Labonte, Canada Research Chair, Globalization and Health Equity, Institute of Population Health, University of Ottawa, Canada
with Ted Schrecker

Transnational economic integration (globalization) is arguably the most important element of the context for improving health equity. Although its benefits in terms of access to social determinants of health (SDH) (as through poverty reduction) are potentially substantial, those benefits are ‘asymmetrically’ distributed within and among nations, reflecting the highly unequal global distribution of economic and political power.

Based in part on evidence assembled by the Globalization Knowledge Network of the World Health Organization (WHO) Commission on Social Determinants of Health, this paper describes major pathways that lead from globalization to health outcomes by way of SDH, and identify priorities for policy innovation. National governments can do more than they have to improve health equity within the context provided by globalization. Opportunities include: avoiding new commitments to liberalize trade in health systems; avoiding net revenue losses from tariff reduction; favouring publicly funded and universal health systems; and putting in place systems of social protection that go beyond residual minima. These are consistent with, and arguably required by, progressive realization of the human right to health.

An increasingly interconnected world creates distinctive obligations for rich nations, which extend outside their own borders. In addition to supporting national policies to improve health equity, opportunities include: reviving multilateral trade negotiations in a way that recognizes the distinctive flexibility needed by developing economies and prioritizes health equity; more extensive cancellation of external debt; increasing the value of development assistance while ensuring that it is effectively directed toward health and other basic needs; devising mechanisms to prevent financial crises and their destructive impact on employment and social provision; finding new ways of financing the provision of global public goods; and incorporating global health equity in the mandates of key multilateral agencies.

These findings point not only to priorities for further research, largely outside the health sciences, but also to the need for health researchers to familiarize themselves with the relevant policy debates and engage nationally and internationally with efforts to entrench health equity as a key concern of domestic and foreign policy outside the health sector.
Health research utilizes the natural and social sciences: empirical sciences based on hypothesis testing through observation or experiment. As such, scientific evidence is subject to and derived from our experiences or observations.

Scientific communities consist of researchers who share paradigms. They have similar educational backgrounds, have absorbed the same technical literature and drawn many of the same lessons from it. As a result, members of a given scientific community see themselves – and are seen by others – as responsible for the pursuit of a set of shared goals. Within such groups, communication is relatively full and professional judgments fairly unanimous.

Global health research consists of scientific communities with varying paradigms joined in the pursuit of a common goal: to address the ‘10/90’ gap. Professional communication across group lines can be demanding and at times results in misunderstandings or unexpected disagreement. The global health research community aims to address global health challenges and enhance equitable access to health, decision-making and governance. With this objective in mind, communication, as well as information and knowledge management are essential to success.

During the past decades, the global resource allocations for health and health research have increased, but limited coordination of narrowly channeled funding for high-profile diseases has weakened the national health and research systems, largely hindering equitable growth and sustainable development. This, and the increased global focus on externally defined result frameworks and indicators, is likely to result in a further weakening of the national health and research systems.

It is time for a paradigm shift. In the pursuit of new values aiming at a more holistic approach to health, and as an integrated part of equitable development, global health research communities need to cease circular arguments in defense of their paradigms. The international community needs to harmonize its efforts in support of locally-owned national development plans and budgets, which enable low- and middle-income countries to take ownership of development, and invest in health and health research capacity-building, as an integrated part of the national programme for science, technology and innovation.
**Clustering of caesarean deliveries in developing countries: lack of access for some and overprovision for others**

Sara Holtz*, Student, Population, Family and Reproductive Health, Johns Hopkins Bloomberg School of Public Health, USA with Nan M Astone and Cynthia K. Stanton

* to be presented by Cynthia K Stanton

Approximately 529,000 women die each year of maternal causes; an estimated 99% of these women live in developing countries. Most complications of childbirth cannot be predicted, but many of these deaths are preventable by early detection and management, including caesarean section delivery. Low maternal mortality cannot be achieved without access to this life-saving operation. Access to obstetric care remains a critical issue in many developing countries. One would anticipate that the further a woman has to travel to receive care, the more likely receipt of this care will be delayed, the complication will become aggravated, and the poorer will be the outcome compared to a woman who lives closer to a facility.

The World Health Organization (WHO) has declared: “countries that have successfully managed to make motherhood safer … made sure that access to these services – financial and geographical – would be guaranteed for the entire population.”

The aim of this study of Demographic and Health Survey caesarean data from 43 countries in sub-Saharan Africa, Latin America and South and South-East Asia is to determine whether caesarean deliveries cluster geographically and whether this clustering persists after controlling for individual and household characteristics that affect the risk of delivery by caesarean.

Preliminary investigation of the extent of clustering reveals that a large proportion of both small (cluster) and large (strata) geographic units in these countries do not have a single reported caesarean. Statistical analyses provide further evidence of geographic clustering of caesareans in 30 countries but finds no clustering in 13 countries. After accounting for the geographic clustering of household wealth, the clustering of caesareans is eliminated in 22 countries but persists in 8. In these eight countries, where a woman lives has an important effect on whether she has a caesarean, irrespective of her household wealth. This may indicate structural variation in the probability of delivering by caesarean. The most effective intervention to achieve substantial increases in access to and use of caesarean delivery may be a policy of geographic targeting to identify areas with low use and either upgrade or build health facilities in the areas that currently lack health services.
How effective are national programmes on maternal and child health (MCH) in promoting women’s equitable access to health care?

Tuohong Zhang, Professor, Department of Health Policy and Management, School of Public Health, Peking University, People’s Republic of China with Joanna Raven, Lennart Bogg and Eva Johansson

The Law of Maternal and Infant Care in China was enacted in 1995 and was followed by national programmes that aim to improve health for all women, and pregnant women in particular. The focus of this research is on assessing women’s access to maternal and child health (MCH) services, including for those women who live far from health facilities and have low incomes. The research also aims to offer strategies for the government to develop MCH services.

Qualitative approaches, including focus group discussions and key informant interviews, were adopted to explore how MCH services worked in improving health care for women in six counties of three provinces with varying socio-economic development. Both health-care providers and users were interviewed using a semi-structured topic guide. The relevant questions to this study were: How are MCH services funded and how are MCH facilities equipped? What groups of women use the MCH facilities? Which groups do not use these services and why?

Although MCH services have been widely recognized as an important component of public health, they are not yet well funded. Most MCH facilities have to make money through fee-for-service approaches, for health promotion, prenatal care and postnatal visits. In addition, the infrastructure and equipment are less than satisfactory, especially at township level. Because the women have to pay an out-of-pocket fee for their perinatal care, the poorest choose not to have prenatal check-ups and deliver at home. Some women deliver at home because of transportation difficulties. This happens most frequently in mountainous and poor counties, and those with less satisfactory health facilities. Lack of health care awareness and health information is another reason why women deliver at home.

National programmes on MCH need to focus more on the poor and those who live in remote areas. In addition, prenatal check-ups and postnatal visits should be strengthened to ensure the mothers’ safety.
Poster sessions
The central concern of this paper is the relationship between socioeconomic status and reported health, as captured in living standard measurement surveys. Reported health is distinguished by the fact that it is based on the individual’s own assessment of his or her physical status rather than being based on some clinical assessment of the individual’s physiological condition. Reported health, therefore, reflects those social factors such as educational levels, access to medical facilities, material deprivation and levels of social exclusion that influence levels of awareness.

An understanding of the relationship between the two variables is important given the central place that the surveys have come to have in the policy-making arena of many of the poorer countries of the world. Furthermore, the association of these surveys with the advent of economic neo-liberalism suggests that they will continue to be an important policy tool in these countries in the foreseeable future.

The paper posits that the institutionalization of living standard measurement surveys in these countries has provided the potential to answer such critical questions of policy as: 1) the nature of the socioeconomic status of the diseases that account for morbidity and mortality in any place; 2) the levels of illness reported by the poor and the non-poor; 3) the ways in which illness affects the poor by age and sex; 4) how poverty affects access to and use of health-care facilities; 5) how environmental factors affect the health status of the poor. Underlying all of these questions, though, is the issue of the nature of the relationship between reported health and socioeconomic status. The paper draws on data from the English-speaking Caribbean to examine this relationship and the health policy implications that follow from it. It then goes on to examine the ways in which this information can be used to foster equity and improve the health status of the poor.
Brazilian information system on science, technology and innovation in health

Maria Cristina Costa de Arrochela Lobo, Coordinator of Communication and Information, Department of Science and Technology in Health, Secretariat of Science, Technology and Strategic Inputs, Ministry of Health, Brazil
with Jacqueline Gagliardi, David Abreu, Karla Lisboa, Suzanne Serruya and Alfredo Schechtman

In 2004, the Brazil Ministry of Health mobilized managers, researchers and users in the Science and Technology in Health (STH) field to assemble two essential documents: The National Policy on Science, Technology and Innovation in Health and the National Agenda of Priorities in Health Research. This gathering concerning actors from different backgrounds represented an important step towards redirecting Brazilian efforts to develop new ways to sponsor health research, strengthening the links between health research and the population’s health needs.

Furthermore, there was a significant increase in financial resources for Brazilian health research that, in turn, fostered health projects supported by the Department of Science and Technology (DECIT) of the Brazil Ministry of Health. Currently, DECIT sponsors around 1,800 health research projects in various areas, including neglected diseases, vulnerable populations, food and nutrition, etc.

In order to properly follow-up and monitor the health research efforts sponsored by DECIT, which have grown significantly, the department is developing a project on Science, Technology and Innovation in Health Information, comprising: an automated system for organizing health research information and generating reports based on indicators related to STH. The project aims to redefine related development strategies, and will feature an Internet-based interface that will facilitate dissemination of research outcomes among managers, researchers and users of public health services.

By developing this information system, DECIT expects to produce high quality information to support health managers’ decision-making; foster networking among researchers, thus contributing towards enhancing the interchange of experiences and expertise; and, publicize the latest discoveries in the health field among users (politicians, managers, health professionals, and the general population) using a language that is easily understood by everyone.

It is our hope that this process will contribute to minimizing the inequity in health, further challenge the culture of keeping knowledge isolated and bring it to those who need it most.
Rural-urban migrant health and migrant access to public health services in China: a case study of a migrant community in Beijing

Yan Li, PhD Student, Centre for International Public Health Policy, School of Health in Social Science, University of Edinburgh, United Kingdom
with Lina Song

The rapidly growing scale and types of rural-urban migration in China raise specific questions for public health and are of great contemporary policy interest but have been neglected by scientific research.

This paper explores whether rural-urban labour migrants are particularly vulnerable to health risks based on a review of key health issues, such as occupational health and health problems related to living conditions. The study will also analyse the possible determinants and consequences of various health problems among migrants by examining their health activities and behaviours, and discuss related policy issues, identifying gaps in the existing literature.

The objectives of this paper are as follows: 1) to discuss the living and working conditions that leave migrants vulnerable to health risks; 2) to describe health care-seeking activities; 3) to evaluate the position of rural-urban migrants in the new health care system; developing a new channel of health service provision for migrants.

This paper utilizes a qualitative case study with a typical rural migrant community: Dengcun village in Beijing.

Results show that temporary migrants are particularly vulnerable to health risks due to their poor working conditions and living standards. The paper investigates the health care-seeking behaviours of migrants and suggests that the main difficulties in accessing health services are not their low income or their lack of health awareness. Rather the main barriers are the institutional arrangements regarding health security and service provision, rural-urban dualism and a unique household registration system in China that makes it difficult for migrants to access public health services in either cities or rural areas. This paper explores the question of why migrants are not covered in the new medical care system. It suggests that although different priorities in health policy should be applied to different groups of migrants and non-migrants, it may not be realistic to expect migrants to be included in the formal health-care system in the near future. Finally, the paper suggests a possible means to provide basic health care for migrants.
Are the reforms of the health sector responding to Latin America’s health challenges? The case of Mexico’s Seguro Popular

Hector Ochoa, Researcher, Health, Society, Culture and Health, El Colegio de Frontera Sur, Mexico
with Rosario García

Following the economic crisis of the eighties, and the ‘structural adjustment’ advocated by the International Monetary Fund (IMF), public expenditure in health in most Latin American countries was reduced substantially. As a consequence, health-care systems weakened and inequities in both health status and health care increased. Multilateral organizations, such as the World Bank and the Inter-American Development Bank (IDB), responded to this situation by promoting neo-liberal reform of the health sector in the region based on privatization and decentralization. Among the principle Latin American examples of this are health reforms taking place in Chile, Costa Rica, Colombia and recently in Mexico.

By analysing the effectiveness of Mexico’s Seguro Popular (popular health insurance) to improve equity, efficiency and quality of health services, this presentation is aimed at responding to the following question: What lessons for Latin America and elsewhere could be drawn from the Mexican experience?

The study uses secondary data from national household health, income and expenditure surveys, national health accounts data, health status, health services and resource statistics, statistics from the National Commission for Social Protection and data from the authors’ own work in Chiapas in southeastern Mexico.

The achievements, drawbacks and problems of Seguro Popular have been analysed by reviewing various aspects such as: the involvement of the main stakeholders (e.g. legislators, health workers, patients and civil society) in the design; national and international evidence used; conceptual orientation (health objectives vs. economic rationality); type of decentralization of decision-making, planning, budgeting and management; content of the health-care services packages; orientation of health programmes (selective vertical vs. horizontal); costs and quality of health-care services; sufficiency of human and financial resources to meet the goals; impact on improving health status and reducing health-care inequities; and impact on health workers salaries and working conditions.

This study recommends the implementation of mechanisms for public monitoring of the performance of Seguro Popular, particularly on health status results and use of financial resources in a more transparent way. Conditions under which the agreements between the federal and state governments were signed should be fully disclosed to the public. The importance of analysis and evaluation of the programme by independent research teams is stressed. Recommendations focus on ways to emphasize the social dimension of health and health care by transforming the minimum health package for the poor to a comprehensive and high-quality health-care service centered on populations’ needs and concerns.
Inclusive health research for equitable access to health

Pia Rockhold, Senior Operation Officer, Disability and Development, Human Development Network, World Bank, Washington DC

To enhance equitable access to health for people living with chronic health problems, functional limitations or disabilities, we must move away from the traditional conceptual model of health and disability towards a more holistic understanding of the determinants and consequences of health as they are experienced at individual and social levels. Subjective health experiences occur in specific contexts and cannot be divorced from personal and environmental factors that may differ between various social, cultural and geographical settings. Disability is a universally used, yet ambiguous term. It is not a defining feature of a minority of people, but a continuum of levels and degrees of health and functionality influenced by cultural expectations and contextual factors, such as access to social services, chronic disease management, rehabilitation, assistive devices, personal assistance and environmental modifications and adaptations. Disability is the outcome of a complex relationship between an individual’s health condition, body function, structure and activity, participation restrictions and the environment.

The concepts of health and disability vary across cultures and sub-cultures, but some universal commonalities of disability include physical, social and attitudinal barriers, stigma and the lack of parity between disabilities.

Social attitudes differ across cultures according to views regarding the responsibility of people with disabilities for the cause of their disability. If the individual or family is seen as being at fault, the society is less likely to support and accommodate people with disabilities. As such, individuals living with a chronic health condition or disability are limited not so much by their impairment, but by the social interpretation of that condition. In resource-poor and unstable environments, such individuals may be marginalized even further.

Inclusive health research for equitable access to health must adopt a rights-based approach, including marginalized groups in all stages of the process from problem identification to policy formulation and action. Based on a holistic model of health, such research reaches beyond natural science, prevention, early diagnosis and cure to include social science, chronic disease management, rehabilitation and inclusion.
Regional strategy for knowledge management to support public health

Najeeb Al-Shorbaji, Coordinator, Knowledge Management and Sharing, Regional Office for the Eastern Mediterranean, World Health Organization (WHO), Cairo

The regional strategy on knowledge management aims to: increase awareness and understanding of knowledge management; identify potential benefits of knowledge management to all stakeholders; provide a framework for resource mobilization in support of specific projects; communicate good knowledge management practice; act as a basis for operational plans for knowledge management at both regional and national levels; and present a road map for action and a mechanism for monitoring of progress.

The strategy sets strategic directions for action in support of knowledge management both at regional and country levels. Strategic directions at regional level include managing knowledge policies at the World Health Organization (WHO) Regional Office for the Eastern Mediterranean (EMRO), enhancing publishing and dissemination of health information, promoting electronic publishing, strengthening multilingualism, and enhancing networking and communication. EMRO is also developing the Eastern Mediterranean Knowledge Network (EMKNet) as a strategic solution for networking and a platform for knowledge sharing in the region.

At country level, strategic directions are to leverage e-health, or the use of information-communication technology (ICT) in health; build capacity for needs assessment, planning and evaluation; strengthen national programmes for knowledge management; enhance ICT infrastructure in health-care institutions; develop human resources; strengthen knowledge translation; promote knowledge generation; and develop knowledge hubs in WHO country offices.

Development and sustainability of EMKNet represent the collective efforts of EMRO and member states to create an integrated system for profiling of knowledge assets including people, studies/reports and institutions with an intelligent interface to support identification of best practices, expertise and evidence. Building of the core network will be based on the identification of the top 200 researchers in the region based on the number of citations each of them has in the Index Medicus for the Eastern Mediterranean and PubMed. For each author/researcher a profile will be built with specific reference to his/her area of expertise and affiliation.
The tsunami disaster of 2004 made a tremendous impact on the health system of Sri Lanka, which left 104 health-care institutions damaged island-wide while destroying the health-care delivery network in most provinces. International donors came forward with substantial support to rebuild the health sector, capitalizing on worldwide sympathy for affected people and communities.

This descriptive study was undertaken in order to document the progress of donor programmes in relation to initial commitments and to recommend actions to be taken on donor-funded projects following a disaster. The data was gathered from the tsunami secretariat of the Sri Lanka Ministry of Health and the Reconstruction and Development Agency (RADA) of Sri Lanka.

The Ministry of Health signed 53 Memoranda of Understanding (MOU) with different donor partners to renovate and reconstruct the damaged (and 32 undamaged) institutions. The total commitment was US$ 207 million, to 243 specific projects.

The government, in partnership with development organizations, identified the following priorities for interventions: reconstruction of damaged institutions; construction to prevent future catastrophes; emergency and disaster management; mental health care; and nutrition. In the following two years, only 23% physical progress was made, though the commitment by development partners represented 238% of estimated need. All four affected provinces showed less than 50% progress in completion of projects against commitments, while the Southern Province led with 33% progress. There was no significant difference observed in physical progress between Western (18%) and Eastern Province (19%), even though Eastern Province is affected by the civil conflict and Western Province is the most advanced province in terms of resources and economy.

Development partners have disbursed US$ 103 million (49%) and recorded expenditure accounted for US$ 59 million (29%) at the end of two years. The differences between commitment, disbursement and expenditure by development partners should be explored in more detail.

Closer monitoring of rehabilitation activities, while addressing national and regional priorities in planning of community-based health projects to maintain equity in fund disbursement and to prevent duplication of interventions, is recommended. Sri Lanka has been successful in rehabilitating the health sector following the tsunami, with the support of donor partners, though there are unresolved issues in terms of commitments and mandates of some donors.
Poster session: Capacity development

Capacity-building in specialities towards global health research

Sandhya Diwakar, Deputy Director General, Manpower Development and Reproductive Health and Nutrition, Indian Council of Medical Research, India with Divya Srivastava and KK Singh

India faces the twin epidemic of continuing/emerging infectious diseases as well as chronic degenerative diseases. Although death rates have been declining, the health care structure in the country is over-burdened by an increasing population. We believe that research capacity strengthening is one of the most powerful, cost effective and sustainable means of advancing medical research.

At Manpower Development we believe in the principle of ‘the right people with the right skills and motivation in the right place at the right time’. To augment this principle, the Indian Council of Medical Research has several different schemes, one of them is the MD/MS/DM/MCH thesis financial assistance programme, which provides 50 places per year.

The council has identified priority areas relating to disease and reproductive and child health. It is felt that many of these priority areas are being addressed by medical graduates while pursuing their MD/MS on the programme.

To take stock of the trends and direction of the MD/MS candidates and the areas being researched by them, an exhaustive analysis of available data has been carried out. MD/MS/DM/MCH candidates selected a total 76 research areas during the period of reporting 2003–2006: 1) Medicine and paediatrics are the most preferred areas with almost 15% of applicants opting for them. 2) Medicine and paediatrics each account for 7.89% of total research areas. 3) Microbiology/virology, pathology, psychiatry and reproductive health/obstetrics and gynaecology each account for 6.58%. 4) Orthopedics, pharmacology, oral health and physiology account for 5.26%. 5) Biochemistry; community medicine; ear, nose and throat; haematology and respiratory medicine each account for 3.95% of research areas.

The MD/MS/DM/MCH programme forms a powerful instrument to arrive at a selection of funding priorities that takes into account overall international trends but does not neglect peculiarities such as strengths, weaknesses and necessities. In the long term, strengthening medical research can help us reduce the disease burden of the country by providing us with very valuable footholds.
Assessing health-care providers’ capacities to acquire, adapt and use health policy and systems research in Mexico

Miguel Angel Gonzalez Block, Executive Director, Centre for Health Systems Research, National Institute for Public Health, Mexico with Francisco Javier Mercado, Héctor Ochoa, Héctor Rivera and Víctor Becerril

INDESES is a consortium of four academic institutions led by the National Institute of Public Health in Mexico. INDESES aims to improve and develop local research capacities of health-care service-providers for the provision of care to four vulnerable groups: Indians, the poor, the elderly and migrants. This project assessed local capacities to acquire, adapt and use research results as a baseline for evaluation of interventions aiming to enhance and develop health-care services for vulnerable groups.

The tool, originally developed by the Canadian Health Services Research Foundation (CHSRF), was translated into Spanish and adapted to the Mexican context through piloting in three contrasting states. A sample of institutions was selected from six contrasting states, to include diverse government and private sector providers, missions and levels of care. This was the first study undertaken in a developing country to go beyond utilization to focus on the capacity to use and develop strategic planning tools.

The self-assessment tool was applied to a group of 96 programmes/institutions responsible for health-care provision, taking into account four variables: 1) region; 2) state; 3) vulnerable group(s); and 4) type of institution responsible for the programme. The self assessment tool was used by 32 programmes/institutions in each region, 16 per state, 8 per vulnerable group and region, 16 per government agency and region, and 16 per NGO and region.

Results focus first on the capacity to acquire research results, considering available trained human resources and agreements with research institutions. The activities for knowledge acquisition are then described, looking into literature retrieval and appraisal as well as knowledge adaptation to local circumstances. The process of knowledge utilization is then discussed in light of the overall capacity. Finally, the paper discusses the range of needs for capacity development and suggests strategies to address such needs.
Building capacity of health managers in the Tibet Autonomous Region of China

You Wen Lai, Health Management Adviser, Tibet Health Sector Support Program, People’s Republic of China
with Christopher Morgan, Cath Barker and Xi Le

The Tibet Health Sector Support Program (THSSP) is a bilateral development cooperation programme of the governments of China and Australia. It runs for five years from March 2004 and aims to improve population health in the Tibet Autonomous Region (TAR) through strengthening health services and includes work on primary health care, control of HIV infection and health system development. In support of this last component, THSSP works with the TAR Regional Health Bureau on a programme of capacity development for senior- and middle-level health managers working in hospitals and public health departments.

The study aims to test models of management development that incorporate action learning principles and are highly relevant to immediate health system priorities in the TAR. Outcome measures include changes in institutional policy and procedures and changes in practice of individual managers.

The programme tested a model for the introduction of modern management methods. This used focused, short-term inputs from Chinese and Australian experts on specific management topics, to stimulate local proposals for operational research. Operational research activities were selected for support if they were deemed feasible, had sufficient local commitment and included clear health system outcomes. They were supported through regular field follow-up by long-term staff. This follow-up also enabled monitoring for objective outcomes.

Examples to be presented demonstrate that support for selected operational research activities proves a viable model for management development. This form of management development can demonstrate outcomes in terms of improved health policy and procedures at the local level. It can also produce changes in management practices and help inculcate a culture of basing improvements on good science. The determinants of a successful programme include solid linkage between new policy and local priorities, the use of a proposal system to select for strong local commitment, the application of focused technical input of high immediate relevance, and consistent long-term follow-up. Improved health services management is a key contributor to improved population health in western China, especially in rural areas. This study is likely to also be relevant to other resource-constrained settings.
The challenge of strengthening district health systems through operational research management by the local government in Tanzania

Tomohiko Sugishita, Senior Advisor, Institute for International Cooperation, Japan with Erika Fukushi and Messhack Massi

Since 2001, the Japan International Cooperation Agency (JICA) has supported the Morogoro Health Project, which aims to develop the capacities, in a self-reliant manner, of the health administrative management of regional and council health management teams. In particular, the broad project objectives are ‘evidence-based district health management,’ which accounts for deliberate and autonomous solutions to health problems in the community. The project supports the process of health sector reform and devolution, in which health priorities have been articulated by the decentralized health system.

The project initiated the Operational Research Working Group organized by focal officers from respective districts in Morogoro Region. The members were given practical training in basic and applied research management, supported by local academic institutions. Thereafter, focal officers and their health management team conducted research activities by involving front-line health workers and the community.

The research topics explored included priority local issues, in accordance with health problems neglected by the central government. The results were analysed, compiled into a final report booklet and presented to central and local government authorities. Lastly, action plans based on the results were developed by health management teams and incorporated into physical budget plans for practical interventions.

Operational research management carried out by local health management teams presents a unique but essential challenge for capacity development overall. Not only are research results enhanced by district health planning, but also overall the activities enhance the comprehensive management skills of health managers with high motivation and team spirit. Consequently, this project drives autonomous innovation in district health systems by listening to the community.
Qualitative research shows detailed processes, interventions, challenges and self-reported changes associated with Health-Promoting Schools in China

Carmen Aldinger, Project Director, Global Programs, Health and Human Development Programs, Education Development Center, USA
with Sen-Hai Yu, Xin-Wei Zhang, Li-Qun Liu, Jun-Xiang Guo, Xue-Dong Pan and Jack Jones (as reviewer/advisor)

This presentation seeks to: 1) describe qualitative methods used in the study of implementation of Health-Promoting Schools (HPS); 2) explain major results and challenges of implementing HPS in Zhejiang Province, China, that can guide further research.

A descriptive study was conducted in nine schools with a total population of about 15 200 students, interviewing a sample of 191 school administrators, teachers, students and parents in three schools at three different time intervals (over a period of 18 months). Conceptually, the study falls into the field of institutional ethnography. To our knowledge, this is the first extensive qualitative evaluation of the implementation of Health-Promoting Schools.

Grounded theory analysis revealed detailed pre-implementation, implementation, and monitoring and evaluation processes; classroom-based, school-wide and outreach activities; and modifications to the physical and psychosocial school environment. Schools faced a number of challenges related to understanding and integrating the HPS concept, including a lack of professional development. Yet, participants reported many health-conducive changes in their attitudes, conceptual knowledge, and behaviours associated with this project.

The self-reports pointed to some unique findings: 1) Participants increased their understanding of the broad concept of health and Health-Promoting Schools. 2) Participants gained a deeper understanding of the relationship between study and health. 3) Teachers and administrators utilized a truly comprehensive approach that addressed various health topics, utilized all components of the HPS model, and focused on holistic development of students. 4) Schools prioritized health and treated it as a co-responsibility with families and communities. 5) Children educated their parents and served as change agents. 6) Leaders provided support and encouragement and served as role models.

In contrast to what would be expected from the traditional education system in China, we observed that: 1) Teachers used participatory teaching and learning strategies. 2) Students worked together instead of competing.

In conclusion, schools' evaluation results indicated the effectiveness of the HPS project, reflected a change in evaluation concepts to a more holistic approach to assessment, but also pointed to a need for more training and technical support, and a desire for further expansion of the HPS project in China as well as other parts of the world.
Childhood drowning in low- and middle-income countries: the need for an intervention study

Nagesh Narayan Borse, PhD Candidate, International Health, Health Systems, Johns Hopkins University, USA
with Hyder Adnan

Data available for low- and middle-income countries (LMICs) indicates that the burden of drowning in children is significant and becoming a leading public health problem. At the same time, interventions for drowning are generally not found in LMICs. The overall purpose of this study is to make the case for research investments in conducting intervention trials to prevent childhood drowning in LMICs.

In high-income countries (HICs), existing drowning prevention interventions include among others: pool fencing, supervision, provision of lifeguards and water safety training at a young age. However, these measures may not be the most appropriate in curtailing the number of drowning deaths in LMICs. There are differences with regard to geographical, social, cultural, and behavioural factors associated with drowning between HICs and LMICs, often making it inappropriate to apply existing interventions directly in LMIC settings.

This study focuses on drowning from LMICs and reveals a dearth of data on incidence rates and risk factors; absence of public health interventions; lack of research on intervention effectiveness and cost effectiveness; and paucity of national drowning prevention programmes. Based on this evidence, this study calls for immediate attention to the issue by increasing research investments, and specifically proposes a drowning intervention study focusing on children less than five years of age in LMICs as an example of appropriate research investment.
A randomized policy experiment in the Philippines

Madeleine Valera, Senior Vice President, Office of the Senior Vice President, Health Finance Policy, Philippine Health Insurance Corporation, Philippines
with John Peabody, Kimberly Yee, Orville Solon and Stella A Quimbo

Randomized clinical trials have long been the gold standard for evaluating clinical treatments, becoming the foundation for evidence-based medicine. However, experience around the world indicates that it is difficult to randomize communities or introduce health-related policies experimentally with a control.

In 2000, the Philippine government launched the National Health Sector Reform Agenda (NHSRA). We recognized that this was a natural experimental setting in which we had a unique opportunity to conduct a social experiment, the results of which could inform health policy. We formed a collaboration of researchers from the University of the Philippines, the University of California’s Institute for Global Health, the Philippine Health Insurance Corporation, the Department of Health, as well as local government units, to carry out the Quality Improvement Demonstration Study (QIDS).

The purpose of QIDS is to evaluate the impact of policy reforms on health-care delivery and long-term health status including cognitive health status in children under the age of five. Specifically, QIDS tests two main hypotheses: 1) Do expanded insurance benefits lead to more utilization and better child health status? 2) Do doctor bonus payments, for high quality care, lead to better clinical practice and better health status?

We used an experimental design and randomized matched sets into one of the two interventions plus a control group. Matching was done using hospital characteristics and sociodemographic profiles of the districts. The ‘Access Intervention’ arm provides for expanded insurance coverage through a zero co-payment benefit package for children under five years old. The ‘Bonus Intervention’ arm entails a performance-based payment scheme for hospitals and physicians. The policy impact of the interventions will be measured through data collected using a random household survey, a hospital-based exit survey, a facility survey, and a physician survey of clinical practice.

The QIDS study demonstrates that a large-scale, prospective, randomized controlled policy experiment can be successfully implemented in a developing country. Furthermore, as randomized clinical trials have become the basis for evidence-based medicine, we believe randomized policy experiments such as this one can become the essential building blocks for informing health policy.
Exploring demand for health research by national policy-makers: an empirical approach

Adrijana Corluka, PhD Student, International Health, Health Systems, Johns Hopkins Bloomberg School of Public Health, USA
with Adnan A Hyder, Peter Winch and Abdul Ghaffar

Health research in low- and middle-income countries (LMICs) faces a number of challenges including under investment, lack of capacity, lack of public demand, inadequate utilization and poor dissemination of results. The mismatch between the need for health research and investments has been highlighted since 1990 and attempts have been made to address the ‘10/90’ gap such as research capacity strengthening, promotion of investments, and the establishment of global and national health forums. The last few years have seen a growing realization, not only among researchers but also among policy-makers, of the need to carry out research to improve management decisions and performance of national health systems in LMICs. This realization is supported by the international development community, one recent example being the Ministerial Summit on Health Research in Mexico. However, despite identification of the problem and willingness to resolve it, there is not enough empirical knowledge – which partly explains why policy-makers are not using the available information to make policy and planning decisions.

The overall objective of this project is to understand the perspectives and attitudes of policy-makers towards the use and impact of research in the performance of the health sector in LMICs, using evidence from Argentina, Egypt, Iran, Malawi, Oman and Singapore.

To understand the attitudes and perspectives of policy-makers, senior researchers from each of the project countries used a qualitative approach using semi-structured, in-depth interviews as the primary method of data collection. Analyses were performed at the country-level, with a comparative global analysis across all countries. This presentation will focus on the preliminary results of the project.
A means of putting research information into practice: application of the project cycle management method to evidence-based district health management

Erika Fukushi, Chief Advisor, Tanzania-Japan Morogoro Health Project, Japan International Cooperation Agency, Tanzania

Many research studies are conducted but the evidence from those studies often fails to form policy or action. Meanwhile, there are many unanswered policy and practice questions that are seldom addressed by research (Upunda, 2006).

Tanzania-Japan Morogoro Health Project (2001–2007) aims at strengthening the managerial capacity of the Regional Health Management Team (RHMT) and six Council (district) Health Management Teams (CHMT) in the Morogoro Region of the United Republic of Tanzania, by encouraging evidence-based district health management. The project found that operational research is a powerful tool for health managers to formulate evidence-based, and therefore more effective, health interventions for their neglected or unsolved health problems by involving frontline health workers and by using the primary data from the community. One of the advantages of RHMT and CHMT conducting operational research is that they can incorporate the research results in their district annual health plan, namely the Comprehensive Council Health Plan (CCHP), soon after the research has been completed.

Project Cycle Management (PCM) is a practical tool to bridge the research question and actions (solutions). It can put complex health issues into simplified hypotheses with causal relations. Health problems are listed and sorted based on hypothetical causality and visualized in a diagram, a so-called ‘problem tree’, from where the most relevant and feasible research topic can be identified. Formulation of the problem tree is also useful for articulating the broad and specific objectives of the research by reviewing the relationships between variables, and is also useful for developing appropriate questionnaires to answer the research question.

At the end of research, the RHMT and CHMT generate their respective Project Design Matrix (PDM), a project summary table transformed from an objective tree (a diagram demonstrating possible solutions), which is then utilized in their health planning, implementation, monitoring and evaluation.

It was mentioned by RHMT and CHMT members that application of PCM was very effective in their evidence-based health planning and implementation. Some teams integrated the interventions designed in their PDM into the CCHP. Indeed, Kilombero CHMT is one of the councils that was successful in controlling cholera outbreaks in 2005–2006, which was endemic in the Ifakara division in the district.
Innovations in evidence-informed health system
decision-making: multi-country explorations

Adnan Hyder, Assistant Professor, Departments of International Health and Health Policy Management, Johns Hopkins University Bloomberg School of Public Health, USA
with G Bloom, Z Hongwen, N Ravichandran, SS Mahmood, O Oladepo and SB Syed

The annual meeting of the Global Forum for Health Research brings together policy-makers, development partners and the directors and users of research, to debate critical gaps and to mobilize campaigns that address the health needs of the poor and marginalized. This session, focusing on knowledge generated by a multi-country project on pro-poor health systems in developing countries, and with a focus on policy processes, provides an excellent opportunity to share experience with and learn from others.

An introduction to the Future Health Systems (FHS) project and the thematic approach used within the consortium will be presented, developmental perspectives at the evidence-policy interface explored, and potential entry points to the interface suggested. The FHS research/decision-making conceptual framework will also be highlighted, potential study designs and methodologies to explore the interface discussed, and the utility of the approach reflected upon.

Four partner country presentations will each highlight an in-depth case study of the use of various methodologies in the context of the country health system research. Key transferable lessons learnt will be articulated and further research agendas will be defined. Country presentations include: 1) Institutional analysis for health insurance programmes in rural China; 2) Health performance and demand in West Bengal, India; 3) Stakeholder analysis for district health systems in Chakaria, Bangladesh; and 4) Institutional analysis: regulating patent medicine vendors’ anti-malarial drugs.
Poster session: Decision-making

Use of information and research for decision-making and policy formulation: preventing maternal mortality

Ruth Iguiñiz Romero, Researcher, Universidad Peruana Cayetano Heredia, Peru with Nancy Palomino

Planning and implementing public health policies requires, among other conditions, the state’s capacity to produce, collect and utilize information and research needed to guide decision-making and implementation. Given the current controversy over maternal mortality indicators in Peru and the wide national and international efforts to reduce maternal mortality, our study focuses on how various entities within the Peru Ministry of Health – which are involved in the formulation, monitoring and evaluation of health policy and indicators – collect, share, and utilize relevant information to reduce maternal mortality in Peru.

The main objectives of this research are to: 1) identify the types of data, evidence and information that Ministry of Health officials consider useful and relevant for decision-making; 2) identify how these types of information arrive and flow among relevant Ministry of Health decision-makers; and 3) explore how information flows from and to the Ministry of Health, regional/local health centres and research institutions devoted to women’s health.

In order to propose, implement and evaluate effective policies and to obtain results that guarantee the health and well-being of all the people, it is crucial to understand and analyse the characteristics of our health system, such as the institutional culture, the managerial problems, the commitment of the public officials, the fragility of health institutions, the existence or absence of channels and systems of monitoring with participation of organized users and/or civil society, among others.

Learning about the internal dynamics and flows of information and power relations within the Ministry of Health is very useful to understand who makes decisions, under what circumstances, and with what information at hand; how are the decisions being made and why; what are the sources that support policy and practices to prevent maternal mortality; and how the information or lack of it, the power relations and institutional culture can help us identify and propose better strategies to develop policy and improve gathering and sharing of useful information at different levels of decision-making.
Evidence-based policy development: the development of a National Diabetes Control Programme in Cameroon

Jean Claude Mbanya, Director, Health of Population in Transition Research Group, Department of Internal Medicine and Specialities, Faculty of Medicine and Biomedical Sciences, University of Yaounde, Cameroon
with Alfred K Njamnshi and Assumpta Bella Hiag

Ten years ago, diabetes mellitus was not considered a public health priority in Cameroon. In 1994, the Health of Population in Transition Research Group (HoPiT) conducted the first epidemiological survey to study the emergence of diabetes and hypertension in urban and rural areas. The results from this study attracted national public attention.

Within 10 years, the results of the community-based surveys undertaken prior to clinic interventions revealed a 1–9% and 0.5–7% prevalence of diabetes in urban and rural areas respectively. From 1995–1999 further studies provided evidence for establishing the first diabetes clinics, staff training guidelines, follow-up protocols and algorithms were drafted and field-tested. From 1999 to 2003 another project undertook a rapid assessment to provide information to improve the detection and management of people with noncommunicable diseases. In consultation with local health community leaders, it evaluated the treatment packages, guidelines, staff and patient-held records in primary health-care centres developed under a previous study.

These projects set the stage for advocating for state and community involvement in setting up and sustaining diabetes clinics and developing diabetes policy and programmes. Evidence-based, comprehensive strategies were therefore required by policy-makers to address this expanding epidemic. HoPiT, in collaboration with the World Diabetes Foundation and the Ministry of Public Health, undertook the Cameroon Burden of Diabetes (CAMBoD) project as a prelude to the development of a nationwide noncommunicable disease control programme.

In 2004, the Department of Disease Control used the evidence from CAMBoD to produce a draft national plan for diabetes control and another for high blood pressure control. The validation and adoption of the draft plans took place later in 2004 and the plans are now in their implementation stages.

The Cameroon Government has used the evidence provided by research to develop national policy for the surveillance, prevention and control of diabetes and high blood pressure. The CAMBoD baseline survey provided new scientific knowledge that guided policy. The lessons learnt include the important role of reliable research data to inform policy, the importance of political will to make and enforce policy and finally the capacity of management of the programme to build partnerships and mobilize both human and financial resources to implement the programme.
The Kerala Tele-Health and Medical Education Project: experiences from a tele-specialist centre

Mangadan Konath Nabeel, Coordinator, Centre for Tele-Health and Medical Informatics, Academy of Medical Sciences, India
with Hariharan S

The Academy of Medical Sciences in Pariyaram is one of the new generation of medical colleges in the southern Indian state of Kerala. It has been chosen as one of the specialist nodal centres under the Kerala government’s tele-medicine project connecting various medical colleges in the state with district headquarters in the first phase and later to be extended to the primary health centres. The project is partly funded by the Indian Space Research Organisation (ISRO) and was christened the ‘Kerala Tele-Health and Medical Education Project’. It is an internet provider-based system, which works using satellite technology.

This paper discusses the issues faced in implementing the project state-wide. Currently the project is getting consultations from district hospitals and at times from other specialist centres as well. Similarly, the project can seek expert opinion from other specialist centres. Customised software helps in transmitting electronic medical records and imaging data from a tele-nodal centre to a tele-specialist centre (store and forward method). Based on the patient record, an appointment is fixed for videoconferencing between the consultant at the specialist centre and the treating doctor at the nodal centre (real-time method). But this software does not support consultations between the tele-specialist centres – this is a major drawback to be worked upon – for which video-conferencing alone has to be used.

The connectivity is extended from the main tele-medicine room to the operating theatre complex, one lecture theatre and a small seminar hall. The connectivity for the operating theatre is being used both for seeking expert advice and to conduct tele-education programmes on surgical techniques. The connectivity with the lecture theatre and seminar hall again is intended to support scaling-up of continuing medical education activities.

In the next phase of the project, apart from extending the connectivity to more centres in rural areas, plans have been put forward for using the connectivity for sharing electronic resources and also to use it for enhancing surveillance and epidemiological research.

A detailed account of the project from its planning stage to the implementation stage has to be narrated in order to derive lessons and best practice guidelines, which shall be dealt with in the full paper. Finally, the paper will compare other institutions within our community and from outside, and shall highlight best practices.
Poster session: Decision-making

Researcher and implementer attributes for greater knowledge translation efficiency in the context of the Zambian public health system: experiences from a pilot project of the African Health Research Forum (AfHRF)

Thabale Jack Ngulube, Executive Director, Health, Science and Social Research, Health Research and Training, Centre for Health, Science and Social Research (CHESSORE), Zambia with Fastone Goma, Clara Mbwili, Lillian Nyendwa and Mary Tuba

The African Health Research Forum (AfHRF) was formally launched at the 2002 Global Health Research Forum meeting held in Arusha, Tanzania. Since then, the AfHRF has embarked on a pilot fellowship programme in four countries, two francophone (Benin and Mali) and two anglophone (Uganda and Zambia), to help identify and map out key challenges to knowledge translation for greater equity of access to benefits from the public health systems in Africa.

With funding received from the International Development Research Center (IDRC) of Canada, AfHRF embarked on an 18-month initiative to establish country teams in each of these four countries. Each team comprised a researcher, an implementer or policy manager, a nongovernment organization representative and a community member. Each of the teams was supported by selected mentors to guide project implementation. In the Zambian project one team was based in Lusaka and another in Ndola. Following an inaugural meeting in each country, the teams went about developing mutually agreed project proposals, implemented their projects, held review meetings with peers from other projects to share experiences; and completed the project, ending the programme with a joint review meeting.

This presentation will detail the experiences of the Zambian teams regarding what the teams learnt and how this happened. The final outcomes from this fellowship programme provide lessons on what we now see as key attributes for both the researchers and programme implementers for greater knowledge translation efficiency in the context of the Zambian public health system.
Summary measures of population health and the Indian health service: strengthening the interface between epidemiology and decision-making

Shamsuzzoha Syed, Preventive Medicine Resident, General Preventive Medicine Residency Program, Johns Hopkins Bloomberg School of Public Health, USA
with Phil Smith, Mary Beth Skupien, Lucie Vogel and James Cheek

Consistent and high-quality estimates of current and projected future burden of disease, both in terms of premature mortality and morbidity, attributable to various diseases or risk factors, are currently unavailable for the American Indian/Alaska Native population in the United States of America. The Indian Health Service (IHS) is responsible for planning and providing population based health care for this population. Summary measures of population health, in particular disability-adjusted life years (DALYs), can be utilized to provide estimates of disease burden thus strengthening the interface between epidemiology and decision-making within the IHS. Equitable access to health care can be enhanced by making use of such an approach in health care planning. This paper reports on initial efforts to utilize such an approach within the IHS.

The paper has six objectives: 1) to provide a brief review of the methodological basis of disability-adjusted life years; 2) to describe the IHS health system (in terms of stewardship, financing, creating resources and delivering services) in relation to the potential utilization of DALYs; 3) to articulate data requirements for DALY calculations and potential IHS statistical sources; 4) to discuss the potential management and administration alignment of the approach with the current IHS organizational structure; 5) to define a ten-step process in operationalizing an IHS Burden of Disease Project; and 6) to provide a critique of the suggested approach.

The full potential of DALY-focused approaches to measuring disease burden has yet to be realized for any global health system. The IHS is well placed to utilize such an approach for a well-defined population. This paper reports on the initial process of incorporating such an approach to health system decision-making within a large health system catering for a vulnerable population, thus enhancing the global knowledge pool on DALY-focused burden of disease approaches. Lessons learned from this process can be applied to other global health systems thus having large potential implications for policy and practice.
Influencing health policies with evidence

Francisco J Yepes, Executive Director, Colombian Health Association – ASSALUD, Colombia
with Manuel Ramirez, Andres Zambrano, Ivan Jaramillo and Luz Helena Sanchez

Colombia's law 100 (1993), which was implemented in January 1995, created a profound change in the health system, developing a national health insurance scheme with public-private participation, significantly increasing public and private health expenditures.

This project was intended to find available evidence that would allow the evaluation of reform outcomes, to guide policy formulation and promote informed civil society participation.

A triple strategy was developed: 1) the search for evidence, through published research (1997 -2005), and direct research by the project team; 2) civil society involvement through participation in two civil society groups, one with participation of important national sector actors and the other with participation of community leaders; 3) involvement of policy-makers.

Besides the research directly done by the team, an internet search was carried out (Medline, LILACS, WHOLIS) complemented by a direct search of institutional libraries, and researchers. Three hundred and forty articles were found and a database developed with 200 articles that complied with LILACS criteria.

With this information, a balance of the gains and loses of the reform was developed which was presented throughout the country in six regional forums, a national forum in Bogota, and additional presentations to the Ministry of Social Protection and Congress.

This balance showed significant gains in public expenditures in health, health insurance coverage, improved targeting of subsidies and decreases in urban-rural, age and education differentials in health insurance coverage. Although the insured population showed better access at the first medical visit than the uninsured, available information did not allow us to present solid evidence on access to referred services (e.g. specialist visits and diagnostic procedures).

Although available information for health outcomes was subject to a degree of interpretation, there was an important confluence in findings among different research groups and administrative data, which raised alarm signals as to the existence of serious fragmentation affecting the quality of services, and even deterioration of several health outcomes.

Since, after 10 years of reform implementation, Congress was in the process of discussing adjustments to the health system, the project team got actively involved with congress persons and was able to influence the formulation of a new law.
Disaster management and disability: promoting a research agenda

Ashok Hans, Executive Vice President, Shanta Memorial Rehabilitation Centre, India with Nizni Hans

Disabled people suffer disproportionately during disasters. Disasters not only create impairment, they also further discrimination against already disabled people, compromising the determinants of their health and creating conditions for the worsening of their overall health and well-being. They perpetuate a cycle of poverty and isolation. Understanding these issues is problematic as there is inadequate documentation of the structural, social, financial and cultural barriers to improving the health and well-being of people with disabilities, in general, and during disasters in particular.

This paper will discuss the creation of a research agenda built around the subject, especially prioritizing those issues with policy implications including: 1) Health of already disabled people and responses towards them during disasters; 2) Legislation on existing international standards including: what has been done, what gaps there are, e.g. in sphere project and national legislation; 3) Use of research to effect social change and construct new inclusive, equality-seeking structures; 4) Intersections of social hierarchies and marginalization, exclusion (employment, income, savings, etc.) and other cultural practices that undermine identity/inclusion/rights; 5) Community coping mechanisms; 6) The need for better data and community mapping to know where people are when disasters strike; 7) Time frame for arrival of professionals to help out (e.g. when should psychiatrists get involved – before, during, after? How many – what ratio needed per person?); 8) Effectiveness of execution of relief efforts, relief coordination/codification etc.; 9) What is already happening around disasters and the need to integrate disability into those efforts; 10) Costing re: inclusion; 11) Intersections of social hierarchies (e.g. gender, poverty, homeless, etc.); 12) Medical interventions vs. social interventions re: disabled persons (when are they needed? How to define which is appropriate and when?).

The paper will prioritize issues that can be taken forward.
Equitable distribution of health-care measures in India: the need for integration of social parameters with existing disease control measures

Pradeep Dam, Technical Officer, Division of Virology & Molecular Biology, Desert Medicine Research Centre, Indian Council of Medical Research, India with Vinod Joshi

India represents a heterogeneous mixture of people of different cultural, religious and socioeconomic backgrounds. A lack of information on the health-specific social behaviour of different caste groups in disease endemic areas of the country, leads to under performance of national disease control programmes. Our studies on malaria and dengue in Rajasthan have shown, a lack of information on human behaviour during ongoing disease control programmes leads to unequal access to the programme by people belonging to different sections of society.

We thus need to differentiate study settings according to their social and behavioural composition, emphasizing attributes that may be crucial to the disease cycle. The knowledge, attitude and competence of subjects to grasp and execute control measures needs to be recorded for different social groups. For any health intervention to be effective across all socioeconomic groups, the implementation of a particular health measure needs to be decided depending upon the receptivity of different subjects, as revealed through the proposed research. This would encourage the equal distribution of expertise, resources and health advantages among all sections of society.

Our studies on malaria in 26 villages in Rajasthan demonstrated that most transmitted malaria is the result of a few cases imported to the state. A simple modification to the existing practice of blood examination and provision of chemotherapy, involving a check of in-migrants, would prevent the spread of infection. Similarly, observations of an outbreak of dengue fever in Jodhpur, Rajasthan showed the significance of socioeconomic group as a major criteria for surveillance design for dengue vectors.

It appears that many disease control programmes in developing countries, such as India, are more technically sound than socially feasible. A careful supplementation of social science to ongoing infectious disease control programmes would substantially enhance programme effectiveness in achieving equity and uniformity of health benefits among all sections of society.
Tobacco will soon be the biggest cause of death worldwide, with the greatest burden being borne by low- and middle-income countries where 80% of smokers now live. Developing countries are also experiencing a rapid increase in chronic diseases.

This study aimed to inform country-specific tobacco policies by quantifying the direct burden of smoking for cardiovascular disease (CVD) deaths. This was achieved by calculating the sex-specific population attributable fractions (PAF) for fatal ischaemic heart disease (IHD) and stroke (haemorrhagic and ischaemic) for all 38 countries in the World Health Organization (WHO) Western Pacific and South-East Asia regions.

Sex-specific prevalence of smoking was obtained from existing data. Estimates of the hazard ratio (HR) for IHD and stroke with smoking as an independent risk factor were obtained from the 600,000 adult subjects in the Asia Pacific Cohort Studies Collaboration (APCSC). HR estimates and prevalence were then used to calculate sex-specific PAFs for IHD and stroke deaths by country.

The prevalence of smoking in the 33 countries for which relevant data could be obtained, ranged from 28–82% in males and from 1–65% in females. The fraction of IHD deaths attributable to smoking ranged from 13–33% in males and from 1–28% in females. The percentage of haemorrhagic stroke deaths attributable to smoking ranged from 4–12% in males and from 1–9% in females. Corresponding figures for ischaemic stroke deaths were 11–27% in males and 1–22% in females.

Important policy and practice implications are revealed by these data. Up to 30% of some cardiovascular fatalities can be attributed to smoking in these regions. This is likely an underestimate of the current burden of smoking on CVD, given that the smoking epidemic in the Asia Pacific region has developed further since many of the studies in the APCSC were conducted. These estimates underscore the importance of ratification and implementation of the policies outlined in the Framework Convention on Tobacco Control.
Commitment of countries with high incidence of malaria towards research of the disease: profile from Medline

Divya Srivastava, Assistant Director General, Division of Publication and Information, Indian Council of Medical Research, India with Rajnikant SRO

Approximately 300–500 million people worldwide are affected by malaria with 1 to 1.5 million deaths every year. It is confined to Africa, Asia and Latin America. Approximately 75% of all recorded cases outside of Africa are concentrated in nine countries: India, Brazil, Afghanistan, Sri Lanka, Thailand, Indonesia, Viet Nam, Cambodia and China. *Plasmodium falciparum* infections increased during the 1990s in India and Sri Lanka because of resistance in *Plasmodium falciparum* to multiple drugs.

For successful control of the disease it is necessary to take stock of the trend of research being done in the area of disability-adjusted life years (DALYs) due to malaria. With this aim, the current study was conducted on the basis of papers from the Medline database that were published between 1980–2005, using five-year intervals. The data has been analysed for developing countries with high DALYs, particularly with reference to control measures.

The growth of malaria research parallels that of biomedical research (from an estimated 0.36% of total research during the 1980s to 0.43% today). Over the period studied, country-specific sources of malaria research were the United States of America (30.73% of research), the United Kingdom (26.88%) and France (5.34%) among developed countries, and India (3.59%), China (2.04%), Thailand (1.67%) and Brazil (1.21%) from developing nations.

Much of the malaria research identified was relatively basic in nature (research level = 2.7 based on individual title words), compared with some other diseases where there is more focus on patient treatment and clinical trials.

There has been an apparently large increase in the amount of malaria research taking place in Thailand. Other countries experiencing increases were India (0.78% in 1980 to 1.38% in 2005), China (0.29% in 1980 to 0.82% in 1995) and Brazil (0.34% in 1980 to 1.42% in 2000). The subject analyses indicated that the most prominent areas of research activities were: drugs, mosquito control, drug development (antimalarials), drug resistance and immunological studies (including vaccines), and artemisinin-based combination therapies (ACT). The data indicates that work on chloroquine has decreased and the newer drug artemisinin is gaining in research popularity. Of the other approaches, genetics is rising steadily, but mosquito study and control is declining in interest. What is perhaps more interesting is the variation between countries in the subjects on which they concentrate. The relative commitment to research subjects from developing countries were: Thailand (general malaria 5.25%, malaria control 1.81%, antimalarials 2.23%, mosquito control 1.22%); India (general malaria 1.47%, malaria control 0.36%, antimalarials 1.03% and immunology 0.18%), China (general malaria 0.38%, malaria control 0.10%, antimalarials 0.54%, immunology 0.05%); Brazil (general malaria 0.96%, immunology 0.19%, antimalarials 0.43%). Results for India indicate that most effort during earlier years was in research...
on spraying with dichloro-diphenyl-trichloroethane (DDT), dieldrin and other insecticides, but in later years the trend changed in favour of more modern and front-line areas of control measure like bed nets, biological control and use of pyrethroids etc.
Poster session: Diseases

Paragonimiasis – a diagnostic confusion for tuberculosis

Bamin Tada, Senior Deputy Director of Health Services, Health and Family Welfare, Tuberculosis Division, Directorate of Health Services, India
with J Mahanta and Kanwar Narain

Miao subdivision of Changlang district of Arunachal Pradesh, in the foothills of the eastern Himalayas, is mostly inhabited by ethnic minority groups. The Tangsa and Singpho are of Burmese origin, the Chakma tribe are from the Chitgang hill tracts of Bangladesh and the Tibetans are from western China (Tibet Autonomous Region).

Miao community health centre had been experiencing a very high reported tuberculosis (TB) case load, mostly sputum negative pulmonary TB, not responding to treatment under DOTS (directly-observed treatment, short-course). High case load focal areas (Deban, Diyum and Empen) were identified and were suspected to be associated with paragonimiasis, which clinically mimics symptoms of TB with chronic cough and haemoptysis.

Paragonimiasis is a disease caused by species of lung flukes of the genus *Paragonimus* and is related to eating infected, undercooked or raw crabs, crayfish or wild boar. With the help of a team of scientists from the Regional Medical Research Centre in Dibrughar a study was conducted to assess possible misdiagnosis of paragonimiasis for pulmonary TB.

Ninety three cases treated for pulmonary TB were examined. Sputum examinations discovered eggs of the paragonimiasis parasite in 23 cases, which were confirmed by enzyme-linked immunosorbent assay (ELISA) test. Only seven cases were sputum positive. Differentiation of the diseases by chest x-ray is not confirmatory.

The study, therefore, emphasizes the need to generate awareness among clinicians regarding paragonimiasis, often confused for TB. In addition, paragonimiasis should be considered in the differential diagnosis of TB. There is scope for further research on the subject.
Poster session: Equity in research governance

SPHERE: strengthening public health in the European region

Mark McCarthy, Professor, Epidemiology and Public Health, University College London, United Kingdom
with SPHERE partners

Public health research has a long tradition, but in the twentieth century biomedical research became a more dominant paradigm. SPHERE (strengthening public health in the European region) is a partnership of 18 institutions across 10 European countries to promote public (population and system level) health research. It is funded by the European Commission.

There are two main strands for the project: 1) to assess the European public health literature and its relationship to policy and practice; and 2) to investigate national and European level support for public health research. During 2007, SPHERE shall circulate a preliminary report to stakeholders on these issues and hold a high-level discussion at the European level between researchers, policy-makers and research commissioners.

There is evidence from the study of considerable variation in support structures for public health research, and of priorities between countries. There has been a greater movement towards organizational and chronic disease control research in countries in the north and west of Europe, while eastern European countries prioritize research in environmental and infectious disease control. Language is a barrier to exchange and dissemination. There is also often poor communication between national ministries of science and of health, with the potential that biomedical researchers advise science ministries without public health input. There is also a lack of coordination between member states in Europe, except that fostered directly by the European Commission.

Nevertheless, SPHERE has shown that Europe contributes a significant proportion to the world’s health research literature, and there are many active institutes and research groups. There is an opportunity to add value to this activity by collaboration across countries and, in particular, to encourage organizational and behavioural research, and agenda-setting for policy, which will complement biomedical health research. Strengthening public health research at European regional level has the potential to improve every citizen’s health and to contribute to reducing inequities. Public health researchers need to coordinate their efforts across Europe to maximize their impact.
Extension of social protection in health in Latin America and the Caribbean: bridging research and practice

Celia Almeida, Senior Researcher, Department of Administration and Health Planning, Sergio Arouca National School of Public Health, Oswaldo Cruz Foundation, Brazil

The Pan American Health Organization (PAHO) and the International Development Research Centre (IDRC) have launched a joint initiative to design, implement and evaluate innovative strategies for extending social protection in health in Latin America and the Caribbean. This is based on the assumptions that improving access to health services is an absolute priority in the region and that to achieve that goal means inducing knowledge production directed to solving crucial health problems, mainly for the most needy and excluded people. This paper assesses some results of this research funding strategy that alter the structure and process of research by requiring interaction between researchers and policy-makers. It argues for strategies that interrelate the processes of knowledge production with those of technical and political decision-making and that strengthen the links between these two fields.

Five research teams – two from Colombia, and one each from Brazil, Argentina and Jamaica – focused on how to expand access to health services for different groups in need in each country and also examined, as case studies, the relations between policy-makers and researchers pursuing research projects under a specific funding mechanism.

Results revealed that research questions were negotiated at the outset, influencing not only project design, but also how decision-makers thought about the problem. Turnover among government officials on four of the teams impaired the process. However, the one team that escaped re-composition saw interaction leading not only to use of data in decision-making, but a clear recognition by all parties that various kinds of evidence were in play, highlighting the importance of encouraging systems of learning in which multiple kinds of knowledge interact. This interaction may be a more realistic expectation for such initiatives than the original goal of ‘transferring’ research knowledge to policy and practice.

The five case studies; a critical, theoretical and analytical review of this complex interweave; a discussion of the concepts of ‘governability’ and ‘governance’; and a final analysis of the cases and analytical framework were published in a special supplement of the Cadernos de Saúde Pública, Volume 22, 2006.
Equity of skilled delivery care in developing countries: financing and policy determinants

Margaret Elizabeth Kruk, Assistant Research Scientist, Health Management and Policy, University of Michigan School of Public Health, USA with Marta Prescott and Sandro Galea

Countries with higher spending on health have greater overall utilization of maternal health services including skilled birth attendants (doctors, nurses, or midwives). However, it is possible that greater overall utilization of attendants is driven by disproportionate utilization by the rich, at the expense of the poor. This study examined the financing and policy determinants of more equitable utilization of skilled birth attendants in developing countries.

Data from Demographic and Health Surveys carried out in 45 developing countries and disaggregated by wealth quintile were used. Multivariable regression analyses were used to assess the joint effect of higher health care expenditures, a redistributive policy environment (as measured by the distribution of fifth-grade completion among reproductive-aged women in the survey), and overall national educational attainment.

The results of this study indicate that poor/rich equity in the utilization of skilled birth attendants was greater when health expenditures rose in concert with a more redistributive policy environment, at any given level of national educational attainment. Thus, this study suggests that higher health care expenditures need to be accompanied by redistributive policies to yield more equitable access to skilled birth attendants for the poorest women in developing countries.
Feasibility of demand-side financing in maternal health-care services in rural Bangladesh

Azaher Molla, Assistant Professor, Institute of Health Economics, Health Economics, University of Dhaka, Bangladesh with SR Howlader, A Rahman and A Mustafa

In Bangladesh, about 92% of births are still delivered at home and skilled birth attendants attend only 13% of births. About 69% of poor households do not have access to any antenatal care (ANC) compared to 22% of the richest quintile. It is hypothesized that various demand-side factors contribute in reducing access of the poor to maternal health care.

The purpose of this study was to look at the feasibility of the demand-side financing (DSF) scheme among rural poor mothers by collecting information on demand-side factors of maternal health care and also to assess the purchasing capacity and communities' behaviour towards introducing the DSF scheme.

Primary data were collected from pregnant mothers and mothers in the postnatal period. Key informant interviews (KII) were conducted with community and religious leaders, and public representatives. Population representative samples were collected from six areas, from 450 pregnant women and women in the neonatal period.

The rate of utilization of ANC was 32.2%, postnatal care (PNC) was 14.3%, and deliveries assisted by medically competent persons were 10.5%. The average cost of ANC was Tk.68.75 (US$ 1), PNC Tk.41.25 (US$ 0.60) and delivery Tk.650 (about US$ 10). The majority of families met the cost of delivery from savings (29.5%), followed by personal loans (4.5%) and the sale of household goods or assets such as cows, goats, trees or ornaments (50%).

Findings suggest that introducing a pre-paid voucher scheme would increase utilization of maternal health care, empower people to make choices among different providers, increase quality of care or supply of goods, make providers responsive to users, and provide financial protection in the event of major illness. Considering the economic status of the households with the pregnant mothers some prepaid voucher scheme may be introduced. The proposed voucher could be introduced on a sliding scale. Targeting the poor and choosing beneficiaries needs to be a careful exercise for a developing country like Bangladesh.
Mobilizing research to design and implement a pro-poor voucher system in Uttar Pradesh

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with William Winfrey, V Jayachandran and Harpreet Anand

The state of Uttar Pradesh (UP) in India is marked by severe poverty, low use of reproductive and child health (RCH) services and an under-performing government health system. On the other hand, there is a relatively strong private health sector that can provide effective health services to the poor if appropriately regulated, and means can be found to make their services affordable to the poor.

An innovative partnership of the Government of India, Department of Medical Health and Family Welfare (UP), Agra Medical College, private health providers and the Innovations in Family Planning Services (IFPS II) Technical Assistance Project is implementing a voucher scheme to make health services available to the poor through private providers. A key element of the design of the voucher system was a systematic analysis of the poor that included a comprehensive private provider/facility study, a baseline survey conducted in one district (Agra) and an analysis of health expenditures in UP. As the voucher system continues to be implemented, operations research will evaluate progress including effectiveness of targeting and increases in RCH services use. The operations research will also help define mid-term course adjustments.

This paper will take a chronological approach to describing how the voucher system was designed. First, we will establish the problems afflicting UP. Next we will describe the analyses that were mobilized and the negotiations with partners that lead to the design of the programme. Finally, we will describe the operations research and monitoring and evaluation systems that are in place to ensure that progress is measured and adjustments to the programme can be made.
Costing different strategies to improve the vital statistics system in Andhra Pradesh, India

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There is limited information available on the costs of different strategies to generate vital statistics in countries without complete civil registration systems. Most often, there is an urban civil registration system with very low coverage and/or a limited number of demographic surveillance sites (DSS), which are not representative and have varying quality.

Andhra Pradesh, India is in a unique situation in that there are various types of systems in place to generate vital statistics: household surveys, urban civil registration, a sample registration system with verbal autopsy, and rural surveys on causes of death, which is similar to a DSS system. The objectives of this study are to assess costs and effectiveness (in terms of vital statistics generated, adjusted for quality) of the different options, and to propose an optimal strategy to improve both quality and quantity of vital statistics.

The Institute for Health Systems (IHS) is carrying out an in-depth assessment using the assessment tools developed by the Health Metrics Network (HMN) and through additional detailed analysis. IHS has developed a template for costing analysis of vital statistics systems. Estimation of unit and programme costs, as well as resource use, is done through literature review, analysis of administrative records, and key informant surveys. Both quantity and quality of vital statistics is assessed through a review of the coverage and completeness of each strategy, the quality of coding in death certificates and verbal autopsies, and the amount of information being compiled and used at both state and district levels. Final results on cost, quality and quantity of information will be presented along with the implications for optimal storage to be implemented in developing countries without complete civil registration systems.
Health financing and social protection in Latin America

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with Felicia Knaul

In most developing countries, and particularly those in Latin America, large segments of the population resort to paying for health directly, out-of-pocket and at point of service. This is regarded as the most inefficient and inequitable means of financing a health system, and often results in severe negative income shocks for families.

While this research seeks to compare results and policy findings across countries, the focus is on promoting in-depth analysis of the impact of health financing and household health spending on financial equity and impoverishment in Argentina, Brazil, Chile, Colombia, Costa Rica, Mexico and Peru.

This project has defined as its main objectives: 1) Analyse and quantify the risk of household impoverishment from health spending and the impact of health spending on poverty and equity; compare the determinants of family impoverishment from health spending; analyse the connection of innovations in access to health insurance and health care with household health spending; and, analyse health system financing, particularly in the context of reform, across seven Latin American countries. 2) Improve the quality of data and methodologies for analysing household health spending and strengthen the human and institutional resources available for the study of these topics. 3) Identify key policy lessons.

The selection of core countries is largely based on contrasting health system characteristics, health system reform experience and other features including data availability and country characteristics.

Multiple products will be the result of the 30 months of work that began in July, 2007. These products include: 16 research papers; a book containing the results of each country case study as well as thematic and methodological chapters; seven policy briefs; a module and other teaching resources designed as components for health economics courses; and ongoing activities to project results to other developing regions. Furthermore, the group will seek to establish the Research on Health Financing Latin America Network.

The original research project is rapidly forming the base for a broader inter-institutional programme that can be extended to countries throughout Latin America and the Caribbean, and to other regional initiatives. To achieve this goal, collaborative programmes are being developed with other institutions.
Improving gender equity in basic health services through the Reproductive Health Improvement Project (RHIP): a Gender and Health Equity Network (GHEN) China case study

Yunguo Liu, Deputy Director-General, foreign Loan Office, Ministry of Health, People's Republic of China
with Joan Kaufman and Fang Jing

China's health status has improved since 1949. However national averages conceal big disparities among regions and groups. Significant gender inequity in health remains. Issues include the imbalanced sex ratio (119 male:100 female), rising HIV transmission in women (32.3%), and higher general illness prevalence in women. Only 38.9% of pregnant women in Guizhou Province delivered their babies in hospitals, compared to 99.5% in Beijing and 99.4% in Shanghai. Maternal mortality rate (MMR) in Guizhou was 95.4/100 000 compared with 18/100 000 in Beijing and 10.8/100 000 in Shanghai. There is limited gender awareness in health planning and services, health statistics are not disaggregated by sex, and gender-sensitive indicators are not used for health planning, monitoring or evaluation.

This paper reports findings from a 2000–2004 reproductive health improvement project carried out by the Foreign Loan Office, Ministry of Health in Dafang County, Guizhou. The project aimed at improving safe motherhood, reproductive tract infection (RTI) prevention/treatment, promoting male and female participation in reproductive health and improving basic services by training health workers and introducing clinical protocols. Women's groups and family planning institutes worked together with health staff.

The project identified 68 demonstration households and 108 groups as peer educators to change community gender prejudice, trained staff at township and village clinics to provide free RTI diagnosis and treatment, established fast track referral of pregnant women to township or county hospitals with community assistance, and provided free, attended hospital delivery. Gender perspectives were promoted among local officials and health managers.

By 2003, the hospital delivery rate increased to 58.7%, infant deaths were reduced to 4 and no maternal deaths have been recorded since 2000. The utilization rate at the township health centre increased to 64.5% for maternal care. A 2005 follow-up study showed 90.5% of villagers understood the importance of prenatal care, 69.8% said prenatal visits should be accompanied by the husband, 87.8% understood benefits of breast feeding, 64.3% correctly knew HIV transmission routes, and 87.1% understood RTI prevention.

The World Bank and the United Kingdom Department for International Development (DFID) reviewed findings and recommended including the strategy into the second phase of a large basic health project covering 46 million people in 10 provinces. Many counties have now adopted the reproductive health improvement approaches.
Analysis of a sectorial fund in health and social security research after four years of operations: is Mexico’s research funding policy adequate?

Francisco Becerra-Posada, Director, Academic Agreement and Dissemination, Health Research Policy Directorate, Coordination of National Institutes of Health and High Specialty Hospitals, Ministry of Health, Mexico with Rafael Romero and Israel Mejía

The objective of this study was to analyse projects funded by the Health and Social Security Sectorial Fund (FOSISS) in Mexico, including assessment of the type of research funded and the percentage of funds devoted to health systems research (HSR), as well as the distribution among different institutions, during the period 2002–2006. The results should help the fund secretariat to re-orient funding policies.

Mexico experienced a series of major changes in health research and in science and technology policies in the period 2000–2006. One of the key innovations was the creation of sectorial funds.

At the Health Research Summit/Forum 8 held in Mexico in 2004, both the Global Forum for Health Research and the World Health Organization (WHO) recommended that funds for health systems research (HSR) should be increased, among other measures directed towards strengthening health research systems in low- and middle-income countries.

FOSISS launched its first call for funding applications at the end of 2002. This Fund receives money from the three main health institutions in Mexico, which is then matched by the National Council of Science and Technology (CONACYT). By November 2006, FOSISS had made nine calls for applications; overall 2513 applications had been received, and of these 433 were selected for financing. The overall funds committed to health research by FOSISS for the period were US$ 62.3 million. Of these, HSR received US$ 4.8 million (8.1%), while chronic diseases/cancer/life style received US$ 18 million (29.8%), infectious-emerging diseases got US$ 12.2 million (20.2%), evaluation/development of biotechnology received US$ 7.5 million (12.4%), nutrition/obesity US$ 5.8 million (9.2%), psychiatry/mental health/addictions US$ 4 million (6.6%). Ministry of Health institutions successfully funded 195 projects, while Mexican Social Security (IMSS) funded 108, and the National University 23.

Mexico is funding a good proportion of FOSISS’ budget towards HSR, though there are areas that have been under-financed (e.g. ageing, accidents and ethics).

Implications: Funding policy should improve through recommending: devoting specific percentages of funds to relevant yet under-funded areas; involving Ministry of Health decision-makers and other institutions in framing research questions and calling for proposals with a practical orientation; creating a special sub-fund for young researchers and for community-based research; and re-designing the evaluation committee to be more inclusive of social and HSR experts.
An analytical study for governance of malaria based on research papers, with special emphasis on East Asia

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Malaria is extremely widespread and prevalent in about 90 countries and is mainly confined to Africa, Asia and Latin America. The distribution varies greatly from country-to-country and within countries. Approximately 75% of all recorded cases outside of Africa are concentrated in India, Brazil, Afghanistan, Sri Lanka, Thailand, Indonesia, Viet Nam, Cambodia and China.

To improve governance of malaria control measures, it is necessary to look into the research activities being done in the field. For this study, papers related to malaria were collected from secondary sources and the Medline database. The study was carried out for a period of 25 years, with intervals of 5 years (i.e. 1980, 1985, 1990, 1995, 2000 and 2005).

Compared to the global scenario of total research publications on malaria, India, China, Thailand and Japan were found to be the most active producers of research among Asian countries, though the percentage of contributions has decreased over the period studied. There was a significant increase in the relative commitment of these countries towards malaria after 1980, but then little change after 1985.

It was interesting to see that with the development of new technologies in medical sciences, there was a tremendous increase in work related to molecular biology, immunology, proteomics, vaccine development and antimalarial compounds. When comparing the relative commitment of India, China, Thailand and Japan towards various sub-fields of malaria i.e. antimalarial compounds/drugs, malaria resistance, malaria control, immunological aspects, malaria vaccines and P. vivax, it was revealed that Thailand produced the maximum research activity followed by India and China. Antimalarial drugs/compounds seems to be the most active sub-field, which accounts for a major proportion of the contribution of all three countries. China produced more papers on antimalarials than other sub-fields, whereas India and Thailand produced the highest number on malaria in general, followed by antimalarials. The majority of research on antimalarials in these three countries focused on chloroquine followed by mefloquine.
The separation of economic linkages between drug prescribing and dispensing

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with Xiaohua Ying and Hongli Jiang

This research aims to define the separation of economic linkages between drug prescribing and dispensing, summarize and assess the practices in progress in China and abroad, and to put forward several recommendations.

The separation of dispensing from prescription (SDP) means that physicians are responsible for consultation and prescription while pharmacists are in charge of dispensing. This is accepted practice in most high-income countries and has been implemented in China for many years. Previously, where physicians, as clinic owners, dispensed drugs, as was commonly found in some Asian countries, profits from drug sales were a major source of physicians’ income. To change the economic incentives for physicians and control overuse and misuse of drugs, Korea, Japan and Taiwan carried out a reform of SDP.

Despite having achieved SDP many years ago, economic linkages between drug prescribing and dispensing still exist within hospitals in China. This is due to low medical service charges and reimbursement to hospitals through the mark-up between wholesale and retail prices of medicines. This provides an incentive for physicians, as employees of hospitals, to prescribe unnecessary medicines to patients. Social medical insurance departments have also failed to regulate prescribing behaviour.

In recent years, some community health centres in Wuhan city have contracted drug retail companies to operate hospital pharmacies in exchange for fixed rental payments. To reduce commercial bribes in drug sales, community health centres and secondary hospitals in Nanjing consigned their outpatient pharmacies to drug companies through public bidding. In Shanghai, management of income and expenditure was separated in the community health centres of two districts to weaken the impetus of hospitals to earn money. The impacts of all these practices have been assessed through a field survey and stakeholder analysis.

The separation of economic linkages between drug prescribing and dispensing does not mean the separation of hospitals and their outpatient pharmacies. Benefiting the patients and providing good incentives for physicians to rationally prescribe are the key points of reform.

Five sets of alternative recommendations are offered, the strengths and weaknesses of each analysed and necessary measures to guarantee operation are suggested.
Improving the social responsibility of public hospitals in China

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This study aims to define the social responsibility of public hospitals in China and tries to find the underlying factors that lead to public hospitals deviating from their social responsibility. This study also proposes policy suggestions for improving the social responsibility of public hospitals.

As non-profit organizations set up by the government, public hospitals should embody social responsibility, which encompasses two domains: accessibility of essential health services and appropriateness of health services. Recently, public hospitals have seriously deviated from these social responsibilities. The equity, accessibility and appropriateness of essential health services has decreased. Most public hospitals now have strong incentives to make money through user charges.

Based on focus group discussions and a literature review, and adopting a ‘diagnostic tree’ approach, this study analyses the underlying reasons why public hospitals have deviated from their social responsibilities. The main reasons are: lack of leadership responsibility from the government, a distorted cost reimbursement mechanism, illogical resource distribution, and a weakened consciousness of social responsibility among public hospitals.

Through a systematic review of policies on public hospital’s social responsibility in recent years, this study analyses the effects and the problems following implementation of those policies. Policy weaknesses are mainly due to lack of coordination, monitoring and governance.

For comparison, this study examines the social responsibility experiences of public hospitals in the United States of America and the United Kingdom, and elaborates on the function of government in the health sector in those two nations. The experiences of the USA and the UK would be useful references for China to improve public hospitals’ social responsibility.

This study proposes policy suggestions for improving the social responsibility of public hospitals by identifying influencing factors. Suggestions include: establishing a health insurance system to cover urban and rural residents; constructing a safety net mainly based on public hospitals; implementing a reimbursement mechanism with positive and negative criteria; strengthening the macro control of public hospitals by the government; and improving public hospitals’ motivation for social responsibility.
Health financing systems and health-care access

Hengjin Dong, Group Leader, Tropical Hygiene and Public Health, International Health Economics and Technology Assessment, Heidelberg University, Germany with Vinod Diwan and Lennart Bogg

It has been argued that a good health financing system should strive for universal access, high quality, socially acceptable costs and a free choice of physician. Traditionally there are three formal health-insurance schemes and one informal component in China: the government health insurance (GHI), the labor health insurance (LHI), the rural co-operative health insurance (CHI), and ‘out-of-pocket’ payment. Recently in some urban areas, GHI and LHI have been combined into a system called ‘social insurance’.

The research focus of this study is the differences in health-care access among the different health financing systems in rural China.

A multistage sampling procedure was used to select county, township and village health facilities. Six counties in three provinces (Jiangsu, Anhui and Jiangxi) in central and eastern China were chosen based on their gross national product levels and infant mortality rates. In each of the selected counties, one town and four townships were chosen. Five villages in each township were randomly selected. 2552 outpatients were interviewed in the six counties in August and October, 1995 and 1064 health-care providers were interviewed.

The empirical data from the six Chinese counties in this study suggest that health-care financing methods differ with regard to the degree of access. A health insurance system can improve access: as indicated in this study, insured people have a higher access to health care and to expensive care, such as high-cost drugs or inpatient care. However, health insurance may lead to a risk of over-use of health resources, by both consumers and providers. It was found that consumption of drugs per capita, for example, is higher among insured patients.

China has low coverage of health insurance, thus resulting in low access to health care. In order to improve people’s health, different types of insurance schemes, with certain measures to control ‘moral hazards’ such as co-payment, can improve health-care access and efficiency.
Separation of regulation and application in health systems in China

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Separation of regulation and application in health systems requires properly separating inner regulation functions, which include functions of decision-making and supervision, from the application functions of government. After separation, regulation sectors are mainly responsible for making decisions, setting standards and establishing processes, while application organizations are mainly responsible for carrying out policies and service provision. In general, application organizations are either part of the government sector or nongovernment organizations that are authorized by the government.

Models were analysed for Shanghai, Wuxi, Haidian (Beijing), Suzhou and Weifang and results showed that current separation reforms focused on transformation of the government role to: 1) reinforce holistic administration in health systems from a macro perspective; 2) prioritize public health and basic health service provision; 3) reinforce entry and supervision of health facilities using legislation, regulation and performance assessment; 4) further public health facility reform to improve governance using proper incentives. The performance of these pilots needs to be further assessed.

Separation reform was inadequate and segmented. Most domestic separation reforms were property rights reforms of public health facilities.

Borrowed experiences were used in local reforms without considering their historical background and context. Segmented policies and reforms were proposed based on the sector’s preferences and lack of a core policy-making level, which made for inconsistencies of policy-making and application.

The paper offers a suggested model for separation reform.
Does rural health insurance bring equity of access to and utilization of health services? A comparison between China and Viet Nam

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with Rachel Tolhurst, Baorong Yu, Nguyen Khanh Phuong, Joanna Raven and Shenglan Tang

Health-care financing reforms in both China and Viet Nam have resulted in greater financial difficulties in accessing health care, especially for the rural poor. Both countries have been developing rural health insurance for decades. This study aims to explore and compare equity issues in rural health insurance in the two countries.

A qualitative study and household survey were conducted in six counties of China and four districts of Viet Nam. Equity was analysed according to geographic and economic factors.

In China, health insurance arrangements greatly vary among counties, in terms of government subsidy, premium level, ceiling, co-payment, and management procedure. Viet Nam is implementing fragmented national health insurance programmes; compulsory health insurance covers employees in formal sectors and from 2005 covers the poor. Different voluntary programmes co-exist. The near-poor are the least supported by any insurance scheme.

In China, poor households (26.4%) were less likely to seek treatment when feeling sick than rich households (21.2%). Among those who had been recommended for hospitalization, 12.9% of people from poor families refused, while only 5.4% from rich households did so. Most (69.7%) of the refusals were due to economic difficulties. In Viet Nam, the poorest households used the most outpatient services, while the near-poor used the least. But 15–27% of health insurance card holders did not use their health insurance cards when using services provided by government health facilities, mainly because of the poor quality of services to health insurance card holders.

The different arrangements of rural health insurance in China and Viet Nam bring different equity considerations. The decentralized context of the New Cooperative Medical Scheme in China may lead to considerable geographical inequity among different counties. Poor people still face serious financial difficulties in accessing health services. The poor in Viet Nam were successfully covered by compulsory health insurance, but still experienced difficulties in accessing high quality health services. The near-poor were least supported by any health insurance programme. Central and local governments’ roles in health insurance in both countries need to be studied and promoted.
Health payment-induced poverty and financial protection in rural China: evidence from the New Cooperative Medical Scheme in Shandong province

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with A Sleigh, G Carmichael and S Jackson

The project’s objective was to measure the impact of China’s New Cooperative Medical Scheme (NCMS) on health payment-induced poverty of rural households in Linyi county, Shandong province. The dataset used for health payment-induced poverty analysis was a household survey initially designed for identifying households with catastrophic health payments. In 2005, from a stratified cluster sample of 3101 rural households, we identified 375 households that might be at risk of catastrophic payments, by searching through NCMS claims and interviewing key informants. We interviewed these 375 households and confirmed that 120 had been pushed under the Chinese National Poverty Line (668 Yuan (or US$ 88)) during 2004. A validity test of our screening method found another 6 cases among immediate neighbours of these 375 households; by extrapolation, we obtained an adjusted total of 157 households suffering health payment-induced poverty in the sample of 3101. We measured the impact of the NCMS on hardship alleviation by counterfactual analysis, comparing health payment-induced poverty before and after NCMS reimbursements. International poverty lines (US$ 1.08 and US$ 2.15 per day) were also applied to measure health payment-induced poverty.

The effect was two-fold. Before NCMS intervention 5.06% of the sample households were below the poverty line due to health payments, compared to 4.03% after reimbursements. The severity for households remaining in health payment-induced poverty after reimbursement dropped by 19.2% to an average of 977.2 Yuan (or US$ 130).

Out-of-pocket medical payments remain a burden for rural households. Financial protection from the NCMS, with an average reimbursement of 17.8%, was modest and should be restructured to provide better benefits targeted at those in most need.
The mechanisms of motivation of medical care workers in public hospitals

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Medical care worker motivation is widely believed to be a key factor of influence on worker/organization performance. In this paper we study major theories about motivation in medical care workers and hospitals, and critically review related empirical evidence. This study follows the historical development of health care system reforms in our country, and provides relevant reform recommendations for health policy-makers.

The methods employed include: 1) a systematic literature review; 2) expert consultations.

The results are as follows: 1) The determinants of motivation of medical care workers can be grouped into seven major classes: work itself, relationships at work, workplace conditions, opportunities for personal development, pay/rewards, management practices, and organizational policies. 2) The method of compensation or payment has an important influence on the behaviour of medical care workers. 3) There is a big gap with some other nations and regions in the motivation of medical care workers. 4) Most medical care workers in public hospitals are not satisfied with their current working conditions. 5) Raising wage levels improves the initiative and efficiency of most medical care workers dramatically. 6) A wide range of motivational mechanisms exist, from psychological to financial incentives. 7) Motivational problems include: incentives systems have not been constructed systematically; the salary system is outdated; medical care workers are poorly compensated for their work; salary differences are not well balanced; ‘red tape’ demotivates workers; and, there is an apparent income gap in comparison with other countries.

Policy recommendations include: 1) The motivation and restriction mechanism for medical care workers in public hospital should follow the principles of legitimacy, equity and stability. 2) Distribution systems and other supporting policies for medical care workers in public hospitals should be improved. 3) Medical care workers should be given independent rights in their work. 4) The skills of medical care workers should be carefully matched with their position. 5) The compensation mechanism in public hospitals should be standardized and perfected. 6) The government should increase investment in public hospitals, and raise fees to reflect the real labour value of medical care work. 7) A performance assessment system and reasonable ‘floating’ mechanism should be established. 8) A reasonable salary system should be established, which reflects the balance between efficiency and equity of distribution. 9) The working environment should be improved for medical care workers in public hospitals, and a harmonious relationship between doctors and patients established in medical care services. 10) ‘Management with humanity’ should be fostered.
Research on the policy process of the New Cooperative Medical Scheme and Medical Assistance scheme in China

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There are two main formal institutions in China for accessing health services for rural residents, the poor and vulnerable populations: 1) the New Cooperative Medical Scheme (NCMS); and 2) the Medical Assistance scheme (MA). Although plenty of research has been done on NCMS and MA, both in China and abroad, since the two schemes came into effect, there is still a gap in the rural health policy process from the viewpoints of politics and public management.

Taking NCMS and MA as examples, this paper discusses the policy process for rural health, including the following questions: 1) What were the problems of rural health and how did knowledge of equitable rural health access improve? 2) How did issues of rural health come onto the central government’s health policy agenda? 3) How were the designs of NCMS and MA chosen? 4) What were the effects, problems and pressures in policy implementation? 5) What are the trends in policy adjustment and innovation.

By exploring the dynamic sequential policy process, we find that economic transition, social innovation, change of political ideas and values, the policy network, and health reforms have had significant influences on the rural health policy process.

This study concludes that: 1) the extent of economic and social development is a precondition for rural health policies; 2) the attention of senior policy-makers to rural health is a crucial factor; 3) the interest of implementers and the coordination among different departments are critical factors in the sustainable development of health policies; 4) researchers and other stakeholders are an important force in providing policy-makers with realistic information on health problems, getting policies enacted and improved. If any innovations in rural health policies are contemplated, we must take into account the above four conditions.
Study on the construction of the New Cooperative Medical Scheme management and executive system

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with Song Daping, Zhao Donghui, Ren Jing, Liu Yonghua, Wang Bing and Hu Shoujing

The New Cooperative Medical Scheme (NCMS) has completed its pilot phase and entered the expansion phase. Consequently, the national NCMS management and executive system faces great challenges. To investigate the status of the scheme and to investigate problems in institution set-up, human resources structure, management costs and function at each level of the system, and to make corresponding policy recommendations, this study will provide a theoretical and statistical reference to the government, and help ensure the healthy running of the scheme.

The study employed the following methods: 1) Document and literature review: Relevant materials on the management system, international experiences in managing health insurance schemes, and NCMS working papers, etc. were reviewed 2) Questionnaire and field research: At the time when the research was conducted, there were three categories of counties implementing the NCMS, distinguished by starting time. Approximately four counties were sampled from each category, in ten provinces, selected according to geographical location and socioeconomic development, in total 144 samples. Questionnaires about the construction of county-level and town-level systems were conducted, followed by data entry and analysis. Field research was also conducted in a number of counties to strengthen understanding. 3) Data analysis from the National NCMS Statistical Forms, 2005: Data on the county-level system was analysed to reveal status and problems.

The overall framework of the national NCMS management and executive system has been established. However, the construction of the management departments at national, provincial and municipal level needs to be strengthened, while the construction of the executive institutions and offices at county- and town-levels needs to be regulated. The present system is faced with the following problems: 1) The set-up of the management departments and the executive institutions is inappropriate in some areas, which creates a lack of reasonable management and executive functions in these areas. 2) Human resources need expansion; the present team is unstable, and the literacy of the personnel needs improvement. 3) Deficient fiscal input is causing unwarranted financial allocation.

Based on research findings, the following policy recommendations are made: 1) regulate system management and strengthen policy guidance; 2) optimize human resource allocation and strengthen capacity-building; 3) increase financial input to support system function; 4) construct a unified executive office for the NCMS and the Basic Medical Insurance for the Urban Employee scheme.
Chinese health system reform: a systematic review of policy and experience since 1949

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The objective of this study was to systematically review the historic policies, experiences and lessons of health system reform in China since 1949, and provide meaningful evidence for further reform of the national health system in the near future.

The results were as follows: 1) The whole process of health system reform in China can be characterized in three periods: planned economy (1949 to 1978); early stages of reform and opening up (1978 to mid-1990s); and social and economic transition (1990s until present). 2) Ten laws, 33 regulations and more than 400 department regulations, which relate to the health system directly, have been enacted since 1984. At least 14 ministries in central government are currently involved in health system governance. 3) Varied benefit-oriented health systems were set up in urban and rural areas after 1949. More recently however, four social medical security systems were started in the 1990s, which include the urban employer basic medical insurance system, the new rural cooperative medical care system, and the urban and rural medical assistance system. 4) Total national health expenditure in 2004 was 44 times that of 1978 and as a percentage of GDP has increased slowly during the same period, but the proportion of patients’ out-of-pocket payments has risen significantly. 5) Most of the property value of health settings belongs to the government, but half of health facilities are private. Health setting management has obviously improved in the last two decades, however, there are some barriers within their management mechanisms. 6) Drug manufacture and distribution systems have experienced reform in several areas.

Health system reform in China has achieved remarkable progress since 1949; it protects and promotes the population’s health effectively. Reform still needs to be continued, however, especially in public health and basic medical care, which require support from public finance mechanisms to allow equitable access to health care.
**Poster session: Health system in China**

**Investigation of socioeconomic characteristics of chronic diseases in low-income groups in Jiangsu Province, China**

Hong Zhang, Student, Southeast University, People’s Republic of China with Chang-Kai Zhang, Zhang Kai-Jin, Zhang Xiao, Wang Ke, Tang Bo-Cai, Qin Ma-Lan, Jiang Ming-Xia, Chen Han

The objective of this study was to improve the equity of health and medical services in China, understand the socioeconomic characteristics of chronic diseases among urban low-income groups, and provide an evidence base for formulating more equitable health policy.

Random selection was made of 336 people from low-income groups from four cities (Nanjing, Wuxi, Xuzhou and Yancheng) in Jiangsu Province. An enumeration method was applied and the survey samples were stratified according to administrative region. All informants were investigated by self-administrated questionnaires, and the survey was followed up with quality control steps.

Those surveyed ranged from 19 to 87 years of age, among whom 170 were male and 166 were female. Their average age was 46.7 (±9.9) years. Of informants, 87.7% were unemployed; about 50% did not have any medical insurance; the average annual individual income of was 1988 Yuan (US$ 264); and average annual individual medical expenses were 1933 Yuan (US$ 257). The primary cause of their difficulties was identified as low income (66.6%). Other causes were as follows: lost employment (62.7%), fallen sick (57.9%) and disabled (26.6%). The prevalence of chronic diseases among informants was as follows: 38.4% of informants had at least one kind of chronic disease; 20.2% had only one kind of chronic disease; 10.1% had two kinds of chronic disease; and 8.1% had three or more kinds of chronic disease. When informants fell ill: 55.4% of informants were afraid of not having enough money to see a doctor; 51.5% only see a doctor if the illness is very serious; and 31.8% buy drugs from retail pharmacies themselves to treat serious illness. Of all informants, 81.0% were satisfied with local chronic disease prevention and control, but 14.4% were not satisfied.

The key to improving equity of health and medical services is to provide diversified forms of medical security and more employment opportunities to low-income groups. At the same time health education and health knowledge dissemination needs to be enhanced to improve understanding of health control and prevention. These are important factors in ensuring equity in health and medical services.
National health promotion capacity-mapping was undertaken during 2005 for the Western Pacific region, using a tool developed by World Health Organization (WHO). The purpose of the mapping methodology was to identify strengths and gaps in health promotion resources and actions.

In response to mapping results from 17 countries, WHO agreed to a revision of the tool, and of the mapping process. The new mapping approach was designed to feature participation by national health promotion stakeholders.

Modification of the tool was carried out in capacity-mapping projects in other WHO regions; capacity assessments elsewhere in the United Nations system e.g. the United Nations Development Programme (UNDP), the United Nations Environment Programme (UNEP); WHO Regional Office for the Western Pacific’s essential public health functions project; and the local public health infrastructure and capacity-mapping project in Australia (Lin and Bagley).

The revised tool consists of three sections: context; infrastructure and capacity across four domains; and system resilience. It was trialed in Brunei Darussalam, Papua New Guinea and the Philippines in 2006 with active support and participation of national governments.

This presentation reviews the experience of the initial capacity mapping, completed for the 6th Global Conference on Health Promotion (Bangkok, 2005), and explains the rationale behind revising the tool and the approach to mapping. The trial process was intended to assist in refining the tool and ensuring its suitability to the region, as well as to test its value as an intervention in different socioeconomic contexts that could actively engage stakeholders in considering their investment needs for health promotion capacity.

The process confirmed earlier observations that the most important attributes of the methodology are: 1) it encourages stakeholders operating at various levels of public health systems (and other sectors) to engage in debate and jointly assess strengths and deficits in health promotion capacity; and 2) it facilitates consensus about strategic directions for health promotion capacity-building among stakeholders. A major policy implication is that a structured approach to capacity assessment provides an essential baseline for capacity-building for health promotion and engages people operating at multiple levels in analysing strengths and gaps. In some countries, the process may provide opportunities for voices not routinely heard in system assessments to help shape system development agendas.
The introduction of new health technologies in India

Shilpa Vuthoori, Policy Associate, Public Policy, International AIDS Vaccine Initiative, USA
with Holly Wong

Building political and financial support and strengthening health system capacity to ensure equitable access to new and future technologies, such as HIV vaccines, can be especially challenging in developing countries. Involving a range of stakeholders in decision-making can help adequately prepare for the adoption, implementation, and delivery of new innovative health technologies. The introduction of new technologies includes the formal government decision to approve the product (or service) and the implementation of programmes necessary for its distribution. To identify and assess the potential issues in introducing HIV vaccines into the Indian health-care system when they become available, a research study was conducted of five health technologies previously introduced in India.

This analysis examines the adoption histories of the Universal Immunization Programme (UIP), hepatitis B vaccine, no-scalpel vasectomy (NSV), voluntary counselling and testing for HIV (VCT) and antiretroviral therapy (ART) in India using literature reviews, national data sets, international health agency reports, and interviews with field experts. We identified key financial, political, social and programmatic factors that influence health technology introduction. Reviewing these five health technologies previously adopted in India within the context of these factors provides health-care decision-makers with valuable lessons applicable to HIV vaccines.

The findings suggest the eventual introduction of HIV vaccines may face numerous challenges and that multiple stakeholders must be involved to successfully introduce any new health technology. For example, defining public health need for – and evaluating the appropriateness of – an HIV vaccine depend on both scientific and operations/social research data. Additionally, involving both nongovernment organizations and the private sector can significantly affect the success of a vaccination programme. Other critical steps, such as obtaining financial and political support and expanding infrastructure, require participation from a variety of stakeholders including policy-makers, programme managers, funders and activists.

Encouraging stakeholders to prepare in advance could substantially ease the introduction of HIV vaccines, reduce the time lag to implementation, and result in more equitable access for the target population. Additional lessons may be gained from the practical experience of introducing other technologies such as the human papilloma virus (HPV) vaccine in India and other developing countries.
Inter-institutional partnerships: a tool for promoting research and health equity

Priscila Almeida Andrade, Consultant, Prevention and Disease Control Unit, Pan American Health Organization, Brazil
with Suzanne Jacob Serruya, Marcia Motta and Antonia Angulo Tuesta

There are several actors in the health research field, with different backgrounds and visions. Building a technical-political consensus related to knowledge production and incorporation is an important strategy towards promoting equity on access to health. However, this is a difficult process. The conflicts between the public and private sectors; the varying perspectives of academics, health services and the general population; in addition to the divergent interests at the international and national level in science, technology and innovation in the health field, all present major challenges to overcoming the inequities in health and health research.

In light of this, inter-institutional partnership stands out as an efficient mechanism, capable of facilitating the convergence of interests and building consensus among actors. In Brazil, for example, several initiatives have been implemented based on the establishment of partnerships with different stakeholders. At a national level, better cooperation between the Ministry of Health and the Ministry of Science and Technology has improved health science and technology development in the country. It has also helped to increase the financial resources assigned to health research.

Another strategy adopted was a public call for bids for health research and development. Those competitive calls aimed to foster the establishment of public-private partnerships to carry out research in priority topics for the Brazilian population, and to increase Brazilian industries’ investment.

Collaboration between academia and health systems and services has been another successful partnership in Brazil. It has expanded the production of scientific evidence to ground the decision-making process, and has facilitating the training of health workers in areas that are still underdeveloped in Brazil, such as health technology assessment. Finally, at regional and global levels, collaboration among Latin-American institutions and international actors such as the Council on Health Research for Development (COHRED), Global Forum for Health Research and the Pan American Health Organization (PAHO) has ameliorated regional challenges and enhanced perspectives on health research in the international arena. This presentation aims to present some inter-institutional partnership experiences that Brazil has established toward promoting the development and use of research as a tool to reduce health inequities.
Artemisinin-based combination therapies (ACTs) are essential components of the global control strategies aimed at curbing the significant morbidity and mortality caused by malaria. In order to reduce economic barriers to access of ACTs for the treatment of malaria, three organizations have come together to identify new solutions and develop new methods for producing artemisinin. Even with current and projected increases in farming of the shrub from which the drug is derived – *Artemisia annua* – all three new technological approaches could satisfy projected global demand. These strategies together will stabilize the supply of artemisinin, lower the cost of artemisinin production, and make ACTs accessible to far more of the people who need them. The three organizations are the Institute for OneWorld Health (OWH), the Centre for Novel Agricultural Products of the University of York, and the Medicines for Malaria Venture (MMV).

There is currently a window of opportunity to reduce the malaria burden through the use of ACTs. All three members of the consortium aim to introduce products to the market beginning in 2010. This period encompasses the potential release of high-yield seeds from York, projected approval of MMV’s OZ synthetic peroxide, and the projected launch of ACTs based on microbially-derived artemisinin, under development by the Institute for OneWorld Health.

In this symposium the different international groups will present their unique strategies and will discuss the forecasted impact of the success of their approaches within the larger context of the global goal to increase access to medicines in the fight against malaria.
Poster session: Inter-institutional partnerships

Developing research partnerships to bring change in policy and practice: experiences from Research for Equity and Community Health (REACH) Trust, Malawi

Bertha Nhlema Simwaka, Acting Executive Director, Research, Research for Equity and Community Health (REACH) Trust, Malawi
with Bertie Squire and Sally Theobald

Research for Equity and Community Health (REACH) Trust conducts research on tuberculosis (TB), HIV and malaria to promote equity in health that is close to policy and informed by new developments, multidisciplinary, and strengthens capacity at community and national levels to promote equitable, pro-poor, gender-sensitive health provision. The purpose of this paper is to highlight key interrelated themes of REACH Trust experiences in translating research on equity into policy and practice.

Although there are substantial obstacles to translating research findings into policy and practice, REACH Trust has found that participatory approaches at community, national and international levels alike can reap benefits in enhancing equity in provision of health services through research. There are three key inter-related themes that are central to a participatory approach to advocating for research utilization to improve access to services: 1) multi-disciplinary and multi-method approaches; 2) advocating research at strategic forums; and 3) strategic framing of research outputs.

REACH Trust undertakes clinical, biomedical and social science research using quantitative and qualitative methods. This has been strategic in terms of both personal preferences and the creation of opportunities to present holistic perspectives. For example, some policy-makers prefer quantitative methods and others qualitative. Also, technical working groups at national and international levels have been used to present research outputs on access to antiretroviral therapy, and on informal health systems to increase case detection for TB among the poor. Strategic framing, meaning adopting or situating research in different languages, or within discourses on gendered research findings, for example, have been used to repackage findings for different audiences.

As individuals working on equity and rights discourses we believe, that women have a right to accessible and high-quality health services. We have argued that if TB and HIV services are inaccessible or unacceptable to poor women, programmes will not be cost-effective nor will they meet their targets.

Research is not a passport to policy. Developing sustained and responsive relationships with policy-makers is also of key importance. These relationships enhance ownership of the research process and hence the likelihood of policy-makers adapting policy and practice.
Stakeholder analysis at the research-policy interface: enhancing equity in health systems research in six low- and middle-income countries

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Utilization of systematic stakeholder analysis enhances equity considerations at the research-policy interface in the developing world. Stakeholders – “organizations and individuals involved in a specific activity because they participate in producing, consuming, managing, regulating, or evaluating the activity” – come from disparate backgrounds, varying from powerful decision-makers to powerless marginalized health system users and beneficiaries.

Four key advantages of stakeholder focused approaches in strengthening health system research-policy interfaces can be postulated. First, systematic stakeholder identification, power analysis, concern reporting, and construction of influencing strategies enhances the likelihood of pro-equity research successfully influencing policy-making. Second, consumer ideas, concerns, and expectations – often ignored due to limited power – can enhance the success of health system reforms based on research. Third, understanding multiple stakeholder perspectives allows intervention refinement using multidimensional thinking and innovation. Lastly, sharing perspectives between stakeholders, and recognizing their inter-relatedness, enhances solidarity around particular interventions – a construction of coalitions.

The research consortium on Future Health Systems: Innovations for Equity is working in six partner countries in Asia and Africa, focusing on strengthening the research-policy interface for specific health systems research projects. Stakeholder analyses are utilized in these settings to enhance equity and access considerations in health systems research. The findings aim to contribute to the global body of knowledge on utilization of the approach in strengthening research-policy interfaces in the developing world.

This paper first presents a review of methodological issues in conducting stakeholder analyses in low- and middle-income countries; then describes findings from application of such analysis in six countries where the consortium is working; and finally elaborates the implications for policies pertaining to health system research in developing countries.
Gossips, rumours and ‘making me funny’: exploring the role of stigma and its impact on disclosure reported by individuals attending an antiretroviral drug clinic in Cape Town, South Africa

Naeemah Abrahams, Researcher, Gender and Health Research Unit, South African Medical Research Council, South Africa
with Siphokazi Dada and Rachel Jewkes

Stigma and discrimination against HIV positive individuals has been identified as one of the greatest barriers to the successful implementation of the South African national HIV plan, and the need to understand how stigma is experienced is important for the development of strategies to improve HIV testing and treatment.

The objective of the research was to explore the role of stigma among a group of individuals attending an antiretroviral drug clinic in Cape Town, South Africa.

Qualitative research methods using in-depth interviews were conducted with 20 women and men who attended an antiretroviral treatment clinic. Between 1 and 3 interviews were conducted with each individual to explore the social experience of being HIV positive and being on antiretroviral treatment.

A treatment buddy was a precondition to commence antiretroviral treatment and this person was chosen based on whether the person was trusted by the patient. All participants chose same sex buddies, with elder sisters often the preferred person. Determining if someone frequented shebeens (township bars), which could provide opportunities for gossip, was also considered. Involvement in arguments, where the risk for insults related to HIV status arises, was also avoided. Body shape was an important source of rumours, including both weight loss and physical changes as a result of antiretroviral treatment. All participants spoke of being the victims of mockery and had developed strategies to determine potential stigma responses during conversations with others. A few participants did not reside in the research area and preferred to attend a clinic outside of their community to avoid stigma. Health workers were also often identified as a source of gossip.

The study has highlighted the huge burden carried by people living with HIV and showed the many strategies they have to develop to avoid stigma. The HIV epidemic in South Africa has reached the stage where many more people will require antiretroviral treatment and decreasing stigma should be an essential aspect of the national treatment plan.
Barriers and enablers to accessing and adhering to antiretroviral therapy in Thyolo: a human rights perspective

Grace Bongololo, Researcher, Research for Equity and Community Health (REACH) Trust, Malawi
with Lot Nyirenda, Dieudonne Bwirire, Magareth Firtzgerald, Sally Theobald and Ireen Makwiza

Malawi is party to a number of human rights treaties that address health-related rights, including the right to health. In Thyolo district, and in all public health facilities in Malawi, antiretroviral therapy (ART) and all HIV-related services are provided free of charge. Access to free ART in Thyolo has been spearheaded by Médecins Sans Frontières (Belgium) since 2003. The government of Malawi with assistance from the Global Fund to Fight AIDS, Tuberculosis and Malaria introduced free ART in June 2004. Emerging evidence from Thyolo showed that a significant number of eligible patients chose not to initiate ART.

The objectives of the current study were to: (1) explore barriers that people living with HIV face in accessing and adhering to free ART; (2) conduct an equity analysis of routine ART and clinic data; (3) assess patients’ and the community’s knowledge and understanding of HIV and ART.

The study used a qualitative approach complemented by analysis of routine ART register data. Data was collected at Thyolo District Hospital, peripheral health centres and the general community, from March to June 2005.

The poor experienced a number of opportunity costs to access and adhere to free ART. Transport costs and lack of food emerged as the major barriers to access and adherence to ART. Availability of free drugs and positive attitudes of health workers were seen as enablers to both access and adherence to ART. Analysis of secondary quantitative data showed that more women (62%) than men (38%) were accessing ART. People on ART showed far better understanding of HIV than any other respondent group. There was very poor knowledge and understanding of ART among the general community members.

Poverty compromises the right to health of most poor people. Making health services free of charge on the point of delivery does not make the services completely accessible for the poor and the vulnerable. Right to health should go beyond access to consider the factors affecting adherence. Mainstreaming human rights in health programmes can help to improve access and adherence to health services for poor populations.
Vaccines are among the most effective tools for fighting infectious diseases, and an AIDS vaccine should be considered one of the best hopes to end the spread of HIV. However, the impact that first generation preventive HIV vaccines may have is uncertain, particularly if they only provide partial protection against HIV. In order to determine how effective HIV vaccines may be, the International AIDS Vaccine Initiative (IAVI) developed an epidemiological transmission model that estimates the impact of HIV vaccines on incidence of HIV infection, mortality, and related treatment costs. This model examines the effects of different delivery scenarios and illustrates how even modestly effective vaccines could have a major impact in halting the HIV epidemic. The model was previously used to estimate the impact of HIV vaccines on all low- and middle-income countries.

The model is currently being used to simulate HIV prevention and treatment scenarios in Uganda. The model captures three possible effects of HIV vaccines (reduced susceptibility to infection, reduced infectiousness of infected individuals, and increase in average survival time following infection). To model the impact of HIV vaccines, we projected the course of the HIV epidemic to 2030 in Uganda based on national surveillance data. We convened a group of high-level policy-makers, public health specialists, and HIV researchers to inform the assumptions behind model inputs. We are also conducting secondary data collection to refine model inputs and generate specific results for indicators of vaccine impact (prevalence, incidence, deaths averted).

Although HIV prevention programmes have expanded in recent years, our global analysis shows that even a dramatic expansion of prevention and treatment services will not stop the HIV epidemic. In these circumstances, even a partially effective vaccine with modest levels of coverage and uptake could make a significant contribution to lowering the number of new infections, slowing the epidemic, and saving millions of lives and hundreds of millions of dollars in treatment costs for HIV-related illnesses and anti-retroviral therapy. This work can help national policy-makers develop different vaccine delivery scenarios (targeting different risk-associated groups), analyse the cost-effectiveness of various tools to combat HIV, and explore the impact of HIV vaccines with a range of characteristics.
Universal access to treatment: who sets the agenda? Whose voice is heard?

Anushree Mishra, Consultant, Panos Global AIDS Programme, India

Access to treatment and specifically antiretroviral (ARV) drugs across the developing world is currently one of the major donor priorities in the fight against HIV. The Panos Global AIDS Programme conducted research in Haiti, Ethiopia, India, Nepal and Zambia. The objectives were to: analyse the way in which treatment roll-out is designed and implemented; identify the obstacles to achieving universal access; and, to establish the extent to which the most affected communities are involved in the current treatment roll-out. The study incorporated the voices of people living with HIV (PLHIV), vulnerable groups, health professionals, public health experts, government officials, industry representatives and others concerned with the programme.

The following themes emerged from the findings: 1) a programme that is poorly conceived, and monitored; 2) a public health infrastructure unprepared to take on this intensive programme; 3) insufficient funding; 4) a lack of transparency at all levels; 5) limited access for marginalised and vulnerable groups such as women, people from rural areas, sex workers and men having sex with men; 6) limited information on treatment literacy and a lack of involvement of community organizations, especially organizations of PLHIV. Issues around patenting and the cost of drugs are also major challenges to ensure universal access.

On the basis of the analysis the study came up with a set of recommendations that will enable effective and inclusive treatment roll-out around the world. These include commitment from leadership and recognition of local circumstances. The study argues that national strategies on treatment can be effective only with meaningful involvement of PLHIV and vulnerable groups and increased communication among groups of people receiving treatment. Advocacy on the need to increase access to treatment and the issues that need to be resolved in order to achieve universal access are essential elements in communication. Dissemination of adequate and appropriate information to all stakeholders is essential to support an environment of increased communication. The role of the media is vital to provide clear and accurate information, and to hold policy-makers and politicians designing national responses to HIV to account.
**Poster session: Issues on HIV**

**Rapid assessment and response formulation for HIV infection among migrant workers returning from the Middle East to Pakistan**

Gregory Pappas, Professor and Chairman, Department of Community Health Sciences, Aga Khan University, Pakistan

with Omrana Pasha and Zia Dawar

Since 2004 Pakistan has experienced a concentrated epidemic of HIV infection, with rates amongst injecting drug users in major cities rising to over 50%. Interestingly, however, the bulk of cases reported to the Provincial AIDS Control Programme (PACP) in the North-West Frontier Province (NWFP) are those of migrant workers returning from the Middle East and their families. We conducted a rapid assessment of this population in NWFP and the Federally Administered Tribal Areas (FATA) of Pakistan to identify information that would be useful in formulating policies for prevention and care.

We constructed a conceptual framework to describe the journey of a migrant worker from NWFP/FATA to the Gulf nations, his experiences in the host country, the process of repatriation and his course after returning to his original home. We conducted focus group discussions with representatives of stakeholder groups including PACP; health-care providers and nongovernmental organizations dealing with people living with HIV (PLHIV); the governments of NWFP/FATA; members of the media; travel agents; faith-based organizations; and PLHIV deported from the Middle East. We also conducted in-depth interviews with two groups of men; those infected with HIV repatriated from the Middle East and those whose HIV status was unknown and who travelled frequently to the Middle East.

This study provides compelling evidence that migrant workers are an important HIV risk-associated group in the country. While population-based studies are lacking, the evidence compiled here provides a rationale for further exploration of the problem and for immediate action in terms of programmes and policies. Migrant workers present a special challenge because many of the factors that are associated with their risk-associated behaviours are likely to be non-modifiable. The focus of programming will be on behavioural harm reduction and on structural changes to facilitate prevention for PLHIV, i.e. provide support to PLHIV towards reducing behaviours that could result in new HIV infections.
Distributional equity in demand-driven HIV programmes: lessons from Malawi

Arild Schou, Associate Professor, Department of Economics and Social Sciences, Buskerud University College, Norway

Over the last decade, development agencies and governments in low- and middle-income countries have turned their eyes towards the local level in implementing national HIV programmes, focusing on local level institutions and processes. The underlying idea is that by ‘going local’, development efforts will promote popular involvement and that programme activities will be attuned to local development priorities. Such programmes are supposed to be superior to traditional public service delivery, with its ‘supply-driven’ problems – centralization, rigid and top-down bureaucracies and insensitivity to service users. However, recent research on such programmes has shown that demand-driven programmes are particularly vulnerable to elite capture and unequal sharing of programme funds.

The aim of this paper is to analyse intra-district distribution of programme benefits to community-based organizations in the Malawi national HIV programme. The evidence is based on a comparative case study of the implementation in two rural district councils. The paper argues that in an early phase of programme implementation there is a tendency of relatively unequal sharing of benefits among the target groups. In both councils it was the most advantaged areas (Traditional Authority Areas) in terms of access to education and closeness to the councils’ headquarters that benefited the most from the programme. Some of these areas were also the most advantaged ones in terms of access to health services, which shows that the programme does not necessarily reach those who are most in need of improved HIV prevention and care. Finally, in both councils it was found that it was the areas that already had a vibrant organizational life in the field of HIV that benefited the most. In all this, elite capture by ‘local strongmen’ serves as an explanation. However, elite capture is systematically correlated with other area characteristics such as educational level and vibrancy of civil society. Thus, in this context the elite capture perspective seems to be too narrow.
A management tool and process to improve access to high-quality HIV and TB services

Vera Scott, Researcher, School of Public Health, Community Health Sciences, University of the Western Cape, South Africa
with Virginia Azevedo, Judy Caldwell, Uta Lehmann, Pren Naidoo, Jabuliswa Zulu and Mickey Chopra

The dual burden of HIV and tuberculosis (TB) presents a pressing health service need in South Africa. Civil pressure has highlighted the issue of adequate access to high-quality HIV prevention and treatment provision as a priority for the general primary care services, which provide the programme delivery platform. The components of the HIV and TB programmes are in the process of being integrated.

The objectives of this project were: 1) To develop an evaluation tool to measure access, service capacity and quality within the HIV, TB and sexually transmitted infection (STI) programmes. (This tool should also be suitable to monitor equity of service provision between districts.) 2) To model a participatory process that engages with middle managers and empowers them to use health information to improve programme performance at the level of implementation, i.e. the primary care facility.

A team of managers and researchers designed a comprehensive health systems framework outlining key conditions for effectiveness. This was used to identify tracer indicators to measure implementation of four of the key components of an integrated HIV/TB/STI package. Sixteen clinics were reviewed and 495 records were sampled. Results were analysed in a participatory process with facility managers.

Half the primary care facilities regularly deferred (turned away) clients because of service overload; three quarters of these facilities offered clients the opportunity to make an appointment to secure subsequent access to services. 64% of voluntary counselling and testing for HIV (VCT) clients who were diagnosed HIV positive (77 out of 144) were referred for further assessment and care. 68% of HIV positive clients who qualified for antiretroviral treatment were referred appropriately. 70% of STI clients and 94% of TB clients were offered VCT.

Access to this priority programme is threatened by inadequate access to the general primary care services. There are opportunities to improve access within the programme to prevention, detection and care by using each client-staff interaction and referring appropriately. We have found that the deliberate measurement of access, referral and integration of the HIV/TB/STI programme and the participatory process of analysis has empowered managers to plan specific strategies to improve access at the facility level.
**Poster session: Issues on HIV**

**The effects of global HIV initiatives on equitable access to HIV services at the sub-national level: Georgia, Kyrgyzstan and Ukraine**

Neil Spicer, Lecturer, Health Policy Unit, London School of Hygiene and Tropical Medicine, United Kingdom
with Gill Walt, Ruairí Brugha, Aisling Walsh, Tetyana Semigina, Gulgun Murzaleiva and Ketevan Chkhatarashvili

Global health initiatives (GHIs), including the Global Fund and the World Bank’s HIV programmes, mobilize substantial new resources for HIV control. However, such initiatives carry risks: pressure to demonstrate rapid impacts means that country programmes may target easier-to-reach populations rather than extend access more equitably to marginalized groups. There has been limited research on the effects of GHIs, especially in ‘concentrated’ HIV epidemic settings.

A network of health systems studies, the Global HIV/AIDS Initiatives Network (www.ghin.lshtm.ac.uk), is comparing the effects of GHIs across 15 countries within sub-Saharan Africa, the former Soviet Union (FSU) and other regions. Research themes include equitable access to HIV services, service scale-up, human resources and coordination of control activities.

This paper presents early results from the FSU country studies: Georgia, Kyrgyzstan and Ukraine, each with concentrated HIV epidemics, predominantly among young drug users and sex workers. It focuses on the effects of GHIs on equitable access to HIV services at sub-national levels, where access is mediated by interrelated factors at different levels – community, service delivery and health policy. The paper draws out general conclusions, especially applicable across FSU countries:

- GHI money is supporting service delivery but multi-level country factors are obstacles to equitable access among women and men in risk-associated groups (sex workers, injecting drug users, prisoners and men having sex with men).
- Human rights and legislative approaches potentially increase access for these risk-associated groups to HIV services in countries with previously poor human rights records.
- Poor coordination between funding agencies, governments and nongovernment organizations risks undermining equitable access to HIV services.
- The paper draws out comparative lessons and recommendations for policy-makers and practitioners by highlighting barriers to access, and policies and practices that help overcome them in different countries. The paper argues that further research is required to fill critical gaps in knowledge: firstly, to understand how to promote appropriate policy environments in countries that will develop generalized HIV epidemics if risk-associated groups are unable to access HIV services; secondly, to measure the relative impact of different service models for HIV prevention and control of HIV transmission.
The objective of this study was to determine whether there were socioeconomic differences in the profile of HIV-positive people living in the community and HIV-positive patients presenting for hospital-based outpatient HIV care and related services.

A cross-sectional study was conducted in Limpopo province, South Africa among 776 HIV-positive people aged 18–35 years, including 534 consecutive patients who presented for care at a hospital-based outpatient HIV clinic, and 242 people living in the community.

People presenting at the clinic had a higher overall socioeconomic profile compared to the community sample. They were more likely to have completed secondary education (P<0.001), less likely to be unemployed (P<0.001), and more likely to live in households with access to a private tap water supply (P<0.001). These differences persisted after multivariable adjustment.

Important socioeconomic differences in uptake of hospital-based HIV care were identified among HIV-positive adults living in a rural region of South Africa. This suggests an important limitation in hospital-based HIV care and underscores the need to monitor the equity implications of antiretroviral treatment scale-up in resource-limited settings.
The benefits of conducting HIV vaccine studies in developing countries

Shilpa Vuthoori, Policy Associate, Public Policy, International AIDS Vaccine Initiative, USA
with Ann Levin and Holly Wong

More than 75 HIV vaccine candidates have entered clinical trials, the ultimate goal of which is to find a vaccine that could reduce the impact of the HIV epidemic worldwide. Though no candidate has yet proven effective at preventing HIV transmission, the trials have had other tangible, intermediate impacts that can themselves contribute toward achieving other development goals.

This study was designed to identify the collateral benefits and possible negative consequences of HIV vaccine trials in developing countries. In the past, the prevailing assumption was that cutting-edge research could not be carried out in the developing world. But these countries have assumed an increasingly critical role in designing and conducting trials among populations that require a vaccine most urgently and stand to directly benefit from research the most.

Authors conducted 95 in-depth interviews with individuals who had experience with HIV vaccine trials in developing countries. Interviewees were located in 13 countries and represented a variety of different stakeholder groups. The paper describes key risks and benefits identified for each of six different constituencies: trial participants, researchers, communities, civil society, health systems and governments, and the global HIV vaccine field. Some benefits include: training, development of research infrastructure and capacity, education about HIV and vaccines, and access to voluntary counselling and testing and other medical services. Some negative consequences include: stigma and discrimination, media misinformation, and false-positive HIV test results. The paper also describes variation in the impact of trials among different countries and regions due to differences in socioeconomic situation, level of HIV incidence and prevalence, and the status of health-care systems.

Based on these results, activities that have helped to maximize benefits and minimize negative outcomes are identified. These include engagement of all stakeholders, comprehensive training for study staff, education of journalists, development of a strategy for working with trial communities prior to the start of research, and continued education and interaction with communities during trials. Implementing these recommendations can help researchers, sponsors, governments and communities obtain maximum intermediate benefits from future HIV vaccine trials, even as they contribute to the ongoing global effort to find a safe, effective, accessible vaccine.
The cost of AIDS care in China: are free antiretroviral drugs enough?

Jie Yu, Assistant Head of Mission, Médecins Sans Frontières (MSF), People's Republic of China
with Suerie Moon, Philip Tavernier and Hu Yang Qiong

Financial access to health care is difficult for many people in China, where there is a widespread fee-for-service system but an estimated 70% of the population has no health insurance. In 2003, the government launched a policy of ‘Four Frees One Care’, in which free antiretroviral (ARV) drugs are provided for all rural and urban poor people living with HIV (PLHIV). However, other components of AIDS care, such as baseline and monitoring lab tests and drugs to treat or prevent opportunistic infections, can be prohibitively expensive yet are not covered. This paper estimates the out-of-pocket costs for treatment and care that PLHIV in China might face over the course of one year.

Médecins Sans Frontières (MSF) provides a free package of treatment and care services in Xiangfan, Hubei province and Nanning, Guangxi province as of March 2003. The programmes pay for many costs that would otherwise be borne by the patient. This paper, based on our clinical data and following national treatment guidelines, aims to assess if there are any financial barriers to entering the national antiretroviral programme and which important factors prevent patients from accessing health care after entering the national ARV programme.

PLHIV have to pay a minimum 7% of annual income before entering the free national programme. AIDS treatment can be extremely costly; for a rural resident in Nanning, this translates into 37–3056% of an average annual income. In Xiangfan, treatment costs 3.8–1330% of an average annual income for a rural resident.

This study found clear evidence that the cost of AIDS care can quickly rise beyond affordable levels, and easily qualify as ‘catastrophic’ health expenditure. While providing ARV drugs free of charge is an important step, the costs of other components of care are also considerable and can even exceed ARV prices. Given the negative impact on adherence and health outcomes when patients cannot afford the treatment they need, policy-makers should consider providing monitoring services, drugs commonly used to treat opportunistic infections and basic laboratory tests free to all PLHIV who need them, as well as financial support for hospitalization and transport.
Measuring the relationship between gender and maternal death using a new gender index

Suzanne Cross, Gender Research Assistant, Initiative for Maternal Mortality Programme Assessment (IMMPACT), University of Aberdeen, United Kingdom with Anna Coates and Ann Fitzmaurice

This paper describes the development and findings of a composite, individual level, ‘gender status’ index, using demographic and health survey variables. We have used this index to analyse the relationship between relative levels of empowerment and maternal death, and here present some of the preliminary findings from this analysis.

The significance of unequal gender relations for a variety of health outcomes is increasingly recognized within policies and programmes. However, to date, it has been difficult to measure this relationship in a way that holistically takes into account the multifaceted nature of gender inequality. Existing composite indicators of gender are useful for ranking and comparing each country according to their progress towards achieving women’s empowerment on a national level. Such indicators, however, are limited in their ability to establish patterns of empowerment and relationships between relative level of empowerment and health outcomes.

The index was developed using demographic and health survey (DHS) variables, corresponding to conceptual areas related to empowerment: 1) relative status of husband and wife (e.g. relative age of husband and wife, relative educational status); 2) decision-making autonomy; 3) attitudes to bodily integrity (e.g. gender-based violence). Using a principal components analysis, the composite index was used to place women into one of five quintiles (similar to the World Bank’s wealth quintiles), enabling an analysis of the relationship between gender status and maternal death, using an adaptation of the familial technique (Graham et al, 2004).

Whilst requiring qualification in relation to significance in different cultural contexts, the preliminary results show a clear relationship between gender status and maternal death in several countries.

The potential policy implications of these findings are significant. Measuring gender status at an individual level, and encompassing a range of different factors, could be used to definitively demonstrate the relationship between gender inequality and health outcomes, raising the profile of gender inequality and ensuring that interventions reach the most vulnerable. The relationship between gender inequality and maternal death highlights the necessity for programmes to address social factors not normally considered within the maternal health remit.
Targeting women for maternal health-care services in urban poor communities in the Philippines

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The paper provides a methodology and ex ante analyses of targeting women in urban poor communities for maternal health care services, which include prenatal, delivery and postnatal care. Empirical results are provided using data from the 1995 Urban Health and Nutrition Project baseline survey that covered 21 key cities in the country. Seven models were chosen using an iterative process and were applied to predict utilization rate and determine the impact of the targeting schemes on utilization.

The results showed that predicted utilization rates for each maternal health care service under the active and passive targeting schemes in all the seven models were close to the true utilization rates. Thus, for the purpose of predicting utilization rates, there is no need to use difficult-to-gather information such as individual and household characteristics. The use of easy-to-verify variables, such as location and dwelling characteristics, is sufficient. Moreover, the models were better in predicting the utilization rate of the poorest women than the women belonging to higher income quartiles.

The targeting schemes were evaluated for under-coverage and leakage rates to determine their impact on utilization. The high leakage rates accompanying low under-coverage rates for prenatal and delivery care imply the inefficiency in targeting women for these services. If the leakage rate is more than 30%, targeting is expensive for prenatal and delivery care because of the high cost of providing the services to the non-eligible women. If leakage is not a problem, the best targeting scheme for prenatal care is the full model/active scheme (the one using easy-to-verify and difficult-to-gather information). In contrast, the best model for delivery care uses easy-to-verify indicators of the location of the women within the barangay (district) of residence.

All leakage rates obtained were less than 30% for postnatal care. The passive targeting scheme in the full model showed the lowest under-coverage. The results imply that there is no need to actively search out women for postnatal care. It is better to provide a health facility near the women that offers high quality maternal care services.
Spatial planning of health-care facilities and equal access to primary health care: a case of GIS (Geographic Information System) use in Bangkok

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The problems of primary health care shortages in Bangkok have been intensified by a population explosion. The concentration of medical facilities within Bangkok’s central business district further complicates patients’ travel problems. Such dilemmas could be solved by careful spatial planning of primary health-care service facilities.

This research aims to: 1) elucidate the factors affecting the patients’ choice of the type of facilities; 2) to model the spatial pattern of the patients’ travel behaviour from the collected data; and 3) to reach the service catchment areas for each type of primary health-care facility, using a Geographic Information System (GIS) approach. Using GIS and the data obtained from phase I of this study, a spatial model of primary health care was constructed, in accordance with the current government’s ‘equal access to primary health-care’ programme.

Based on Walter Christaller’s ‘Central Place Theory’, this research assumes three primary variables affecting the travel patterns of patients: 1) the range of treatment in a particular facility; 2) patients’ attributes; and 3) acquaintance with medical personnel. A structured questionnaire was utilized to obtain the primary data, while locational data from the Bangkok Metropolitan Administration was used to identify the spatial location of each health-care facility. The results were used to represent the patients’ decision-making pattern in choosing primary health-care services.

The research findings were able to model the patients’ travel patterns by means of GIS buffering, to establish the catchment areas of public/private hospitals, health-care centres, and medical clinics. Out-of-reach areas were then identified. Modeling according to the type of sickness and patient, and personal attributes were also charted to identify the respective groups’ travel patterns. The study then compared the carrying capacity of health-care facilities and the spatial organization of population (population density) to identify the out-of-service areas and the patient assignment in order to maintain ‘equal access to primary health care’.

One can conclude from this study that modeling could be helpful for the prediction of health-care sufficiency and the planning of the spatial organization of facilities in the future.
Mental health research in Latin America and the Caribbean:
devising mechanisms for capacity strengthening

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Low quality and limited access to mental health (MH) care in low- and middle-income countries (LMICs) are consequence of the scarcity of resources to perform research. This report aims to identify individual and institutional factors associated with MH research success and failure in the Latin America and Caribbean (LAC) region, to use them as the basis for research capacity strengthening.

Our study is part of a larger initiative of the Global Forum for Health Research, directed to map MH actors and their research agendas in LMICs.

A questionnaire was sent to 792 researchers in 15 countries in the LAC region. The 216 respondents were classified according to their research success. Group 1 researchers (G1R) were those funded with more than US$ 5000 in the last year, and with at least 2 publications in international journals in the past 5 years (n=50). Group 2 researchers (G2R) were all those reporting less funding or publications (n=88). Fifty-nine researchers were excluded for having missing data in either of these parameters. The principal affiliation of both G1R and G2R were universities (66% and 50%, respectively); 48% of G1R were affiliated to research institutes; 62% of G2R were affiliated to hospitals or the private sector. Compared to G2R, G1R had a higher level of involvement in human resource training (76 vs. 47%), consultancies (58 vs. 36%), networking with colleagues (78 vs. 51%), more participation as scientific editors (86 vs. 57%) or reviewers (80 vs. 43%), more access to paid internet resources (66 vs. 33%) or specialized journals (64 vs. 43%), more access to support in epidemiology/biostatistics (82 vs. 67%), neurosciences/basic sciences (80 vs. 41%), and more graduate students (84 vs. 41%). G1R and G2R also differed in prioritizing the challenges they envisage for implementing research in the near future: for G1R the lack of trained human resources ranked as the main challenge, while for G2R the main challenge was the lack of a research culture in their institutions.

Our results identify public and private MH care institutions as the main focus for research capacity strengthening (at both the individual and the institutional level). This task could be achieved through an active interaction with universities and research institutes in the region that already have greater research strengths.
Health research initiatives of the International Organization for Migration (IOM)

Jesus Sarol, Migration Health Studies Manager, Migration Health Department, International Organization for Migration, Geneva
with Janet Hatcher Roberts, Jacqueline Weekers, Mary Haour-Knipe, Anita Davies and Paola Pace

Worldwide, public health professionals are increasingly concerned about population mobility and the health of those who move. The Migration Health Department (MHD) of the International Organization for Migration (IOM) addresses the health needs of individual migrants and the public health needs of hosting communities. This paper aims to present the current research work of MHD, highlight important results, encourage discussion on migrant health issues, and solicit inputs from stakeholders on further research directions that MHD should strategically identify and adopt.

The Migration Health Department considers research to be an integral component of its mission. Its activities are implemented in over 40 countries. Effective migration health policies, programmes and management are based on evidence from research on the health of migrants and mobile populations. The MHD seeks research partnership with internal departments, international agencies, governments, academia and other stakeholders. Its strategic presence offers many advantages for conducting research among migrant populations, even those who may be difficult to access.

Over the past two years the MHD has heavily concentrated on research related to HIV risk and mobile populations. Research has included assessment of needs and perceptions of migrants, vulnerability assessment mapping, determination of best approaches for HIV prevention activities, mainstreaming HIV in counter-trafficking responses and discussion on the issue of mandatory HIV testing of migrant workers. Access to health care and mapping of health services matched against specific needs, such as reproductive health, have been investigated. Lessons learned and suggestions for future research will be specifically addressed in this presentation. In addition, presentation of a recent analysis of European and international legal instruments relating to migrants’ right to health will be highlighted in order to help develop future research directions. Research based on analyses of MHD databases of pre-departure health assessments of resettling migrants and refugees at the request of receiving governments (e.g. tuberculosis testing, HIV, mental health), and evaluation of health interventions are possible. This presentation hopes to foster discussion of pervasive issues concerning migration health and offers opportunities for future research collaboration.
Strategic demand forecasting for a future first generation HIV vaccine: shaping health policy to maximize access to a new health technology

Shilpa Vuthoori, Policy Associate, Public Policy, International AIDS Vaccine Initiative, USA
with Gian Ghandi

An HIV vaccine could play a significant role in reversing the HIV pandemic, saving millions of lives. For a vaccine to have such an impact, it must be both widely available and adopted/implemented quickly in the worst affected countries. A demand forecasting model provides a valuable tool that can identify policy actions to help achieve these goals.

A consultation was conducted to assess policy-maker/influencer perceptions regarding determinants of demand for future preventive HIV vaccines. Interview findings were synthesized, combined with published data, and incorporated into a linear discrete deterministic forecasting model. The model was used to examine the effects of potential policy change on demand. The demand determinants modeled on a country-by-country basis include future characteristics of the epidemic, capacity/funding constraints, vaccine implementation strategies that might be employed, and the effectiveness of these strategies to reach recipient populations.

Forecasts suggest that annual global demand for an HIV vaccine could range between 10–90 million courses over the 30-year period following its launch. These forecasts range widely depending on assumptions about the vaccine's likely characteristics (as defined by efficacy, duration of protection and price). In most scenarios modeled, the Africa region dominates global demand, accounting for around 20–60% of annual courses demanded. The private market makes up <10% of overall demand, and populations at higher risk of exposure account for around 20–40% of all courses utilized. Policy efforts to address regulatory, infrastructure and political constraints in the ten countries worst affected by the epidemic could increase access to, and utilization of an HIV vaccine by more than 30 million additional people each year over baseline projections (117% increase).

In order to achieve these increases in access and utilization, considerable lead time is required to implement policy change. Since the search for an HIV vaccine is likely to take several more years, an opportunity exists to engage policy-makers to stimulate action to streamline regulatory systems, improve health-care capacity and infrastructure, and increase political and financial commitment. Using this modeling tool to initiate dialogue with policy-makers might therefore improve access to future HIV vaccines throughout the world.
Poster session: Patient safety

Patients’ involvement in patient safety research in Africa

Garance Upham, General Secretary, Safe Observer International, Switzerland
with Aimée Mwadi Kadi, Jean-Marie Ndi and Mohamed Sano

Participatory research has been extremely fruitful and rewarding in a number of domains, yet has had only limited application within health-care settings where vertical pyramidal structures predominate. Today, however, patients and consumer groups increasingly demand to be included in health care decision-making, and the importance of patients involvement in health-care safety research has been acknowledged. The World Health Organization (WHO) has proposed a model of ‘patient-centred health care’ as the way of the future.

Low- and middle-income countries, and notably those in sub-Saharan Africa, could take the lead in bringing about patients’ involvement in patient safety research, which would be cost-saving, efficient and more rapid in bringing about desired change than traditional vertical methods.

It is an understanding of the importance of patient safety research and implementation that has motivated the Francophone Africa group of countries to elaborate a plan to improve patient safety for 2007–2014 that involves patients from the start. This initiative will be launched in September 2007 at the Ministerial Summit to be held in Bordeaux, France.

Contributing to the preparations for the project, we conducted a review of the literature focusing on one specific domain of patient safety: health-care system infection control, to review experiences in Africa and India with patient involvement, or research which included an estimate of the need for patient involvement.

As the Uganda Health Minister reported during the World Alliance Patient Safety ministerial level meeting on 10 November 2006: a tentative estimate is that “around 25% of patients contract a nosocomial infection during health care”.

The outbreak of extensively drug resistant tuberculosis (XDR TB) spread nosocomially in hospital settings in South Africa and elsewhere in 2006, is a relevant example of where participatory research is urgently needed.

We conducted a review of publications over a five-year period concerning patient safety research regarding infection control, to examine how the participation of patients was treated in low- and middle-income countries. Most of the research was not elaborated from the standpoint of patient participation. Patients’ involvement would increase performance and efficacy of health care in low-income settings.
‘Patients for Patient Safety’: an initiative to improve equitable access to knowledge and information

Mingming Zhang, Researcher, Chinese Cochrane Centre, West China Hospital, Sichuan University, People’s Republic of China

Patients and consumers of health care are at the very centre of the quest to improve patient safety. When things go wrong they are the victims of the harm induced. The World Alliance for Patient Safety has established ten areas of action; ‘Patients for Patient Safety’ is one of these. The first Patients for Patient Safety workshop, held in London in November 2005, brought together 24 participants (7 from developing countries) who had suffered harm from medical errors. Difficulties in advancing health system safety were identified, especially in developing countries, including lack of information access, knowledge dissemination and public recognition.

During the past year, some actions have been taken to start this initiative to improve equitable access to knowledge and information in developing countries, including: submitting funding proposals, publishing advocacy papers, and introducing the concept of ‘patients for patient safety’ among clinicians and medical students. As elsewhere in developing countries, challenges include: timely access to treatment and information; problems funding workshop organization and providing information materials for the public; and the values, culture and educational level of patients.

The objectives of the programme are: 1) to describe the needs of patients living in China that may be addressed by the above; 2) to analyse the foundations of equitable access to knowledge and information; and 3) to develop or establish strategic plans or alliances with other organizations whose activities are focused on developing countries.

There are many pressing needs facing health care in China. According to a Chinese funding agency, “the ‘Patients for Patient Safety’ programme is very important and innovative”, but “patient safety is a system project, it is very difficult to launch only ‘patient for patient safety’ before the whole system has matured”. Under these circumstances, standardization of national policy, improvement of the health-care insurance system and management of medicine are priorities in patient safety.
An assessment of the impact of a DOTS programme in North Western Province, Sri Lanka

Sunil Bernard De Alwis, Provincial Director of Health Services, North Western Province, Sri Lanka

The objective of this study was to assess the impact of the directly-observed treatment short course (DOTS) programme of the District Respiratory Disease Control Programme of Kurunegala and Puttlam districts, in North Western Province, Sri Lanka.

The study was based on an analysis of patient and service related factors influencing the outcome of tuberculosis (TB) treatment in pre-DOTS, transition and DOTS periods (1998–2000, 2001, 2002–2003). A survey of health personnel and DOTS providers was conducted in the province to identify their perceptions of the TB control programme.

The treatment outcomes for 1191 pre-DOTS patients, 506 patients in the transition period and 1600 patients in the DOTS period were compared. In addition, a sample survey was conducted among 337 patients from the pre-DOTS period and 342 patients from the DOTS period. In addition, 218 health personnel were also surveyed in the study.

There was a significant improvement in the treatment success rate and a significant reduction in defaulting and treatment failure in the DOTS period. Treatment outcome was found to be significantly related to the age and level of education of the patient.

There was a reduction in distance to the treatment centre and transport cost for a single journey in the DOTS period. In a logistic regression analysis significant predictors for positive treatment outcome were, cost per single journey (P<0.001) and the marital status of the patient (P<0.004). The majority of defaulters and other patients wanted to have health personnel visiting their homes to provide anti-TB drugs.

The majority of health personnel were of the opinion that DOTS is a better strategy in comparison to previous regimens, and that it should be strengthened further by various means. To make this programme more successful, the practical difficulties experienced by patients and service providers need to be addressed by relevant health authorities.

In an overall assessment, DOTS is a better approach than previous strategies. Nevertheless, it was observed that there should be some flexibility over daily travel to the treatment centre by patients. The necessity of community mobilization and identification of the most appropriate DOTS provider was also emphasized. The regular training of health personnel in TB management, and in programme management, is essential for effective programme implementation. The advantages of good supply logistics and improvement in infrastructure/facilities were also highlighted. Better coordination with other similar programmes and integration of the TB control programme with the existing public health care network will improve performance.
Researching linkages between the right to health and TRIPS: developing normative frameworks and policy tools to promote access to essential medicines

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The internationalization of pharmaceutical patents under the TRIPS (Trade-Related Aspects of Intellectual Property Rights) agreement significantly restricts equitable access to essential medicines in developing countries. However equitable access to essential medicines is a core duty under the human right to health. Despite a growing awareness of the rights implications of inaccessible medicines, this has not impacted World Trade Organization (WTO) adjudication, nor domestic trade policies.

This research adopts a two-pronged approach to addressing this gap: first, by developing arguments in international law for linking human rights and trade; and second, by developing a right to health impact assessment tool (RTHIA) adopting an explicit gender-perspective, to ensure that policy-makers alleviate trade restrictions on medicines access. This research draws from a two-year postdoctoral fellowship, and a completed legal doctorate exploring the power of human rights in increasing access to AIDS medicines.

Key issues are: 1) access to medicines as a human right; 2) the impact of trade rules on medicines access; and 3) normative and practical methods of ensuring the integration of rights into international and domestic trade law and policy.

The primary argument is that international human rights law offers a potentially powerful mechanism for mitigating the restrictive impact of trade rules on access to medicines through legal and policy changes.

This research may contribute to more equitable access to medicines by enabling and requiring international and domestic adjudicators and policy-makers to interpret and formulate trade rules in the least restrictive manner possible. Its normative and practical components may influence global and domestic policies on medicines in two distinct ways: first, by offering normative frameworks capable of shifting unjustifiable prioritizations of property over health, including through contributing to a global ethical commitment to equitable medicines access; second, by providing tools such as litigation and impact assessment that are capable of coercing or persuading more equity-oriented public policy on essential medicines.
Strengthening alignment of global programmes focused on tuberculosis control: congruence of proposals to the Global Fund with the Stop TB Strategy

Stephen Haering, Resident Physician, General Preventive Medicine Residency Program, Johns Hopkins Bloomberg School of Public Health, USA with SB Syed, H Lanthorn, A Godfrey, PY Norval and L Blanc

Since 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria has received six rounds of proposals. With the Millennium Development Goal target of reducing tuberculosis (TB) prevalence and deaths to 50% of 1990 levels by the year 2015, the World Health Organization (WHO) published the revised Stop TB Strategy in 2006. The strategy articulates 6 components and 18 subcomponents for National Tuberculosis Programmes (NTPs). Recognizing the need for alignment between the Global Fund and the Stop TB Strategy, an evaluation of proposals to the Global Fund as they relate to the subcomponents of the strategy was conducted by the WHO Tuberculosis and Health Systems Team of the Stop TB Department.

Narratives of 24 proposals from 20 TB high-burden countries (HBC) over the first 5 rounds of proposals were evaluated for their level of congruence to each of the 18 subcomponents of the strategy. Additionally, five budgets and work plans from four HBC Round 5 proposals were analysed for budgetary associations to 17 of the strategy subcomponents.

Narratives of proposals had high degrees of congruence with subcomponents of the strategy: 74–83% for Rounds 1 and 2, and 88–89% for Rounds 3, 4 and 5. Round 5 work plans and budgets, however, revealed that vital subcomponents that were included in the narrative had no proposed funding. Of the 85 possible associations among 5 budget proposals (across 17 Strategy subcomponents), 37 had no monetary allocations. Three subcomponents (International standards for tuberculosis care; Patient’s charter for tuberculosis care; and Research to develop new diagnostics, drugs and vaccines) had no monetary allocations in any of the Round 5 proposals, 2 subcomponents only had 1 proposal allocating funds, and 5 subcomponents were allotted monies by only 2 or 3 of the 5 proposals.

These data suggest that while proposal narratives may be congruent with strategy subcomponents, financial mechanisms associated with particular subcomponents are missing. Adoption of the WHO Stop TB Department’s new ‘Planning and Budgeting Tool’ will assist NTPs in identifying financial needs when developing comprehensive proposals. Evaluation mechanisms described here for TB can be replicated for other disease control priorities to strengthen alignment among programmes focusing on specific diseases.
How sound are diagnostic studies in China? Implications of diagnostic studies on dot-immunogold filtration assay to diagnose tuberculosis

Jing Li, Vice-Director, Evidence-based Medicine and Clinical Epidemiology, West China Hospital, Sichuan University, People's Republic of China
with Xia Liu, Changlin Ai, Changlin, Yuanxun Zhao and Youping Li

Dot-immunogold filtration assay (DIGFA) is widely used in the diagnosis of tuberculosis (TB) in China. This study aims to assess how valid and reliable the information provided by diagnostic studies is in China by assessing the quality of the tuberculosis antibody detection.

The VIP (WEB) database (2000–2006) was searched; any diagnostic studies that used DIGFA to detect the TB antibody were included. The Quality Assessment of Diagnostic Accuracy Studies (QUADAS) was used to assess the quality of included diagnostic studies, using two independent researchers.

Thirty-eight papers were included and assessed. We found that most quality criteria were not met. Most papers adopted a retrospective diagnostic case-control design. Thirty-one papers did not describe the selection criteria clearly, 18 did not describe whether all included patients were verified using a reference standard of diagnosis, 36 did not describe whether index test results were interpreted without knowledge of the results of the reference standard, 37 did not report uninterpretable/intermediate test results, and 34 did not report withdrawals from the study.

There are few high quality studies on the use of DIGFA in detecting tuberculosis antibodies to diagnose TB.

China is facing great challenges in its health care reform because of its large population, changes in disease spectrum and some newly emerging problems in its health service system. On the one hand, the demand for health care is rapidly increasing, and on the other limited health resources are inadequately managed; characterized by poor allocation and inefficient use. Endlessly emerging diagnostic technologies can increase health costs and may have adverse effects, despite some obvious benefits.

Understanding the value of diagnostic techniques can help physicians to make appropriate and rational selections. Therefore, the quality of diagnostic studies is very important in providing valid information. Our assessment concludes that there is a lot of room for improving the quality if diagnostic studies and strengthening research capacity.
A model for economic evaluation of a new pharmaceutical product

Zofia Pawłowska, Head of Department, Health and Safety Management Department, Central Institute for Labour Protection, National Research Institute, Poland with Robert Kosiński and Andrzej Grabowski

An important factor influencing decisions about introducing a new pharmaceutical product is the economic and social impact. The main objective of this paper is to present a model for economic evaluation of a new pharmaceutical product and an example of its implementation.

The basic method of economic evaluation of a new pharmaceutical product used in the model is a cost-benefit analysis. Costs related to a disease after introducing a new medical treatment (in which new drugs will be used) are compared with costs related to the disease when the ‘traditional’ medical treatment is used. All the costs are expressed in monetary terms.

The cost of a disease includes both direct and indirect costs. Direct costs are the value of resources used in the treatment, care, and rehabilitation of ill people. Indirect costs represent the value of economic resources lost because of disease-related work disability, decreased productivity or premature mortality. The cost of the disease is calculated for three types of stakeholder: individuals and their families, employers, and society. For each stakeholder the main cost items have been identified and rules for their calculation established.

Changes in the costs over time are estimated in the model taking into account: 1) effectiveness of a new therapy – resulting in changes of parameters influencing direct and indirect costs of the disease; 2) the demographic changes in the whole population and resulting changes in the population of diseased people.

The data needed for implementation of the model includes statistical data (e.g. collected by insurance institutions or statistical offices) and data available from questionnaire surveys of groups of patients and doctors. The implementation is supported by appropriate computer software.

An example will be presented of implementation of the model in assessing the economic impact of introducing monoclonal antibody therapy in rheumatoid arthritis in Poland.

The developed model for evaluating the economic impact of a new pharmaceutical product can be an effective tool in supporting decisions surrounding introducing a new product to the market.
Research in health promotion is an integral part of the Brazilian National Agenda of Priority Research in Health, which was formulated and implemented by the Ministry of Health in 2004. The methodology employed to set research priorities aims to highlight the technical-political consensus among social stakeholders: decision-makers, researchers, professionals and users.

Established research priorities seek to: 1) understand the links between health promotion, social determinants, social exclusion and life quality; 2) contribute towards reducing the disease burden and risks; 3) assess policies, programmes and the effectiveness of technologies oriented to promoting health.

This presentation will focus on: 1) the confluence of the development of research in health promotion and the management of the national health promotion policy, launched in March 2006; 2) strategies to disseminate research results and support civil society’s use of the research results; 3) the distribution of resources to research financed by the regions, from 2004 to 2006; 4) the themes studied, with emphasis on specific actions of the national health promotion policy (including: healthy food; physical activities; prevention and control of tobacco use; reduction of morbidity/mortality from the abuse of alcohol; peace culture; sustainable development promotion; and the perspective of gender, ethnics and equity); 5) the participation of health services; and 6) the potential impact according to the researchers.

Recommendations will be made on: 1) the optimization of health promotion research management, including the highlighting of knowledge gaps in specific health-related topics; 2) strengthening scientific capacity, notably in less developed areas; and 3) the systematization of successful experiences.
The BIAS FREE Framework: a tool to be adopted by The AIDS Support Organisation (TASO), Uganda

Betty Babirye Kwagala, Medical Counsellor, Counselling, Mulago, TASO, Uganda with Nkayivu Hannington

The BIAS FREE Framework is based on a human rights and equity model, and the idea that good quality health care is a right for all people. These fundamental beliefs are shared by The AIDS Support Organization (TASO).

A key concept in the BIAS FREE Framework is the idea of social hierarchies and how they can contribute to the oppression of lower-powered people. The framework states that within social organizations there are people who are powerful and people who are not. There are also people who are highly able (successful, educated and wealthy) and people who are less able (impaired, disabled, elderly, ill, etc.). The BIAS FREE Framework seeks to identify and address related inequities in service delivery.

TASO requires shifts at all levels of the organization and needs to choose the categories on which it shall focus at an organizational service delivery level, and social hierarchies need to be analysed within the organization if clients and staff are to be examples of equity. The non-dominant groups need to be integrated into the system. Social hierarchies must be analysed to ensure that everybody in the group is treated equally and fairly.

The process of applying the BIAS FREE Framework is a valuable one that provides insights about existing power imbalances. One serious issue that needs to be given consideration, however, is the time required to implement the BIAS FREE Framework process. TASO and the Global Forum for Health Research continue to discuss the feasibility of using the BIAS FREE Framework as an organizational strategy, with the goal of establishing human rights equality and good quality health care for staff and clients.
The Brazilian government established the National Commission on Social Determinants of Health in March 2006, as a response to a global initiative promoted by the World Health Organization (WHO). The commission aims to monitor inequities and systematically study their determinants, in order to identify vulnerable aspects that can be overcome by means of public policies. Among others, the commission has the following lines of action: civil society mobilization to advocate for the principle of equity regarding the implementation of public policies; promotion of actions to reverse social inequity at the governmental level; articulation of public policies on poverty reduction and promotion of the dissemination and utilization of knowledge.

This presentation focuses on an analysis of the results from the joint initiative developed by the National Commission on Social Determinants of Health and the Ministry of Health, towards supporting studies in this area.

Of these studies, 45% (22) were financed and around US$ 1.5 million was committed. 45.5% of the studies related to first-line research, while 36.4% were second-line. The main knowledge fields studied were public health (63.6%) and epidemiology (27.3%). The studies approached a range of issues including: inequities in access to and use of health services; evolution of social disparities in relation to morbidity/mortality; conditioning factors for health; social and ethnic-racial inequalities – child epilepsy, non-transmissible chronic and chronic-degenerative diseases; and assessment of the government programme of income transfer, the so-called *Bolsa Família*.

The studies financed were analysed taking into consideration the commission’s goals and the scientific capacity and qualifications of researchers. Recommendations were presented on: 1) advertising strategies and strategies for using the research results; 2) the optimization of research management in that field; and 3) the systematization of successful experiences.
Poster session: Primary health care

Organization, coverage strategies and financial sustainability of the immunization programme in Paraguay

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with Sonia Bumbak

The Republic of Paraguay is a middle-income country by Latin American standards, with a health-care system that relies on a poor public sub-system for low-income groups, and social and private insurance plans for middle-high income groups. The need for expanding immunization coverage, and the appearance of new vaccines with significantly higher prices than the ones already marketed, required the Paraguay authorities and donor agencies to analyse the financial sustainability of the Expanded Program of Immunization (EPI).

The research objectives of this paper are two-fold: 1) to identify the main factors that affect the financial sustainability of the programme; and 2) to evaluate its performance by region and by vaccine. For these purposes, the study brings a qualitative analysis of the relationship between the programme financing sources and immunization coverage levels, taking into account non-financial factors that may contribute to explaining coverage variability over time.

The study uses data from official sources and interviews with key personnel from each region. A series of immunization effectiveness indexes were constructed based on management, financing and vaccine provision criterion, distinguishing among financial sustainability, management effectiveness and antigen supply volatility. The analysis of EPI financing sources shows that the role of external funding is not very significant although its permanence, heavily oriented towards technical assistantship, guarantees a lower imbalance of resources. On the other hand, non-financial factors present limitations related to immunization management mechanisms. The study also shows, based on a panel time-regional analysis, how relatively successful coverage relies on the alignment of immunization strategies (traditional health centre-based, campaigns and outreach efforts) with departmental characteristics (population density and dispersion, and geographical access), providing insights for policy-makers.
Segmentation of the Argentina health system structure forces the public health system to concentrate its efforts mainly on people without formal health coverage, resulting in a systemic bias towards higher epidemiological and financial risks. In order to avoid resources being misallocated, alternative types of services should be considered based on the needs of the poor, using primary health care centres (PHC) and hospitals. An inadequate geographical distribution of PHCs affects both service delivery and effectiveness of programmes based on such centres, with serious implications for equity of access. In this context, the current study analyses PHC geographical distribution, between and within provinces (among municipalities), linking them with indicators of health care needs (populations without formal health coverage).

As different levels of urbanisation lead to alternative supply requirements (e.g. dispersion, fixed costs), the analysis is adjusted by scale factors, creating density quarters by municipalities. Data was obtained from the 2001 National Census and the Ministry of Health Statistics Department.

Country results show a median of 3183 people without health cover for each PHC, with significant differences between and within provinces. For example, La Rioja province reports a 15 times lower average than Greater Buenos Aires (543 vs. 8325). Both cases may be associated with inadequate resource allocation, reflecting sub-utilization and overload of infrastructure, respectively. Important differences are also found within each province, with a 3400% difference among municipalities in Buenos Aires province. Differences of PHC distribution among provinces arise because healthcare policies promoting access apply to the jurisdiction of each health authority, and are linked to the nature of the national decentralization model. This is not the case within each province, however, where variation between municipalities with similar socioeconomic characteristics highlight a lack of equitable and effective criteria for resource allocation based on health care needs.
Barrier of access to social protection in health for unemployed workers in Medellin, Colombia

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with Emmanuel Nieto L, Román Restrepo V, Luz Mery Meaña O, Carlos Enrique Cardenas R, and Felipe Aguirre A

Access to social protection in health in Colombia is affected by various factors linked to unemployment. One of these factors is the lack of health insurance for a large percentage of workers who lose their jobs. Many workers and their close relatives are exposed to loss of family economic resources (and thus are vulnerable to poverty) if any member of the family requires health services he/she has to pay for.

The objectives of this study were: 1) to identify relevant barriers of access to social protection for unemployed workers in Medellin, Colombia, and to discover possible windows of opportunity to address those barriers through their equitable participation in policy-related decision-making; 2) to disseminate the findings in order to foster discussion about how to translate academic research into public policies for equitable access to health.

The methodology included: a descriptive-retrospective study that combined qualitative and quantitative methods; a survey of a representative random sample of unemployed workers; and a systematic review of the Colombian legal framework on social protection in health and the rights of civil society to become organized.

The study revealed: 1) A similar proportion of women and men lost their jobs (51.8% and 48.2% respectively). 2) 37% of unemployed workers and their relatives do not have any kind of health insurance. 3) The average salary in the last position held was only 1.2 times the legal minimum wage. 4) The average employed/unemployed cycle was 21.7 months of employment in the last post and 6.3 months needed to find new employment. 5) Unemployed workers have a very little representation in social participation networks. There is no organization that represents their opinions and demands.

The results of this study have encouraged us to propose the creation of a fund with public and private financial resources that combines a low rate loan and financial aid to unemployed workers. This will permit them and their relatives to maintain a basic level of health insurance. This initiative has received the enthusiastic support of unemployed workers and has stimulated them to undertake the process of creating an organization through which to channel their opinions and demands.
Unequal distribution of childhood malnutrition in Iran: contribution of the primary health-care system in addressing basic determinants

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with John Coveney and Udoy Saikia

Despite a well-structured primary health-care system in the Islamic Republic of Iran, and impressive improvements in health indicators over the last few decades, childhood malnutrition, and particularly its unequal distribution countrywide, remains a main concern for Iranian public health policy-makers.

This study aims to investigate the perception of different stakeholders, including recipients, health providers and health organizations with regard to factors affecting distribution, and to explore strengths, weak points and opportunities in the Iranian primary health-care system in addressing underlying and basic determinants of childhood malnutrition. It also seeks remedial actions to move primary health care towards a more comprehensive approach.

To achieve that, a qualitative study has been undertaken in Iran. Face-to-face interviews and focus groups were designed engaging top health and nutrition managers and experts in the Ministry of Health as well as health providers and mothers of children under five years of age in two different provinces.

The outcome of the study highlights the fact that a comprehensive vision exists among health stakeholders, considering social determinants (economic, cultural and women's status) as the main factors affecting distribution of malnutrition.

The contribution of primary health care in addressing those factors, however, is influenced by existing strengths and weak points in the system. Easy access to free health services, regular growth monitoring for children and nutrition education are the main strengths. Potential pitfalls are: 1) managerial problems including rapid changes, political impacts and lack of motivation; 2) health provider problems such as lack of motivation and low wages; 3) lack of appropriate intra- and inter-sectoral collaboration; 4) limited resources including financial, human and physical resources.

Commitment at government level and political support are considered the most effective means to tackle malnutrition countrywide. In this case, relevant social organizations also take responsibility to include nutrition as one of their organizational missions, which in turn leads to appropriate inter-sectoral collaboration.

Appropriate resource allocation, community participation and health staff support were other areas considered as remedial actions.

The findings of this study represent the voices of health stakeholders, which help policy-makers in moving towards a comprehensive approach in addressing social determinants of childhood malnutrition.
The use of research in international organizations’ recommendations and their impact on health policy in a sample of low- and middle-income countries

Sara Bennett, Manager, Alliance for Health Policy and Systems Research, Switzerland
with Steven Hoffman and John Lavis

Recommendations from international organizations are an important mediator between research and action for the many low- and middle-income countries that rely on them. In order for these countries to best utilize their limited resources, international organizations must link research to action by basing their recommendations on the highest quality research and share them effectively with those who can act on them. An effective partnership among international organizations, the research community, and developing countries is required to ensure that opportunities for improving equitable access to global health are not squandered. Nevertheless, previous research suggests that some international organizations may not be using research consistently in the formulation of their recommendations.

This study sought to examine the extent to which research informs the recommendations of two prominent international organizations – the World Health Organization (WHO) and the World Bank – and the subsequent influence of these recommendations on national health policy-making in a sample of low- and middle-income countries.

Specific WHO and World Bank recommendations were identified and categorized along with available research using two taxonomies (applicability to different country contexts and type of recommendation). Questionnaires were distributed (in collaboration with WHO’s Department of Knowledge Management and Sharing) that asked key informants, including senior government and civil society representatives from 39 countries, to assess the influence of five sampled World Health Assembly resolutions on the policy-making process in their country.

Preliminary analyses suggest that the identified recommendations rarely cite research in the form of systematic reviews. Ongoing analyses involve comparing the recommendations to the research available at the time of their development. The survey is currently in the field but once the dataset is complete the influence of these recommendations on national health policy-making in a sample of low- and middle-income countries will be described using descriptive statistics.

This research will provide a basis for promoting partnerships among researchers, nongovernmental organizations, international organizations and other knowledge brokers to encourage the use of research in developing both recommendations at the international level and health policies at the country level.
Collaboration and ‘visibility’ of health research in the Western Pacific Region

Guillermo Paraje, Lecturer and Researcher, Universidad Adolfo Ibáñez, Chile with Ritu Sadana and Reijo Salmela

Using a bibliometric approach, the current paper firstly documents the collaboration pattern of countries in the World Health Organization (WHO) Western Pacific Region, and, secondly, illustrates how ‘visible’ health research is from this region and how different patterns of collaboration (i.e. with certain groups of countries – high-income or low-income countries) can alter the ‘visibility’ of such research.

More than 3.5 million bibliographic references in Thomson ISI Web of Science (health-related articles, notes and reviews) were analysed. Citations were established and recorded for each reference over a three-year period after initial publication. Thus, publications in health-related disciplines from 1992 to 1998 were considered, and publications up to 2001 were used to count related citations. This procedure allowed the identification of publications with ‘high visibility’ (those having more citations than expected according to their field) and those with ‘low visibility’ (i.e. less citations than expected). Research production by ‘visibility’ level can, thus, be estimated, clustering countries according, for instance, to their income level (using World Bank classification) or to their geographical location (using WHO Regions).

Two findings are of particular interest given the theme of Forum 11: ‘Equitable Access: Research challenges for health in developing countries’ . The first is that intra-regional collaboration is low and that large regional producers of research (i.e. Japan, Australia, the Republic of Korea) collaborate more with high-income countries from other regions than among themselves or with smaller regional research producers. The region shows an ‘insular’ collaboration pattern with several big centres of research with little connection between them. The second is that ‘visibility’ of health research in the region is relatively low, even for high-income countries. High ‘visibility’ research is mostly done with the involvement, through collaboration, of extra-region high-income countries. Collaboration between low- or middle-income countries is mostly in low ‘visibility’ research.

Increasing visibility has several dimensions, including more equal research partnerships between different countries and institutions; increasing collaboration between low- and middle-income countries and access to the resulting research within the global scientific pool; developing alternative approaches to diffuse scientific findings that are judged of sufficient quality.
Increasing health expenses are closely related to the constant developments in health technology and innovation. In a context of increased expenses, with continuous restriction of resources, decision-makers need coherent information about technology benefits and their impact on health systems to make rational decisions. However, health systems and their regulating agencies cannot assess all health technologies, because technological innovation is much faster than decision-makers’ capacity to assess it. Governments need to prioritize relevant health technology assessment (HTA) studies within the whole universe of proposed studies.

The objective of this study was to describe the process of selection of prioritization criteria for HTA studies that need public resources, and the criteria of application in the Brazilian public health system.

Brazilian criteria were obtained from a search of international scientific literature and adapted to the Brazilian reality, based on equity parameters.

Brazilian prioritization criteria include: severity and prevalence of the health condition; social cost of the health condition (impact on non-medical sectors of economy); potential of the study’s results to improve health outcomes; potential of the study’s results to change costs for the health system; potential of the study’s results to contribute to improvement of the quality of assistance; potential of the study’s results to reduce risks for health; the technology’s unitary or added costs; availability of scientific evidence; controversy or great interest among health professionals; and government pressure.

Application of prioritization criteria for HTA studies is intended to help in the selection of proposed HTA research to be realized by the Brazil Ministry of Health. In order to guarantee equity in the application of criteria, a group should be formed made up of: decision-makers, researchers, the judiciary, civil society, patients and Ministry of Health representatives.
Research on medicine prices reveals problems in equitable access

Andrew Chetley, Director, Healthlink Worldwide, United Kingdom
with Marg Ewen

The price, availability and affordability of medicines are major determinants of access to treatment. The health expenditure of the world's poor is largely devoted to buying medicines, so the price of essential medicines really does matter – not only to patients, but to governments who are charged with the responsibility to provide health care for their citizens. Surveys undertaken in more than 40 countries using a standardized World Health Organization (WHO)/Health Action International (HAI) price measurement methodology have found: 1) Unaffordable treatments – costing as much as 50 day's wages for 30 day's supply. 2) Medicines priced at over 80 times an international reference price. 3) Some governments purchase expensive originator brands of medicines that have been off-patent for years, charge patients for medicines well over the procurement price and apply numerous taxes to medicines. 4) In many countries the availability of medicines in the public sector is extremely low. 5) Often the manufacturer's price is the major determinant of the final medicine price, but sometimes the add-on costs in the supply chain can double the price. 6) Mark-ups applied by pharmacists and dispensing doctors can be excessive. 7) In many countries, household income is the largest source for paying health care costs, including medicines. Therefore, many people (particularly the poor and marginalized) are spiraling into debt when they purchase needed medicines, or are simply going without.

Evidence-based pricing policies are needed to reduce medicine prices, and improve the availability of affordable treatment. Effective advocacy is needed to encourage governments to implement effective policies.

This paper will explore the implications of these research findings for policy and practice, and highlight the ways in which the communication of this research is now being used to lower medicine prices. It will provide policy-makers with a clear set of options to choose from as they seek ways to improve access to medicines. It will also provide a number of approaches that can be used by health workers, citizens and patients to use the findings from such research to advocate for change and demand better service provision.
A proposal for a health research and development monitoring system in Brazil

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with Rosângela Caetano, José Antonio Ortega, Luiz Otávio de Figueiredo Façanha, Gabriela Bittencourt Gonzalez Mosegui, Rondineli Mendes da Silva, Mariana Miranda Autran Sampaio, Rodolfo Rego Deusdará Rodrigues, Marien Siquiera and Tiago Ascensão Barros

Information gaps are an obstacle to both knowledge and use of financial resources applied in health research and development.

The objective of this work was to propose a regular and continuous monitoring system of these resources in Brazil, which may increase the knowledge impact of health research. It was a spin-off from research with a primary objective of measuring of financial flow invested in health research and development for the period 2000–2002.

The organizational format was based on a group of both public and private institutions, which were selected on the following criteria: importance in relation to the financing; easy access, availability, and relative organizational level of existing information; and strategic importance as a point of access to other information sources.

This organizational format also took into consideration the following elements: necessity of a coordination effort to establish partnerships with key institutions and thus establishing a participatory process; organizational structure responsible for data collection and analysis and also for the availability of the information obtained by both health managers and users.

Because of the nature of essential inter-institutional attribution, the Technology and Science Department of the Ministry of Health is in charge of formulating, implementing and evaluating national science and technology policy in health.

This project also included an attribution definition of the monitoring system; key institution detailing; hierarchy definition and functional nature with an estimate of the human resource necessity and respective professional profiles.

The proposed monitoring system is a tool for evaluation of the potential of Brazil’s technological and scientific basis; for identification of the most promising activities and projects for the future; for highlighting imbalances between current health research and research and development priorities; for development of indicators to measure performance and impact of health research and development products in the health system. It aims to ensure the equitable and efficient use of applied resources and assist strategic decision-making on scientific and technological policy for health.
The unique role of the media in addressing the ‘10/90’ gap

Joanne Carpenter, Programme Manager, Relay: Communicating research through the media, Panos, United Kingdom

Successful research communication is about more than the one-way dissemination of research results. It fosters two-way debate and dialogue, ensuring that research agendas are responsive to need. In developing country contexts, where many people can neither access nor send information, and where influential international research often results in national policy change, there is a responsibility to broaden debate around research information and processes. Yet, the unique role the media in developing countries can play in this is often overlooked. By engaging with the media, health researchers working to contribute to development can reach the public in developing countries – strengthening the legitimacy, accountability and transparency of both research and policy processes. Researchers can work with the media to build the relevance of their research to the health (and other) problems of developing countries, and to increase the impact that this research has on policy.

Panos’ Relay: Communicating research through the media programme works in southern and eastern Africa and south Asia to build links between academia and media. Over the past three years Relay has addressed issues leading to mistrust between the two communities (e.g. lack of journalistic specialization and weak investigative reporting skills, loss of control of research messages and the commercial concerns of both media and research organizations in terms of sensationalizing stories or ‘spinning’ research results).

Successful research communication requires ongoing interaction between research and media communities, building up individual contacts, confidence and trust. To this end, Relay has established sustainable networks of researchers and journalists at national and regional levels. The programme also utilizes existing links between researchers from developed and developing countries created through the structure of development research funding. This paper discusses the rationale and experience of Relay, with special reference to communicating sexual and reproductive health research with the Realising Rights consortium (working across Kenya, Ghana, Bangladesh and the United Kingdom). This collaboration opened up opportunities to link debates around health research at the national and international level.
HIV reporting in Zimbabwe

Forward Maisokwadzo, Coordinator, Exiled Journalists’ Network (EJN), United Kingdom

Southern Africa is home to nearly two thirds of those living with HIV globally. And Zimbabwe is one of the most affected countries in southern Africa.

It is widely agreed that a free press plays a key role in sustaining and monitoring a healthy democracy, as well as in contributing to greater accountability, good governance and economic development. The media can play an important role in tackling the HIV pandemic – both by giving voice to those most affected by the pandemic, and by holding international and national policy-makers to account.

This case study will interrogate print media coverage of HIV in Zimbabwe and will analyse news coverage of HIV by two British and two Zimbabwean newspapers.

Related research has examined news coverage of HIV in the United Kingdom and the United States, with a particular emphasis on the early years when the primary definitions of the crisis were established (Allan, 2002). While some studies have examined the dynamics of news production and have shown, for example, how the day-to-day imperatives of making HIV ‘newsworthy’ occur in relation to a diverse array of institutional constraints. Research into how journalists frame HIV similarly helps to disclose the strategies by which different news actors, some of whom are stakeholders with vested interests, seek to advance their definition of the situation (Murray, 1991; Lupton, 1994; Miller et al., 1998; Eldridge, 1999).

In the case of Zimbabwe, the only significant research carried out related to this study was a report produced by Panos (2005) entitled ‘Reporting AIDS: An analysis of media environments in Southern Africa’.

Only limited comparisons have been made between print media coverage around the world, and very little has been done looking at media coverage of issues relating to international development in western media. Of the studies that have been done including those mentioned above, none have disaggregated their analysis to look at specific themes such as HIV, nor have they looked at critical issues such as stigmatizing language, voice, homophobia, racism, representation and visibility of people most affected. Due to the increased linkages between HIV and TB, this research will also attempt to identify the amount of media coverage of TB and in what ways the reporting is relating to HIV especially in Zimbabwe.

This study will draw from a baseline content analysis to explore the role of the media in promoting informed public debate and accountability in relation to HIV. It will examine which sources and voices are presented in print media, how are they portrayed and the extent of critical questioning of key issues raised.
What the papers say: a comparative global analysis of HIV and TB in print media

Lucy Stackpool-Moore, Policy and Programme Officer, HIV/AIDS, Panos, United Kingdom

This research examines print media coverage of HIV and TB at an international level. The Panos Global AIDS Programme has examined the sources and voices presented in the print media in 12 countries: Haiti, Jamaica, Kenya, Mozambique, Sri Lanka, South Africa, Tanzania, Uganda, the United Kingdom, the United States of America, Viet Nam and Zimbabwe. We have used a combination of quantitative and qualitative approaches. The research has also been used to generate discussions in each of the countries to debate the findings, explore the implications for policy and practice, and collaboratively develop possible strategies to address the emerging challenges. These country discussions included media professionals, people living with HIV, politicians, policy-makers and others interested in media development, human rights and accountability on HIV, TB and access to health care.

The media can play a vital role in sharing information and influencing public opinion on HIV and TB. But there have been few studies specifically looking at the amount and quality of reporting. Only limited research has examined print media coverage of HIV and TB and none to date have looked specifically at critical issues such as stigmatizing language, voice, representation and visibility of people most affected by HIV.

The objectives of the study were to compare print media coverage on a global scale. In order for the media to maximize its potential role in responding to the HIV epidemic, we use the evidence to argue that it needs to go beyond providing information and in fact provoke informed dialogue and debate. We argue that through informed debate, the media in turn has a critical role in promoting – and sustaining – well-informed and inclusive decision-making processes and health policies.

The paper will present findings from the global analysis, drawing on key issues emerging in the country studies and discussion events. The paper will locate the findings in the geo-political context of each country and highlight key gaps and needs identified as well as strategies for change. Recommendations will include strategies to enhance the quality of coverage of issues around TB and HIV in the media.
Ensuring access: the new reproductive health target for Millennium Development Goal 5

Marianne Haslegrave, Director, Commonwealth Medical Trust, United Kingdom

Heads of government at the World Summit in 2005 called for the introduction of a new target on reproductive health. It was subsequently introduced by the United Nations secretary-general in his report to the General Assembly in 2006 and by the time of Forum 11 new indicators will have been agreed to monitor its implementation. This target echoes the goal of universal access to reproductive health by 2015, which was agreed in the Programme of Action of the International Conference on Population and Development held in Cairo in 1994.

While progress has been made in ensuring universal access to reproductive health by 2015 it is evident that much more needs to be done if the target is to be met in the next eight years. Health services, as they now exist, do not allow equitable access to reproductive health services for all who need them. While products are being developed to protect women against infections, such as microbicides for HIV prevention, and other initiatives are being undertaken; the onus of contraception remains with the woman in most situations and not with her partner. Yet, in some cultures, if she has failed to produce an heir, she is expected to undergo as many pregnancies as necessary to do so.

This paper will address the research agenda that is required to ensure that both men and women contribute fully to the implementation of the new target for Millennium Development Goal 5 as soon as possible and hopefully by the target date of 2015.
Decision-making processes related to family planning and the use of contraceptives among Muslim couples in an urban area of Sri Lanka

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with DB Nugegoda

A community-based cross-sectional study was carried out from August to September 2005 to study the decision-making process related to family planning and the use of family planning methods among Muslim couples in the municipal council area of Matale, Sri Lanka. A pre-tested, structured questionnaire was used to interview 445 married females in the reproductive age group, selected randomly, of whom 99% participated.

In this urban Muslim community a high educational level was noted. The mean age of the wives was 33.2 years and their husbands 38.9 years. The majority of the females were housewives (93.9%), while 38.0% of the husbands were businessmen. Of all the pregnancies 86.4% were planned. Unplanned pregnancies increased with increasing birth order. 5.8% of the respondents had resorted to induced abortions at any given pregnancy.

Overall contraceptive prevalence among the study population was 58.9%, lower compared to the national prevalence of 70%, although, the awareness of respondents of modern methods was high: pill (98.9%), injectable contraceptives (98.7%), likelihood ratio test (LRT) (96.9%), intrauterine contraceptive device (IUCD) (93.7%), condom (89.9%), vasectomy (63.1%) and Norplant (16.6%). Of the 183 non-users 55.2% indicated their willingness to use family planning in the future.

Reasons for disapproval of modern temporary methods by the wives were due to side-effects, health concerns, and misconceptions. Religious reasons were low, except for permanent sterilizations. However, nearly a quarter (24.3%) of the husbands opposed contraceptive use by their wives mainly due to religious reasons. Even in extended families the opposition from mothers and mothers-in-law to the use of contraceptives was negligible. In two thirds of families, the couples have not discussed the number of children they should have.

Family planning practices among Muslims in this urban area was low compared to the national prevalence. The reasons for low prevalence were opposition by husbands, mainly due to religious reasons and fear of side-effects. Family planning counselling involving both wives and husbands is recommended. Steps should be taken to remove misconceptions and fears.
Community-based Participatory Research, an approach towards equity in developing countries: an Iran experience

Ensie Jamshidi, Executive Manager, Social Development and Health Promotion Research Center, Tehran University of Medical Sciences, Iran
with Khandan Shahandeh, Azita Kheiltash, Behdad Majdzadeh, Mohammad Javad Roozbehani, Abbas Vafaii Zonouz, Mohsen Aghajani, Fariba Akbari, Hanih Aboulhassani and Seyyed Reza Majdzadeh

Community-based Participatory Research (CBPR) is an equitable and collaborative research approach that is designed to ensure and establish structures for participation by communities, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change.

In Iran, the CBPR approach has been adopted by the Social Development and Health Promotion Research Centers in 33 medical universities to address the persistent problem of disparities in the use of health care and health research outcomes for several populations, including those of low socioeconomic status, women, at risk youth, people without health insurance, and various minority groups. The main goal of this paper is to illustrate the use of this method in resolving health disparities, and to examine opportunities and challenges for CBPR in Iran.

First, socioeconomic determinants of health were assessed to engage researchers and communities in examining how people’s personal experiences with health disparities are linked to policies, social structures, and other forms of institutional control. To assess socioeconomic determinants of health, a power analysis was conducted in which, systematic disadvantage, failure to advocate, or merit that was not being recognized or acknowledged was detected. The Socio-Economic and Gender Analysis (SEAGA) method was used to involve all socioeconomic and gender groups in determining health needs and priorities. In accordance with these priorities, multilevel participatory interventions were developed including: organizing affected communities to present and share their potentials with other organizations (governmental, nongovernmental and private sector); and preparing an enabling environment and advocating for policy change.

This CBPR approach enabled the equitable participation of many research stakeholders in planning for priority areas such as drug misuse, risk behaviours in young people, violence etc.; facilitated the incorporation of knowledge gained with taking action; stimulated co-learning; and affected social change and built collective capacities to improve the health and well-being of community members. Although there were some challenges, such as imbalanced distribution of power among the research collaborators, varying degrees of self assurance among individual participants, and the existence of a government-centred system.

Overcoming the complex problems of developing countries requires participatory approaches and solutions that bring together the community with other partners in order to utilize resources most effectively and appropriately. Decentralization of power in research decision-making should create social and policy change – the ultimate goals of collaborative research.
Potential years of life lost (PYLL) from cancer and infectious diseases are used to illustrate different scenarios, usually associated with economic and social development. However, there is a group of countries in epidemiological transition, where in spite of increasing rates of cancer; mortality and morbidity associated with infectious diseases, still remain significant. Argentina represents an example of this situation.

This study challenges the status of cancer as a marker of developed populations, by analysing its evolution and correlations with social factors. The hypothesis is that population groups with strong gaps in income distribution and access to health care services present a dual epidemiological profile where different types of tumours are associated with different levels of sanitary and economic development. In order to illustrate this, the paper uses panel data on mortality rates for a group of ten types of tumours, by sex, over a period of 15 years (1987–2001), originating from a collaborative study between the National Ministry of Health, a major municipal hospital and the Italian Directorate General for Development Cooperation.

The document also analyses, across provinces, the evolution of mortality due to tumours with effective screening and prevention interventions, in order to identify the presence of active prevention policies. Results show that the most developed provinces (in terms of poverty, health care coverage and education) have achieved the highest reductions in cancer mortality, whereas the poorest have experienced the opposite. These outputs are also seen in the case of preventable tumours, confirming an inverse correlation between poverty and access to preventive health care services.
Access to health services is a fundamental aspect of the right to health. Violations of women’s right to health – physically, emotionally, spiritually and socially – inherent in the experience of sexual violence is further compounded when victim/survivors are denied access to gender sensitive sexual violence services. This paper explores qualitative responses from service providers, activists and researchers from 14 low-income countries (as defined by the World Bank) who participated in the ‘Practice Wisdom’ online survey of the Sexual Violence Research Initiative (SVRI).

Thematic analysis of responses from workers in South Asia, Eastern Europe, South America and Africa revealed that lack of access to services was not merely a function of insufficient numbers of services relative to need, lack of community awareness of services or inadequate funding of services by governments and donor agencies. Of equal importance was the interplay between high levels of negative community attitudes towards victim/survivors including victim blaming, stigmatization and discrimination, and the corresponding shame and unwillingness of survivors to disclose sexual violence and to access the few available services. This was reinforced by a fear that services might not protect privacy and confidentiality.

Strategies were identified to overcome the dynamic operating between social blame and impunity for perpetrators on the one hand, and the engendering of private shame and silence in victims on the other. Significant changes are needed in community attitudes, perceived deficiencies in the health care system and the skills of health-care providers to be more responsive to victims of trauma; together these provide the basis for health sector and policy reform.
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Sharma, Shuvi
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Stackpool-Moore, Lucy
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Suk, William
Sun, Xiaoyun
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Tao, Dai
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Tran, Nhan
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van Riet, Marinke
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Vincent, Robin
Vuthoori, Shilpa

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Wang, Zaoli
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Xu, Huan

Yepes, Francisco J
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Zhang, Hong
Zhang, Mingming
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