Governance for Global Health: Power, politics and justice
**Abudu, Elfreda, Plan International Ghana, Ghana**

**Strengthening health outcomes for women and children living in vulnerability and hard to reach areas**

**ISSUE(S)/OBJECTIVE**

- Gender norms, negative community perceptions toward men who play an active role in caring for their family's health and lack of knowledge regarding men's role in MNCH dissuade men from taking an active role in caring for the health of their wives and children. Gender related barriers inhibit women's and girls' capacity to make positive health choices resulting in delay the use of MNCH/ SRH services.
- Poor infrastructure, inadequate logistics and skilled workforce coupled with inadequate knowledge and skills to handle emergency situations contributes to maternal and new born mortalities in developing countries.
- The Strengthening Health Outcomes for Women and Children (SHOW) project is a four and a half year (2016-2020) gender-transformative initiative aimed at increasing the quality, availability, utilization and accountability of essential MNCH/SRH services to reduce maternal and child mortality amongst marginalized and vulnerable women, specifically adolescent girls, and their children across eight districts in Ghana.

**METHODOLOGY**

Health System Strengthening:

- Health care providers trained in various skills including Basic Emergency Obstetric and New-born Care (BEmONC).
- MNCH/BEmONC equipment including delivery beds, delivery kits, suction machines, examination tables etc. were provided to 40 health facilities.
- Increasing demand for quality MNCH/SRHR and women and girls empowerment:
  - Mother support groups established and strengthened to act as local agents of change on Gender Equality (GE).
  - Promoting girls' rights and life skills development using adolescent girls' clubs.
  - Women and adolescent specific VSLAs established and strengthened to promote financial empowerment and social capital.
  - Local influential women empowered as champions of change to increase women's participation in Community Health Committees and female involvement in decision making.
- Engaging Men and Boys in MNCH/SRHR:
  - Formation of Daddies adolescent boys clubs in project communities to promote long-term changes in gender relations and power dynamics.
  - Engagement of traditional leaders and male role models to promote the importance of male engagement in MNCH/SRHR, gender equality and promotion of women and girls participation in decision making.

**RESULTS:** Mid-term results show a significant improvement in some maternal and child health indicators such as ANC, PNC, Skilled birth attendance, measles vaccination, female involvement in decision making and an improvement in providing gender responsive and adolescent friendly service delivery by health care providers.

**CONCLUSION:** The project seeks to acknowledge and improve gender inequities that impacts maternal, new and child health and sexual and reproductive health and rights through community mobilization, empowerment and social inclusion approaches to ensure communities demand for quality health care services.

Co-Authors: Elfreda Abudu, Plan International Ghana, Ghana
Adams, Alayne, Georgetown University, USA

Strengthening urban health service delivery and governance by institutionalizing a geo-referenced health information system tool in Bangladesh

Issue/objective: Urban health governance in Bangladesh is complex as multiple actors are engaged simultaneously. Health management information systems (HMIS) of the country lack information on urban areas where health inequalities persist. A novel geospatial information communication and technology (ICT) tool – the Urban Health Atlas (UHA) - provides critical information on the type and location of healthcare facilities for strengthening service delivery and quality. The objective of this study was to identify barriers and facilitators in institutionalizing UHA in planning processes which will ultimately enhance understanding of how an ICT tool can inform health service planning and oversight in urban Bangladesh.

Methodology/approach: This mixed methods implementation research was conducted in three cities in Bangladesh: Dhaka, Dinajpur and Jessore; during June 2016 to May 2019. Capacity building of urban health managers were undertaken through two hands-on trainings on UHA in each study site and information were collected on its usability, understandability and utilization through in-depth interviews. The institutionalization process of UHA was conceptualized to involve three stages: uptake, use and regular update of UHA. Stakeholder analysis was carried out to understand and document stakeholder perceptions and experiences of institutionalization.

Results: The capacity building around UHA substantially enhanced understanding of health managers around its utility. Consequently, UHA was utilized in local level service planning and decision making for providing equitable health service and disaster management. However, use of UHA was hindered to some extent by inadequate ICT infrastructure, shortage of human resources and general lack of ICT skill among the available staff. “Technology Champions” both at local and national level embraced its utility and favored the institutionalization process but short stay of the decision makers at key position resulted in loss of institutional memory and hindered the progress of regular update. Absence of clear coordination among the stakeholders both at national and local level affected building a consensus on how regular update of UHA could be achieved.

Discussion/conclusion: The institutionalization process is influenced by multiple national, local and personal level factors and attributes. Efforts to facilitate use of evidence in decision making are prerequisite to enabling uptake of UHA or any ICT by government systems. Clear understanding of context, actors and system readiness is crucial for implementation of ICT tools to strengthen government HMIS and ensuring governance and accountability in resource-poor country like Bangladesh to achieve Universal Health Coverage and ensuring social justice.

Co-Authors: Sohana Shafique, International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b); Dipika Bhattacharyya, International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b), Bangladesh; Susmita Das, International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b), Bangladesh; Shaikh Hasan, International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b), Bangladesh; Alayne Adams, Georgetown University, USA
**Ag Ahmed, Mohamed Ali, S.O., Mali**

**Stratégies facilitant le recours à l’accouchement assisté par les pasteurs nomades en Afrique subsaharienne : Cas de Gossi au Mali**

**Enjeu/Objectif**

Les pasteurs nomades sont nombreux (20 à 30 millions dans le Sahel) et ont un accès limité aux services de santé en raison de leur mode de vie mobile à la recherche des pâturages et des points d’eau. Pour les femmes nomades, le non-recours à l’accouchement assisté les expose à un risque important de décès maternel. Plusieurs intervenants s’interrogent sur les stratégies qui pourraient faciliter leur recours à l’accouchement assisté. L’objectif de cette étude est d’identifier les stratégies les plus utilisées localement (endogènes) par les nomades pour les valoriser.

**Méthodologie/approach**

Les stratégies ont été identifiées au cours d’observation non participante en milieu nomade pendant trois mois, de 26 entretiens en profondeur avec des femmes nomades et d’entretiens informels avec les hommes nomades de Gossi au Mali lors de notre recherche doctorale portant sur leurs déterminants du recours à l’accouchement assisté.

**Résultats :**

Les nomades de Gossi utilisent quatre stratégies qui contribuent à leur recours à l’accouchement assisté : la téléphonie mobile, les maisons d’attente, les extensions communautaires et un système de transport des parturientes. En effet, au sein de chaque campement nomade visité, au moins un téléphone portable est disponible et utilisé pour s’informer sur les services de santé et pour les évacuations obstétricales. Il contribue ainsi à faciliter le processus de prise de décision. De même, des parturientes nomades indiquent s’être déplacées par anticipation à proximité du centre de santé pour attendre leur accouchement ce qui rejoint le concept de « maisons d’attente ». Elles apprécient cette proximité qui leur a permis d’accéder à pied au centre de santé. Les nomades de Gossi indiquent la présence d’agents de santé communautaire et d’accoucheuses traditionnelles recrutés localement qui les orientent et donnent des conseils. Enfin, pour pallier au manque de transport des parturientes, les nomades de Gossi empruntent ou louent des véhicules de transport des locaux et apprécient ces possibilités qui leur sont offertes.

**Discussion/conclusion**

Les stratégies identifiées semblent adaptées aux besoins, aux attentes et aux réalités socioculturelles des nomades. Elles sont complémentaires du système de santé et potentiellement porteuses pour faciliter leur recours à l’accouchement assisté. Elles ont déjà été implantées dans plusieurs contextes africains. En outre, l’aspect novateur réside dans leur combinaison avec un effet attendu plus important. Nos résultats appellent ainsi à de futures recherches pour approfondir et évaluer ces stratégies en milieu nomade en Afrique subsaharienne.

**Co-Authors:** Mohamed Ali Ag Ahmed, S.O., Mali
Agbaiyero, Kehinde, Systemone, Nigeria

Effectiveness of gxconnectivity to increase dr-tb treatment enrolment rate in nigeria.

Issue: The world Health organization rank Nigeria 6th among 30 high TB burden countries in the world and 1st in Africa. Nigeria commences the use of Rapid diagnostic machines (Genexpert MTB/RIF) to test for infectious diseases such as tuberculosis (TB) and drug resistant TB in 2011 with the number of the machines in-country progressively increasing from 7 in 2011 to 394 in 2018. The introduction of this machine contributed to an increased in number of MDR/RR-TB diagnosed from 38 in 2011 to 2275 in 2018. However, despite this progress, the treatment enrolment gap continued to increased, the average time to initiation of treatment was also above two months. In order to address this gap, the Nigeria National TB programme introduced the use of GxAlert system in 2012 in addition to service decentralization. This study was therefore conducted to evaluate the effectiveness of the GXconnectivity on the DR-TB enrollment rate and the average time to treatment initiation in Nigeria from 2013-2018.

Methodology: Systemone designed GxConnect which sends GeneXpert MTB/RIF diagnostic results (GxAlert) in real time to a secure web-based database, shortening a reporting period from months to mere seconds and enabling better data quality and faster recruitment of patients into appropriate care and treatment. The GeneXpert machines in the country were connected to GXAlert with the number of machines connected increasing from 45 in 2013 to 392 in 2018. A notification is sent from the GXAlert to the clinician, the DRTB focal person, the State programme and the NTP managers as soon as a Rifampicin Resistance-Tuberculosis (RR-TB) is diagnosed to ensure and facilitate prompt enrollment. A line listing tool was also developed and used to monitor time of initiation of treatment.

Results: The number of diagnosed RR-TB increased from 665 in 2013 to 2275 in 2018. As the coverage of the GxAlert system increases, the proportion of RR-TB enrolled on treatment also increased from 53% in 2013 to 83% in 2018. The average time to initiation of treatment also reduced from over 2 months to less than 14 days.

Conclusion: The enrollment gap is increasingly closing with the use of Gxconnectivity, the time to the initiation of treatment also drastically reduced. As the country advocates for more GeneXpert machines, plans for connectivity to GxAlert should be of priority globally.

Co-Authors: Kehinde Agbaiyero, Systemone, Nigeria; Chris Macek, Systemone, USA; Obioma Chijioke-Akaniro, NTP, Nigeria
Akbari, Fawad, Aga Khan Foundation Canada, Canada

Role of community institutions in local health governance: a case study of Community Development Councils and Health Committees in rural Afghanistan

Background: Governance is one of the six building blocks of any health system (WHO, 2011. Although it is; primarily the responsibility of government, the private sector and civil society including community institutions, also play a key role (Siddiqi et al, 2008 & 2007). Good governance in the health sector promotes evidence-based decision making, transparency, accountability and inclusiveness. Health governance at the global, regional, and national levels is a well-studied topic, however, local health governance that is particularly concerned with the role of local actors and institutions, such as community organizations, women groups, youth associations and civil society actors in health governance, is an under-studied field for which there is a paucity of literature (Akbari, 2014).

Objective: This study explores the role of community institutions, particularly Community Development Councils (CDCs), in local health governance in rural Afghanistan. Specifically, it compares the role of CDCs with the role of health committees, assesses their potential for future local health governance, and makes policy recommendations to improve local health governance structures and practices.

Methodology: This qualitative study adopted an interpretative qualitative research approach grounded in positivist positionality. Through purposive sampling, respondents were recruited and 12 (8M/4F) in-depth semi-structured key informant interviews were conducted in three areas in Baghlan and Kabul provinces. Interviews included members of CDCs and health committees, provincial and national government officials, and representatives from donor and NGO organizations. Thematic content analysis was used to analyze the data. Ethical considerations were strictly adhered-to and written ethical approval was sought from the University of Liverpool’s Ethical Approval Board and local Institutional Review Board.

Result:

1) health committees are involved in operational and health promotional activities while CDCs are more active in governance such as decisions and accountability;

2) Adopting integrated local health governance structures will require combining and coordinating the activities of community institutions that have a stake in health governance.

3) A review and revision of existing policies on local governance responsibilities to improve coordination amongst health committees and CDCs in local health governance.

Conclusion/Discussion: ‘Integrated local health governance’ and policy modification related to health committees and CDCs are specific recommendations that are believed to strengthen the institutional capacity of and better coordination among local institutions. This is key to improved local health governance and enhanced efficiency and accountability of the local health system. The findings were widely disseminated that contributed to policy change that led to the Citizen Charter in Afghanistan.
Community Score Card process improves citizen engagement and governance of gender responsive MNCH service delivery in Chitipa and Kasungu districts in Malawi

Background:

The Community Score Card (CSC) methodology is used as a successful community governance and social accountability tool in Malawi since 2003. Plan International’s Integrated Pathways for Improving Maternal, Newborn and Child Health (InPath) project is implementing CSC in Chitipa and Kasungu districts to facilitate engagement between citizens, particularly women and adolescents, and Ministry of Health to strengthen the governance of MNCH services and advise District Implementation Plans (DIPS).

Approach:

Inpath built CSC facilitators’ capacity to identify and systematically address gender-related barriers faced by women and adolescents and ensure their active participation in focus groups and interface meetings between community, health providers and district health government. Further, adolescent girls, boys and women separately form focus groups to clearly capture their unique needs and opinions. The MNCH CSC checklist, jointly developed by service users and providers, contains gender-responsive indicators to be tracked during CSC process. Aimed to improve district level governance, service users and providers decide together how to improve MNCH care based on these indicators, and recommendations are included in DIPS. Inclusive CSC committees were formed and trained (29 in Kasungo, 12 in Chipita) to monitor each CSC action plan’s implementation.

Results:

Women’s, adolescent boys’ and girls’ voices and confidence to demand services and hold duty bearers accountable increased, leading to their needs being met: i.e. 12 ANC outreach clinics started in hard to reach areas, and 3 facilities now offer Youth Friendly Health Services. Community engagement and responsibility for health initiatives increased: in Kasungu community members now monitor their facility ambulances, while duty bearers now consistently supply air time to health facilities, increasing the use and improving timely referral for MNCH emergencies.

Gender-responsive CSC contribute to improved dialogue between community and duty bearers, reducing gender barriers in MNCH, illustrated by making gender-responsive sanitary facilities available, while construction of waiting shelters, bathrooms, and toilets led to increased access to MNCH services and institutional births. Communities now appreciate women leadership in community health governance structures i.e. all 40 HCMC in Kasungu and Chitipa have women in leadership positions and over 40 % community women representation.

Conclusion:

Plan International’s approach of integrating gender equality in the CSC brings another dimension to citizen engagement to improve accountability between service users and duty bearers in Malawi. It deliberately accords women and adolescents the opportunity to contribute towards the improvement of MNCH services and use CSC to address gender disparities in their communities.

Co-Authors: Cynthia Mzembe, InPath Project - Plan International Malawi, Malawi; Carolien Albers, Plan International Canada, Canada; Mathews Chavunya, InPath Project - Plan International Malawi, Malawi; Madalitso Chimweneje, Plan International Malawi, Malawi; Aaliya Bibi, Plan International Canada, Malawi
Allison, Jill, Memorial University of Newfoundland, Canada


Issue: Adolescent sexual and reproductive health (ASRH) is a global health concern. Providing the right information to young people empowers them to make good sexual health choices and offers the opportunity for social change. In Nepal, child marriage, harmful social practices such as menstrual exclusion, births without skilled attendance and unmet contraceptive need indicate the importance of promoting adolescent sexual and reproductive health education. This is a Ministry of Health and Population priority. Adolescent friendly health services are offered in Nepal but adolescents lack the knowledge needed to access services and take responsibility for their own health.

Methods: Our project combines peer to peer educational approaches with a tablet based, games and activities centred learning program for youth aged 10 to 14. The program is based on Ministry of Education curriculum and designed in collaboration with a Nepali software development company. Ten intervention schools and ten control schools were selected in two districts in rural Nepal. Data collection over a one-year period included surveys, interviews, focus groups and information recorded from the use of the tablets themselves. Peer education training workshops provided an important opportunity for youth to contribute stories and experiences to enhance the content of the educational program. Peer mentors kept logs of interactions with fellow students around the use of the tablet-based program, recording activities and observations.

Findings: Youth were interested in playing the games, using the applications and improving their scores in the activities. The peer learning component provided support for the program and helped reinforce information through social interaction in the classroom and community. Overall, we demonstrated an increased knowledge of ASRH through the educational program. Challenges included teacher control over access to the tablets and lack of support in some schools for the overall use of the program highlighting the need for high level ministry support for new curriculum innovation.

Discussion: Peer education approaches to ASRH have been shown to have mixed results in past studies. We based our project on the need to include youth in ASRH learning with peer educators and an entertaining and youth friendly approach to sharing information. The interactive and fun technology-based program provides an internal incentive for learning. The combination enhances learning while enabling on the ground observations recorded from the perspective of the adolescents themselves. Youth also felt empowered to share stories as part of the opportunity for proactive content contributions to the program.

Co-Authors: Jill Allison, Memorial University of Newfoundland, Canada; Laxmi Tamang, Midwifery Society of Nepal, Nepal; Elawati KC, WOREC Nepal, Nepal; Shweta Karna, WOREC Nepal, Nepal; Abhiram Roy, WOREC, Nepal, Nepal; Rajendra Poudel Yagiten, PVY, Nepal
Amon, Samuel, School of Public Health, College of Health Sciences, University of Ghana, Ghana

The political economy of health governance in a decentralized health system of Ghana

Issue/objective:

A critical challenge in global health is to achieve Universal Health Coverage by 2030. Ghana is a democratic country based on a multi-party political system. Generally, Ghana’s governance arrangement and practices are considered as ‘competitive clientelist’, where ruling elites use public institutions in securing short-term political gains, and decisions to invest in the health sector are made through political lenses. The study seeks to assess power dynamics in the governance and management processes of the Ghana health sector. The study is relevant as it highlights the effects of ‘competitive clientelist’ governance system on equity in health, and women’s involvement in health management.

Methodology

Data were collected from September 2017 to February 2018 through desk review and semi-structured interviews with stakeholders from national, regional and district levels, as well as from non-governmental and faith-based organizations. The interviews were recorded, verbatim transcribed and coded according to an existing coding framework based on the interview guide (deductive approach). Emerging new codes or themes were included in the already existing coding framework. Participants consent was sought and data were anonymised.

Results

Tension exists between Ghana’s health management policy guidelines, which affects vertical and horizontal accountability and fosters dominant relationships. The relationships between District Health Management Teams (DHMTs) and local governments (District Assemblies) remain ad hoc and at the mercy of dominant personalities. Ghana’s health sector is politicised in a manner that technically undermines health policy formulation and implementation. During health policy formulation and implementation, performance for political gain is prioritised over quality of care. These deficiencies lead to persistent poor financial and human resource management practices, growing weakness in the sector partnership arrangement, limited community involvement, ownership and participation in health activities, and challenges in the implementation of Public Private Partnership policies and strategies. The capacity of local, regional and national decision makers to perform their roles is constrained by limited autonomy and decision-spaces. Distribution of women and men in management and leadership positions is unequal (ratio of approximately 1:10).

Discussion/conclusion

The highly politicized nature of the health sector means that enhanced community involvement may be critical for the success of health interventions. Women empowerment through an equal share in leadership positions within the health sector could translate into more diversity in leadership styles. The myriad of competing interests, dynamic political environments and shifting national funding priorities within the scarcely resourced health sector affect health management and sustainability of health interventions.
Amporfu, Eugenia, Kwame Nkrumah University of Science and Technology, Ghana

**Effect of energy shortages on institutional deliveries in India. Does facility ownership make a difference?**

Issue/objective: Energy shortages, a frequent challenge in many developing countries, increases the probability of power outages, which can disrupt the operation of health facilities yet little is known about the impact of such shocks on the utilization of health services. Since health facility ownership has effect on governance, the impact of energy shortage on institutional delivery rates could vary according to health facility type. This study investigates the impact of state-level energy shortages in India on institutional delivery rates focusing mainly on differences in impact due to ownership type of the health facilities.

Methodology: Data used came from the 1998/9 and 2005/6 Indian Demographic and Health Survey with energy data from India’s Central Electricity Authority. We used instrumental variable estimation to address measurement error in the data and logistic and multinomial regression to estimate the impact of energy shortages on institutional deliveries.

Results: Our results show that energy shortages reduced institutional delivery rates and increased home deliveries. However, the effect on institutional deliveries depended on whether the facility was publicly or privately owned and managed. A 10 percent increase in the probability of an energy shortage reduced institutional delivery rates by 1.1 percentage points in public health facilities compared to 0.3 percentage point in private facilities. The reduction in deliveries in public health facilities, due to power shortage, was greatest among higher wealth quintiles and urban dwellers. These cohorts were more likely to deliver in private facilities than public facilities.

Discuss/Conclusion: Such results are consistent with previous studies that reported better quality of care in private facilities relative to public facilities. Private health facilities were likely to use energy back up to mitigate the negative impact of energy shortage, hence the lower reduction in deliveries in private facilities. Poor electricity supply is an important determinant of institutional deliveries in India and policy makers should develop plans to mitigate the impact of these disruptions to health systems.

Co-Authors: Eugenia Amporfu, Kwame Nkrumah University of Science and Technology, Ghana; Karen Grepin, Wilfrid Laurier University, Canada
**Annih Akofu, Aweh, Effective Basic Services (eBASE) Africa, Cameroon**

**Healthy Kitchens for Healthy Mother Earth: Evidence Informed Policy and Practice for Indoor Pollution Resulting from Cooking in African Kitchens**

In Cameroon, preparation of food is usually done by women and children using wood on the traditional ‘three stone fireside’, causing indoor pollution. This exposes them to inhalation of smoke and other by-products of burning wood which predisposes them to Chronic obstructive airway diseases (COAD), with 34% of women against 13% of men suffering from COAD in Africa. Women and children also spend long hours fetching wood and cooking on inefficient cooking technologies.

We sought to use a systematic approach to evaluate evidence for clean cooking energy for African kitchens for incorporation into a development project for the Bororo indigenous community of Cameroon. We targeted households that were off the electricity grid, with indigenous Bororo communities and sought to impact on women and children. We conducted a systematic evidence search using the evidence barometer. We used identified evidence to inform design of a project which supplied solar cookstoves and lights to households in the Ndzah Bororo indigenous community in Cameroon. Community members received training use of solar cookstoves for cooking, lighting, and charging of mobile phones. We conducted a cluster randomized control trial between 2 indigenous communities (Ndzah: Intervention using solar cookstove technology and Bali: Control using regular 3 stone fireside wood technology): https://www.youtube.com/watch?v=2qEv584cn18 We used the results to inform policymakers at regional level, develop a proposal for scale out, and support an ongoing maternal and child health project supported by the University of Ottawa and WHOCC with funding for Grand Challenge Canada. We measured the effect on episodes of cough, sore eyes, cooking times, and school performance for kids over a 6 months period.

Households using evidence-based solar cookstove technologies had 3 times less weekly cough episodes; 4 times less weekly sore eyes; and 2.7 hours less daily cooking time compared to the control community. Women in the intervention community were able to dedicated freed up time for adult learning programs. We used results to advocate for policy change for improved cooking technologies for indigenous women living off the electricity grid and to develop proposal for scale up.

Improving cooking technologies for poor communities globally will impact on global health, education, and reduce carbon emissions and deforestation. Women and children fetching wood and cooking indoors suffer disproportionately from avoidable disease burden and poor educational outcomes due to their social status. This can be addressed by intersectoral actions for governance and policies that are more gender friendly.

Co-Authors: Aweh Annih Akofu, Effective Basic Services (eBASE) Africa, Cameroon; Cheabum Raphael Oujowgah, Effective Basic Services (eBASE) Africa, Cameroon; Patrick Mbah Okwen, Effective Basic Services (eBASE) Africa, Cameroon
Apolot, Rebecca Racheal, Makerere University School of Public Health, Uganda

Social accountability improves utilization and quality of maternal and newborn health services in Kibuku district, Uganda: A pilot intervention using Community Score Cards

Issue/objective

Annually, 99% of maternal deaths occur in LMIC and 66% in Sub Saharan Africa. Consequently, there has been a renewed commitment at both the global and local level to accelerate reduction in maternal and child mortality. This requires increased monitoring and accountability. Our study was testing the feasibility of community and facility scorecards as tools for monitoring and exerting social accountability from health workers and communities in order to improve delivery and utilization of Maternal and Newborn Health (MNH) services in Kibuku district-Uganda.

Methods

This was a 2-years pilot intervention study that used community and facility scorecards for quarterly scoring of performance on utilization and delivery of MNH services using colours. Implemented in 5 health facilities and their catchment communities in five sub counties, and at the district level. A total of 20 community Focus Group Discussions (FGDs), 5 health facility FGDs and one district FGD scored facility and community performance per quarter. A total of 6 scoring rounds were done and after each round, score cards developed and dialogue meetings held where work plans developed to improve poorly performing indicators

Results

Improvements across different MNH service delivery and utilization performance indicators; seeking Antenatal care within first trimester, institutional assisted deliveries, birth preparedness, male involvement, saving for MNH, attitude of health workers, availability of midwives, availability of delivery beds in the health facilities and communities. Kibuku as a district has also improved some MNH indicators like maternal and newborn death audits.

Conclusion

Community and facility score cards are a strong social accountability tool that can amplify community voice and ultimately trigger joint action from different stakeholders to improve MNH services.

Co-Authors: Rebecca Racheal Apolot, Makerere University School of Public Health, Uganda; Elizabeth Ekirapa, Makerere University School of Public Health, Uganda; Suzanne Namusoke Kiwanuka, Makerere University School of Public Health, Uganda; Christine Aanyu, Makerere University School of Public Health, Uganda; Aloysius Mutebi, Makerere University School of Public Health, Uganda
Arogundade, Kazeem, Pathfinder International, Nigeria

Strengthening the capacity of the government to engage private sector in improving access to quality maternity services in Nigeria: SMGL Experience

Issue: Despite the substantial level of commitment demonstrated by the public health sector in improving availability and accessibility to maternity services among the vulnerable population (pregnant women and newborn), achieving optimal health services delivery still remains a major challenge especially in resource-limited settings. Hence, engaging the private health sector to strengthen the public health systems cannot be overemphasized. In Cross River state, findings from the health facilities assessment conducted in 2014 revealed a weak referral and linkage system across public and private health sector, poor government regulation of the private sector and poor health information management system.

Approach: The Saving Mothers Giving Life Initiative (SMGL) in collaboration with government of Cross River state (CRS), Nigeria created cluster-model platforms to strengthen referrals, linkages and professional working relationship across private and public health facilities including capacity building on health management information system. CRS government was supported to develop a Mother-Baby care card to address gaps in documentation along the MNH continuum of care in private and public facilities in the state. Furthermore, Implementation of Maternal and Perinatal Death Surveillance Response was scaled up to 30 private facilities. The Initiative supported Cross River state government to understand the legislative, organizational and regulatory roles of private health sector and implement the best practices in the state.

Findings: As a result of improved referral system across public-private facilities and vice-versa, over 50 maternal near miss and 100 newborn deaths over a 3-year period have been averted and 100% of supported private health facilities now reports timely to the National (government-owned) Health Management Information System compared to 40% at baseline. All supported facilities now notify maternal and perinatal death using the national MPDSR electronic platform. 30% of supported private health facilities have adopted a sustainable financing model to improve access to quality maternity services through provision of discounted user fees for referrals made from the community and or public facilities and over 200 women have benefitted from this innovation over a 3-year period.

There has been an improvement in coordination and regulation of private health sector evidenced by development of policy briefs and guidelines.

Conclusion: While the public health sector may not sufficiently meet the health needs of mothers and newborns, the private sector complements roles by addressing the existing gaps in the health system especially in the area of health financing, essential drugs and supplies, health infrastructure as well as effective health policy reform.

Co-Authors: Kazeem Arogundade, Pathfinder International, Nigeria; Yemisi Femi-Pius, Pathfinder International, Nigeria; Yemisi Erhunmwunse, Pathfinder International, Nigeria; Farouk Jega, Pathfinder International, Nigeria
Arthur, Megan, University of Edinburgh, United Kingdom of Great Britain and Northern Ireland

Community-based health system governance and the data agenda in global health: a scoping review

Issue:

This project investigates the intersection between two important fields of research within health governance: (1) community mobilisation as a way to improve health services, in particular in contexts of limited state capacity (McCoy et al., 2011; Mansuri and Rao, 2012; Falisse, 2016) and (2) the benefits of the current ‘data revolution’ for improvements in service provision (AbouZahr et al., 2015; Walker 2014). The explosion of data availability within health systems could carry considerable potential for social accountability within health system governance on behalf of participatory institutions such as community volunteers and citizens’ committees, however to date this has not been apparent in the literature. We conducted a scoping review to map the development of inquiry at the intersection of these fields, in particular how community-based actors understand and make use of the data ‘revolution’ within health system governance.

Methodology:

The scoping review followed the framework set out by Arksey & O'Malley (2005), including an in-depth review of the literature and two ‘consultation exercises’: seven semi-structured interviews with relevant stakeholders in LMIC contexts, and an interactive online workshop. Based on qualitative thematic analysis, we present a synthesis of emergent themes identified within the literature and stakeholders’ inputs.

Results:

Our scoping review indicates limited exploration of the intersection between community-based health system governance and the data revolution, within the literature or in practice contexts. A prominent theme from our review was that of imbalances of power in the design and control of data systems, undermining their efficiency and relevance. For example, the role of community-based actors was often discussed in terms of providing data for use at higher governance levels, versus being engaged in the interpretation and use of data for local health system management. Challenges for the use of data in community mobilisation included data availability and accessibility, data literacy and community capacity, and data quality. Despite these challenges, through our literature review, interviews, and workshop we identified a number of cases in which community-based data collection, interpretation, and/or communication have provided avenues for political empowerment and mobilisation for social accountability within health systems.

Discussion:

To date there has been limited inquiry into the intersection between the data revolution and community mobilisation in health system governance. This review provides insights into critical themes for a future research agenda exploring how data systems within global health relate to community-based health governance, social accountability in health, and ultimately health outcomes.

Co-Authors: Jean-Benoît Falisse, Centre of African Studies, School of Social and Political Science, University of Edinburgh, UK; Megan Arthur, Global Health Policy Unit, School of Social and Political Science, University of Edinburgh, UK
Ayaz, Basnama, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, Canada

Participation of women in the health workforce in Fragile and Conflict-Affected countries— a Scoping Review of the Literature

Objective

The full participation of women as health care providers is recognized globally as critical to favourable outcomes at all levels of the health care system, yet systemic challenges, gender biases and inequities exist for women in the global health care workforce. Fragile and Conflict-Affected States (FCAS) experience additional pressures that require specific attention to overcome challenges and disparities. FCAS account for 42% of global deaths due to communicable, maternal, perinatal and nutritional conditions (WHO, 2015). Consequently there is a need to understand the impact of gender on career trajectories in the health workforce, particularly for women. This scoping review examined the extent and the nature of existing literature on women’s participation in the health workforce in FCASs. It also identified factors affecting women’s participation in administration and leadership positions.

Methodology

Arksey and O’Malley’s scoping review methodology framework guided the conduct of this scoping review. The search focused on the systematic search of published literature in health sciences database including MEDLINE, CINAHL Plus, Scopus and Web of Science. Besides, grey literature in Google Advance and Google Scholar, it included relevant websites of international development agencies such as WHO, World Bank, the Research in Gender and Ethics, and REBUILD consortiums. The search utilized terms related to women’s participation, health workforce, and fragile and conflict affected situation/states from the WB’s harmonized list of 36 countries for the year 2019, and identified sources that met the inclusion criteria. Two reviewers independently screened title and abstracts for 1983 sources and listed 100 for full text review. The full text review is in progress and results will be available for dissemination by September 2019.

Results and discussion

The findings from FCASs will be presented, guided by the gender analysis framework developed by Morgan et al. (2016). The framework presents key domains to understand gender as power relations and a driver of unequal access to resources, division of labor, social norms, ideologies, beliefs and perceptions, and rules and decision making. Gender equality is an essential and integral part of health workforce to transform the distribution of opportunities, resources, and choices for males and females for sustainable development of the society, and achieve the United Nations’ sustainable development goal for gender equality and women empowerment by 2030.

Co-Authors: Basnama Ayaz, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, Canada; Sioban Nelson, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, Canada; Carles Mutaner, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, Canada; Tina Martimianakis, Wilson Centre for Research in Education and University of Toronto, Canada;
Barimah, Kofi, Centre for Plant Medicine Research, Ghana

Ghana’s National Insurance Scheme: Insights from administrators, health care providers and members

Issue/Objective: Under-funding of healthcare is worse in sub-Saharan Africa where the dearth of financial resources remains an enduring problem. In the 1980s, persistent budgetary constraints compelled Ghana to implement a cost recovery regime. This regime has undermined access to health services, with many low-income households regularly postponing medical treatment, resorting to self-treatment, or relying on unregulated traditional healers. In 2003, the government established a National Health Insurance Scheme (NHIS) as a poverty reduction strategy towards Universal Health Coverage to ensure that no one is left behind in accessing affordable healthcare. The aim was to evaluate the NHIS within the context of maternal and child care to determine whether NHIS is fulfilling the needs for which it was established.

Methods: Carefully selected informants from districts in the Brong Ahafo and Upper East regions participated in focus group discussions (FGD). The Upper East, is highly economically depressed, and its inclusion provides insight into how poor women interacted with NHIS. The FGD dealt with several pertinent issues concerning the NHIS including premiums, benefit package, and exemptions, protocols on prescriptions, maternal care benefits. “Carefully selected” is emphasized to hint of the attention we paid to power dynamics and issues of positionality in selecting stakeholders. With the permission of our participants, deliberations were tape-recorded.

Results: The NHIS has yielded some verifiable positive outcomes: women who are enrolled are more likely to give birth in hospitals, to have births attended by trained health professionals, to receive prenatal care; to have fewer birth complications, and to experience fewer infant deaths. Affordable health care services and prescription drugs are now accessible. The accountability system is poorly defined leading to a major challenge of fraud and corruption.

Discussions/Conclusion: NHIS has yielded positive health outcomes for maternal and child health. Another related project focused on universal coverage in South Africa, Ghana, and Tanzania concluded that Ghana appears to be pursuing a universal coverage policy in a more coherent way as compared with South African and Tanzania. We shed light on the governance, benefits, processes, outcomes and challenges noting that more people are enrolling in NHIS. Without a doubt, much of the answers we sought in this study could have well been procured from various NHIS documents and legislative instruments. Still, with our qualitative approach we managed to humanize the discussion with narratives and insights from the subjective views and interpretations of key stakeholders which is often rare in such studies.

Co-Authors: Kofi Barimah, Centre for Plant Medicine Research, Ghana; Phyllis Owusu-Ansah, Wisconsin International University College, Ghana
Batange, Haruna, African Research center 4 Ageing & Dementia, Uganda

Does governance plays a key role in influencing public-private partnership in Uganda healthcare system: a case study of Uganda local health care system

Background:
Over the past two decades, low Middle Income countries (LMICs) have witnessed the rapid increase in private health sector. In countries with mixed mode of health care financing, private health sectors plays a critical role. In order to achieve Universal Health care coverage (UHC), LMICs should focus on harnessing Public-Private Partnerships (PPPs). As one of the strategies to leverage the available limited resources (human, infrastructural and financial), the Ugandan government has embarked on promoting and encouraging the Public-Private Partnership model as a way to improve efficiency and achieve economic growth, national health development, and poverty eradication. However, the implementation process of the PPPH policy in local health care systems is slow.

General objective: To assess the governance factors that affect partnerships between the public and private health sectors in local health care system.

Methods: This study employed a case study approach that allowed in-depth data collection through literature review of relevant studies and documents related to PPPs in health in Uganda. A conceptual framework that identifies and defines the interactions between governance and Public Private Partnerships in health was used to systematize data synthesis and analysis. Findings were triangulated with literature from LMICs especially in the Sub-Saharan region. Additional literature at national level was also consulted together with secondary data from reports and policy documents.

Result: District level, health sector governance is provided through three oversight structures: the management, governance and partnership structures. District Health office (DHO) assumes stewardship of the health sector through the management structure with coordination of all actors. There is noted evidence of weaknesses in the functionality of the coordination structures including the private sector governance bodies. The documented reasons includes: inconsistencies in convenings, under-resourced operations, and weak participation of both public and private actors. The study reveals factors that facilitated the PPPH policy development process that included: the historical government-faith based collaboration; the presence of influential private sector (PNFP and PFP) and champions; donor support and influence and the proliferation of PFPs that under-pinned government to propagate engagement of private actors among others.

Conclusions and recommendations: Sustainable PPPH in Uganda thus calls for stronger coordination and creation of legitimate collaborative frameworks that stipulate mutually agreed goals and provide for balanced participation, informed monitoring, complementarity, transparency, accountability and effective governance structures. Integration of strategies to mitigate and solve system-wide challenges is critical to facilitate health system strengthening, including alignment of HDPs/donor actions with national priorities.

Co-Authors: Haruna Batange, African Research center 4 Ageing & Dementia, Uganda; Geoffrey Kabanda, African Research Center 4 Ageing & Dementia, Uganda; Isaac Ddumba, African Research Center 4 Ageing & Dementia, Uganda; Daniel Ssentamu, African Research Center 4 Ageing & Dementia, Uganda;
Beckworth, Colin, Nutrition International, Canada

The Nutrition Intervention Monitoring Surveys toolkit: Improving the quality of program monitoring surveys

Nutrition International (NI) is an international NGO which works to improve the health of adolescent girls, women and children by reducing micronutrient deficiencies in 10 core countries across Africa and Asia. Like many organisations, NI uses periodic program monitoring surveys to assess the coverage and effectiveness of their programs. But finding the right balance between statistical rigour, adaptability, frequency, and the cost and logistical burden of putting on a survey can be difficult.

NI and the University of Toronto collaborated on the Nutrition Intervention Monitoring Survey Toolkit as a way to standardize surveys and harmonize data collection methods across the NI portfolio of programs. The standardized approach builds time and cost efficiency as tools can be adapted rather than reinvented each time. The modular design makes adapting them to the local context easy. A further advantage is that the toolkit builds in quality assurance at each stage of the survey process, and measures data quality in ways that are easily understandable to program managers, who may or may not have any statistical training.

The toolkit includes standard modularized questionnaires with associated ODK and SPSS syntax; quality checklists to verify that survey planning, implementation, and analysis are methodologically sound; guidelines for data quality and analysis; syntax and guidance on calculating measures of data quality both during- and post-data collection; and a technical review template that includes a traffic light system for data quality so that program managers can instantly assess whether an indicator is of acceptable, marginal, or unacceptable data quality.

NI’s partnership with the University of Toronto capitalized on the strengths of the two organizations – the statistical knowledge, research experience and academic rigour of U of T, and the practical field experience and knowledge of NI. Using an iterative approach of design, implement, joint review and adjust resulted in a toolkit which combines academic rigour with practical ease of implementation and interpretation.

Co-Authors: Colin Beckworth, Nutrition International, Canada; Sara Wuehler, Nutrition International, Canada
Maximizing use of existing data to strengthen program design, evaluation, and impact

ISSUE

Effective health programming and good governance rely on data for priority-setting, monitoring of progress and measurement of outcomes. Adequate assessment of baseline conditions is essential when planning programs in Low- and Middle-Income Countries (LMICs) so that interventions respond to the varying health needs within populations and promote equitable policies. NGOs and health authorities typically spend substantial human and economic resources to collect and analyse data in target areas to characterize baseline conditions. However, in most countries, there are publically available datasets from the same or similar targeted regions and often collected within a few years of the NGO’s baseline study. We hypothesize that publically available health data are useful proxies for NGO-collected data.

METHODS

Baseline reports from Canadian and Vietnamese NGOs and publically available datasets from DHS/MICS were acquired. Baseline prevalence of different groups of health indicators (such as maternal and child health, household characteristics, WASH indicators) were extracted from NGO reports which had a match to DHS/MICS. The prevalence of each NGO indicator was compared to the prevalence calculated from DHS/MICS for different regional levels and years of data collection. For example, since DHS does not report at the village level, an NGO’s prevalence would be compared to the DHS estimates for the province and the country, as well as to different years of the DHS data. To do so, the absolute and relative differences between NGO and DHS/MICS estimates were calculated.

RESULTS

Data were extracted for over 100 indicators from 20 baseline reports from three Canadian and three Vietnamese NGOs covering 17 LMICs. Concordance between NGO and DHS/MICS estimates was highly variable. Preliminary results show that differences were very small for some indicators related to maternal and child health, and household characteristics. However, larger differences were observed for WASH indicators. An additional 20 baseline reports are currently being analysed to increase the precision of the estimates to assess the usefulness of using DHS/MICS as proxies for NGO baseline data.

DISCUSSION

The initial results hold promise that, for certain indicators, NGOs can forego collecting baseline data; redirecting saved resources to better understand key contextual characteristics, like gender dynamics, in target areas through qualitative and participatory assessments. The results of the present study can be extendable to health authorities for informed decision-making through efficient identification of health needs and inequalities. Streamlining and reducing the burden of data collection where possible should also enable data-driven and evidence-informed actions and evaluation.

Co-Authors: Peter Berti, HealthBridge Foundation of Canada, Canada; Bana Salameh, TRANSNUT, Université de Montréal, Canada; Rebecca Brodmann, HealthBridge Foundation of Canada, Canada; Milena Nardocci, TRANSNUT, Université de Montréal, Canada; Minh Tran Hung, Center for Creative Initiatives in Health and Population (CCIHP), VietNam; Naomi Saville, Institute for Global Health, University College London, UK
Community Health Committees improve Maternal, Newborn Child Health and Sexual Reproductive Health outcomes - a roadmap for good governance from 5 SHOW countries

Background:

Governance for health at the local level with Community Health Committees (CHCs) holds significant importance: community and health care workers work together for health promotion and systems strengthening. It is important to actively engage women, girls, boys and men in planning, decision making, and resource allocation leading to gender-responsive health governance in providing efficient and accessible services.

Approach:

Strengthening Health Outcomes for Women and Children (SHOW) is a 4.5-year multi-country gender-transformative project funded by Global Affairs Canada, implemented by Plan International Canada aiming to help reduce maternal and child mortality amongst vulnerable women and children in Bangladesh, Ghana, Haiti, Nigeria and Senegal. The CHCs in SHOW envision improved MNCH/SRH outcomes relying on shared responsibility, accountability and sustainability at health facility. A cross cutting Gender Equality (GE) strategy embedded within the project ensures improved outcomes for women and girl’s empowerment and agency. CHC trainings are focused on building capacity of CHCs in health governance for gender responsive and adolescent friendly Maternal, Newborn, Child Health and Sexual Reproductive Health (MNCH/SRH) services.

Findings:

SHOW countries exhibit varying levels of program implementation and success. Written guidelines on female membership and leadership in CHCs now exist in Bangladesh, Ghana, Haiti and Nigeria, whereas Senegal is renewing its national CHC model. Agreed quota for female membership is 30% in Bangladesh, Haiti, Nigeria and 40% in Ghana. 30%, 33% and 50% of leadership positions are reserved for women members in Nigeria, Ghana and Bangladesh, respectively. Bangladesh and Nigeria also promote membership for an adolescent girl and boy at each CHC.

Project’s midterm data notes improvement in women’s participation increased by 20%, 13% and 16% in Ghana, Haiti and Nigeria respectively. Bangladesh and Nigeria demonstrate an increase by 7% and 10% respectively for women in leadership positions, demonstrating positive results on community level health governance.

In Bangladesh, CHC generated funds are deposited into bank accounts for facility improvement and financial support for vulnerable groups. In Ghana, CHCs play role in community emergency transport system and male engagement. In Haiti, increased awareness by the CHCs resulted in higher number of pregnant women using mobile clinics. In Nigeria, CHCs supports health facilities for small-scale refurbishment.

Conclusion:

SHOW’s gender-responsive CHC process for community engagement ensures better governance, accountability enabling transparent utilization of resource allocation. Presence of women and adolescents in decision-making, bridges gaps in understanding their unique needs for better health programing and reducing GE related barriers.
**Bicaba, Frank Lionel Bouéko, Société d'Etudes et de Recherche en Santé Publique (SERSAP), Burkina Faso**

**la gratuité des soins de santé et l’assurance maladie universelle : comment les jumeler pour atteindre la couverture sanitaire universelle ?**

**Enjeux**

Deux politiques ont été mises en œuvre dernièrement au Burkina Faso afin d’améliorer la Couverture Sanitaire Universelle : (1) la gratuité nationale des soins de santé pour les mères et les es enfants de moins de cinq ans, introduite en 2016 et (2) le régime d’Assurance Maladie Universelle (AMU), implanté en 2018. Afin d’assurer un bon arrimage des deux initiatives, les autorités gouvernementales ont décidé de les jumeler et d’intégrer leur gestion par la création de la Caisse Nationale d’Assurance Maladie Universelle. Or, cette décision politique n’est pas accompagnée de document de planification stratégique ou technique, rappelant ainsi la mise en œuvre improvisée de la politique de gratuité. Cette étude vise à documenter comment s’opère l’arrimage dans le système national de santé de deux politiques qui présentent des logiques et des enjeux différents au niveau de l’organisation, de la pérennité (notamment financière), du contrôle de la qualité des soins, de la couverture et du suivi des adhérents.

**Méthodologie**

Cette étude est de nature qualitative et prospective, car elle explore différentes étapes du processus de jumelage des deux politiques. Elle repose sur des entrevues semi-dirigées conduites : (i) au niveau central, auprès des directions et secrétariats techniques des ministères concernés, des partenaires techniques et financiers et des organisations non gouvernementales ; (ii) au niveau périphérique (districts sanitaires de Nouna et de Séguénéga), auprès des acteurs chargés de sa mise en œuvre opérationnelle. Au total, 29 entrevues ont été réalisées et retranscrites. Une analyse thématique du contenu est en cours à l’aide du logiciel QDA Miner.

**Résultats**

Les entrevues mettent en exergue des logiques contraires dans la prise de décision entourant le jumelage des deux politiques. Les quatre sous-fonctions pour lesquelles les enjeux d’arrimage sont particulièrement saillants nécessitent des mécanismes de conciliation. Les résultats préliminaires suggèrent que l’arrimage organisationnel retient plus d’attention que les trois autres, à savoir la pérennité financière, la qualité des soins et la couverture / le suivi des bénéficiaires.

**Conclusion**

La gratuité des soins et l’assurance maladie universelle sont deux politiques qui ont été entamées à des périodes différentes et qui sont implémentées par des acteurs différents. La décision de combiner ces deux politiques devrait s’accompagner d’une dynamique au plan technique des différents intervenants en vue d’une efficacité et d’une efficience dans leur mise en œuvre.
**BILA, Alice, Société d’Etude et de Recherche en Santé Publique, Burkina Faso**

**soins gratuits pour les uns, payants pour les autres : perceptions et stratégies d’adaptation dans le district de Boulsa (Burkina Faso)**

**Enjeu**

Le Burkina Faso est l’un des premiers pays à introduire une politique nationale de gratuité pour les femmes enceintes et les enfants de moins de cinq ans. Il a été démontré que cette stratégie améliore l’accès équitable aux soins de santé des populations cibles. Par contre, très peu d’études ont examiné les dilemmes associés au respect des critères d’admissibilité. Cette étude vise à documenter les perceptions et les stratégies d’adaptation, à la fois des cliniciens et des mères, dans les situations de non-admissibilité à la gratuité.

**Méthodologie**


**Résultats**

Tant les mères que le personnel de santé éprouvent des difficultés concernant le respect des critères d’admissibilité. Pour les mères, le dilemme est principalement économique, car sans l’appui du conjoint, elles ne peuvent assumer les coûts de consultation des personnes non admissibles, tels que les enfants de plus de cinq ans. Les stratégies adoptées consistent notamment à : (1) ne pas amener de pièce d’identité de l’enfant et/ou mentir sur l’âge (2) utiliser un enfant admissible pour faire bénéficier un autre membre (3) amener l’enfant dans plusieurs centres de santé pour accumuler des médicaments. Pour le personnel de santé, le dilemme est à la fois éthique et déontologique : (1) dans un contexte de grande pauvreté, il leur paraît injuste de ne réserver les soins gratuits qu’aux mères et aux jeunes enfants et (2) sur la base de critères arbitraires, des soins doivent être refusés à des patients malades qui ne peuvent payer. Alors qu’officiellement les agents de santé encouragent le respect des directives, ils ont adopté des stratégies de conciliation pour assouplir les critères d’admissibilité.

**Discussion/Conclusion**

Alors que la politique de gratuité soulève des dilemmes et des pratiques imprévues, une approche de conciliation a été adoptée par les agents de santé à l’égard des cas de débordement de la gratuité. La nécessité d’étendre la politique de gratuité aux enfants plus âgés se fait ressentir, ce qui s’inscrirait dans l’objectif des autorités sanitaires d’améliorer la couverture sanitaire universelle au Burkina Faso.
Impliquer les hommes dans la Prévention de la transmission mère-enfant du VIH au Burkina Faso : Une étude qualitative exploratoire

Enjeu

L'implication des hommes est reconnue comme une priorité pour les programmes de prévention de la transmission mère-enfant du VIH au cours de la dernière décennie car celle-ci pourrait être l’un des moyens les plus efficaces à privilégier pour réduire le taux de transmission du VIH de la mère à l’enfant. Pourtant, au Burkina Faso, comme dans la plupart des pays de l’Afrique Subsaharienne, l’implication des hommes dans la conception et l’élaboration des programmes de prévention de la transmission mère-enfant du VIH représente un défi.

Cette étude vise à explorer les perceptions des utilisatrices et utilisateurs de service de santé, des cliniciens, des décideurs et gestionnaires de programme concernant la place et l’importance des questions de genre dans la conception et la mise en œuvre de la PTME dans le but de déterminer des techniques de changement de comportement pour promouvoir l’implication des hommes dans la PTME.

Méthodologie

Cette étude qui s’inscrit dans un devis qualitatif descriptif, a été menée dans un hôpital de Ouagadougou. Nous avons réalisé des entretiens semi-dirigés avec 12 couples (n=24), trois (3) professionnels de santé, neuf (9) décideurs et gestionnaires de programme PTME. Les entrevues ont été enregistrées et retranscrites. Une analyse thématique de contenu a été réalisée à l’aide du logiciel QDA Miner, en utilisant la roue du changement de comportement de Michie et al. (2014) comme cadre d’analyse pour identifier des techniques de changement de comportement.

Résultats

L’implication des hommes est influencée par les valeurs socio-culturelles, le statut d’infériorité de la femme, le niveau de connaissance sur le programme, l’attitude des soignants. Ceci a une influence négative sur le partage de l’information VIH, la fréquentation des formations sanitaires par les hommes, l’observance du traitement pour la mère et l’enfant.

Les fonctions de formation, persuasion, modelage, coercion, facilitation, restructuration de l’environnement, et d’incitation déterminent leur implication.

Les participants ont identifié 15 techniques de changement de comportement qui favoriseraient l’implication des hommes. Ces techniques se regroupent dans 5 catégories que sont : la communication, le guide de pratique, la réglementation, l’environnement et la fourniture de services.

Discussion/Conclusion

L’implication des hommes dans la PTME demande d’adopter une approche holistique qui tient compte des valeurs socio-culturelles et des notions de genre, et du comportement des professionnels de la santé. Des techniques de changement de comportement centrées sur la communication et une restructuration de l’organisation des services de santé représentent une avenue prometteuse.
Bone, Jeffrey, University of British Columbia, Canada

Anemia and adverse maternal-fetal outcomes in pregnancy. Subgroup analysis of the CLIP cluster-randomized trial in India

Background

Previous studies have identified that iron-deficiency anemia in pregnancy is a risk factor for adverse maternal and perinatal outcomes, however, the impact of anemia severity on these outcomes is unclear. The WHO defines anemia in pregnancy as a hemoglobin < 11 g/dL, or hematocrit < 33%. This is further subdivided into mild (Hb 9.0-11.0 g/dl), moderate (7.0-9.0 g/dl) and severe (4.0-7.0 g/dl) anemia.

Methods

Data was prospectively collected as part of a larger cluster RCT, the CLIP Trial (NCT01911494). Within India, the CLIP Trial was carried out across 12 clusters, six control and six intervention, located in Karnataka State. Only women from the control arm were included in this analysis (N=6058). Data was collected through the Maternal and Newborn Health registry system. Demographic variables and obstetric outcomes were stratified across three groups (non-anemic, mild, moderate, severe anemia). The primary outcome was pre-eclampsia related morbidity. Secondary outcomes were overall maternal morbidity and mortality, early or late neonatal death, stillbirth, low birth weight, preterm birth, and overall neonatal morbidity. Outcome differences in groups were assessed via hierarchical logistic regression model with a random intercept for cluster and were adjusted for maternal age, education and parity.

Results

Out of the 6058 women, 5326 were anemic (88%), the majority had mild anemia (N=4615, 76%). The prevalence of anemia in pregnancy tended to be higher in families with lower rates of education and in multiparous women. Maternal age, religion, gestational age at enrolment and malaria status were similar across groups. The majority of anemic women were taking iron supplements (N=4779, 90%) and rates of adverse outcome increased with increasing severity of anemia. Pre-eclampsia morbidities were significantly increased in the severe (aOR = 2.95, 95%CI = (0.979, 8.91), p = 0.05) and the moderate (aOR = 1.76, 95%CI = (1.076, 2.879), p = 0.024) groups compared with those with no anemia. The risk of low birth weight was elevated in the severe vs. no anemia group (aOR = 2.14, 95% CI = (1.067, 4.301), p = 0.032).

Conclusion

The majority of women in this study were anemic despite being on iron supplementation. Pre-eclampsia related morbidities increased with increasing severity of anemia. Severe anemia also increased the risk of low birth weight.

Co-Authors: Marianne Vidler, University of British Columbia, Canada; Maria Lesperance, University of British Columbia, Canada; Jeffrey Bone, University of British Columbia, Canada; Sumedha Sharma, University of British Columbia, Canada; Petervon Dadelszen, King’s College London, UK; Laura Magee, King’s College London, UK; Shiva Goudarprasad, KLE University, India; Bellad Mrytunjaya, KLE University, India; Ashalata Mallaput, KLE University, India; Geetanjali Katageri, KLE University, India
Bortolussi, Robert, Dalhousie University, Canada

Evaluation of Research Ethics Committee (REC) practices for minimal-risk research in Eastern Africa

Introduction: Sub-Saharan African countries face many challenges to providing good health care and will need research to identify effective new approaches to address these challenges. In 2008, a WHO conference of low income countries demanded action to strengthen research training and research ethics capacity, for health care workers (HCWs). MicroResearch© tries to answer this call by supporting local investigator-initiated research, and building research capacity in Africa through training, mentoring and small grants to local HCW-researchers. Since 2008, 40 workshops, 1,000+ HCWs have been trained and 100+ minimal risk research projects launched. All projects were approved by their local African research ethics committee (REC). The purpose of this study was to evaluate MR researcher perception of the REC process in Eastern Africa.

Methods: Data on REC experiences was collected using semiannual reports from MR project investigators. Data included REC cost, process and approval time. Comments were analyzed to identify themes, by two authors (RF and RB). The themes helped us develop a questionnaire for perspectives on the REC process, which was validated for clarity by 3 African researchers, then sent to past African MR HCW participants. This study was approved by the Research Ethics Board of the IWK Health Centre.

Results: In phase 1, we analyzed 40 written semi-annual reports from MR Principal Investigators between 2012 and 2019. Length of time for REC approval was available in 22 studies. The mean time to receive final REC approval was 13.7 weeks (Standard Deviation 9.4) with 9 projects (40%) requiring over 16 weeks. Three themes were identified from the responses on REC process; excessive cost to applicants, time for approval and complexity of REC process. Despite these challenges many respondents identified strengths in the REC processes.

In phase 2, we analysed 63 questionnaire responses from 182 sent to valid participant email addresses. Many respondents had positive comments, and appreciated the advice of the REC. However, others had negative experiences. Payment for REC review varied, in some, the institution paid, but most required the researcher to pay from $50-$600. Of the respondents; 36% paid over $100 USD, 56% felt cost was excessive and 36% felt it was a deterrent to doing research. Also, 56% felt the approval time negatively impacted their research.

Conclusion: The process for REC reviews of minimal-risk, investigator-initiated research in Eastern Africa varies widely. Some researchers identified REC cost and time for approval as excessive and deterrents to their research.

Co-Authors: Robert Bortolussi, Dalhousie University, Canada; Rania Fashir, Dalhousie University, Canada; Noni MacDonald, Dalhousie University, Canada; Michael Bowen, Daystar University, Kenya; Harriet Chemusto, Mildmay Research Institute, Uganda
Chelimo Chemusto, Harriet, Mildmay Uganda, Uganda

Urban Refugees successfully negotiating for core human rights including Sexual and Reproductive Health services in Kampala Uganda

Issue

Uganda has the highest unmet Family Planning (FP) need in Sub-Saharan Africa; contraception is practiced by only 30% of the population, teenage pregnancy is 24% and unsafe abortions account for 28% of maternal death annually. As the largest refugee hosting country in Africa, Uganda is also home to 1,240,000 refugees and asylum-seekers from Rwanda, Burundi, Congo, Eritrea, Ethiopia, Somalia and Sudan. Approximately 103,694 refugees have settled in urban areas like Kampala. Although the Uganda Refugee Act provides for access to education, healthcare, water, and security/protection and plots of agricultural land, refugees still face many barriers integrating into national systems, including health. We studied how urban refugees negotiate for core human rights services like SRH and FP in Kampala Uganda.

Methods

Mildmay Uganda in partnership with Dalhousie University, Canada used Gender Action Learning Systems (GALS) community engagement methodologies to improve access and uptake of Sexual and Reproductive Health/FP services for refugees with funding from Grand Challenges Canada. Using In-depth interviews, key Informant interviews and desk/records review of GALS vision maps and diaries, qualitative and quantitative data were collected at baseline, during the GALS meetings and at the end of the study.

Results

802 urban refugees aged 15 – 78 years were enrolled in our GALS project between October 2018 and March 2019. 405 (51%) were female, 400 (50%) were referred for Sexual and Reproductive Health (SRH) and FP services in a public health facility. Despite constraints, some refugees have improved health outcomes, for example, successfully “lost the refugee shame” they experienced initially. In-depth and informant interviews and focus group discussions identified 5 contributors to this success: a) Collaboration among community leaders to ensure fellow refugees receive SRH services, e.g., by recruiting Community Health Workers (CHWs) to facilitate access; b) GALS training of local CHWs on SRH and Gender approaches in their communities; c) Establishing a referral system for all services including SRH in their communities that referred, escorted and followed up on health services; d) Establishing cohesive teams of refugees in the community who work to improve health and economic outcomes; e) Encouraging individual and group economic activities to help overcome barriers associated with lack of finances that hinder accessing SRH/FP services.

Discussion

The strategies identified in this study helped refugees with diverse cultural and linguistic backgrounds to successfully integrate and use SRH and FP and other national health services.

Co-Authors: Harriet Chelimo Chemusto, Mildmay Uganda, Uganda; Barbara Mukasa, Mildmay Uganda, Uganda; Esperance Nyirabega, Mildmay Uganda, Uganda; Wiliam Kizito, Mildmay Uganda, Uganda; Immaculate Atwooki, Mildmay Uganda, Uganda; Mary Odit, Mildmay Uganda, Uganda; Robert Bortolussi, Dalhousie University, Canada; Noni MacDonald, Dalhousie University, Canada; Christoher Semei, Mildmay Uganda, Uganda; Pallen Mugabe, Mildmay Uganda, Uganda
Chibane, Sarah, McGill University Faculty of Medicine, Canada

Using community outreach through peer education to foster advocacy and mobilization amongst Quebec medical students

Issue:
Medical students are regularly confronted with the downstream effects of limited health literacy in the general population. Highlighting the importance of layman education requires weaving advocacy into medical education, particularly as student interest is shifting towards global health. Faculties have begun to mold their curricula accordingly while not-for-profit youth associations like the Quebec branch of the International Federation of Medical Students Association (IFMSA-Quebec) attempt to fill the gap in global health education. Particularly, IFMSA-Quebec’s peer education projects encourage students to be advocates outside the clinical setting and raise public awareness about health-related issues.

Approach:
Since 2002, medical students have approached IFMSA-Quebec with knowledge gaps identified in their community; ranging from mental health, to sex education to the impact of climate change on health. They mobilize classmates to take on the topic of interest and develop a workshop, an interactive presentation or a series of talks to fulfill the identified educational need. Content is produced in an evidence-based manner, and must invariably be vetted by a recognized health professional. With the support of IFMSA-Quebec, a trial run of the project is undertaken within the team’s community, particularly in association with local elementary and high schools. Provided a positive response from educators and targeted groups alike, more recently verified through impact assessment forms, the initiative is voted on as an official project within IFMSA-Quebec.

Results:
IFMSA-Quebec has 8 official peer education projects. Over 1100 presenters have been trained in all Quebec medical campuses by motivated project coordinators, with support from medical residents. IFMSA-Quebec fosters interdisciplinary work as presenters stem from varied healthcare programs. Close contact with community partners such as the Association pour la Santé Publique du Québec and Fondation Jeunes en Santé has allowed for increased visibility. As such, over 33000 community members have been reached by IFMSA-Quebec projects. Student engagement platform Forces Avenir and Quebec medical faculties alike have repeatedly recognized the reach and impact of the projects through grants and accolades. IFMSA-Quebec is shifting towards formal community health needs assessments for the development of its future initiatives.

Conclusion:
Taking a grassroots approach to raise awareness about health-related issues within the general population has created an opportunity for medical students to mobilize and advocate for their community. By prioritizing youth, IFMSA-Quebec projects have made prevention a major goal and targeted a vulnerable population. They make up a global health initiative that motivates medical students’ civil engagement.

Co-Authors: Sarah Chibane, McGill University Faculty of Medicine, Canada; Rosa Lakabi, McGill University Faculty of Medicine, Canada
Cleaver, Shaun, McGill University, Canada

Developing a Zambian disability Knowledge Translation (KT) Triad

Issue/Objective: Generating policy relevant evidence is a persistent challenge faced by researchers. Collaboration between policymakers, community and researchers is one way to address this challenge. However, there is much to be learned about how to foster effective, equitable and responsive relationships between these actors.

The Knowledge Translation Triad (KT Triad) was developed to systematize research-policymaker-community collaboration. The KT Triad was informed by the literature on community-based participatory research where it synthesized lessons for collaboration including a specific focus on structures, processes, relationships, and principles. The purpose of this poster is to share lessons learned from the application of a Zambian disability KT Triad.

Methodology/Approach: Zambian disability researchers, policymakers in government and international organizations, and disability advocates were identified for inclusion in the KT Triad. We undertook this initiative in the context of a research project about the development of disability policy in Zambia. The research has included 27 interviews with disability policy stakeholders and an interactive workshop with 13 stakeholders. Qualitative thematic data analysis of interview transcripts and participant observation fieldnotes, complemented by dialogue between KT Triad organizers, was used to review the process of supporting a Zambian disability KT Triad.

Results: Our initiative to instigate a KT Triad was met with varied responses according to the category of stakeholder. Disability advocates were immediately interested in collaboration to support their advocacy causes and demonstrated interest in research findings when these were thought to help or hinder advocacy causes. After initial challenges engaging policymakers, several expressed interest to become more involved in the project. The identification of Zambian disability researchers began at a later stage of the initiative and has been more difficult than foreseen. Among advocates and policymakers, discussions about research have focused on quantification (i.e., prevalence of disability, quantitative needs assessments). More prominent research findings, especially those about disability prevalence, are contentious among stakeholders. One important lesson was that the type and use of research was viewed differently by different stakeholders, often creating tension.

Discussion/conclusion: The Zambian disability KT Triad is an approach that shows promise. From our experiences to date, we have learned that time and ongoing attention can encourage, but does not guarantee, stakeholder engagement. We remain unsure of the optimal balance between a KT Triad that is formalized as compared to one that is maintained primarily through organic bonds. We think that the lessons to date can help inform the development of KT Triads elsewhere.

Co-Authors: Shaun Cleaver, McGill University, Canada; Raphael Lencucha, McGill University, Canada; Virginia Bond, London School of Hygiene & Tropical Medicine, Zambia; Matthew Hunt, McGill University, Canada;
migration et santé : une priorité pour la santé publique mondiale

Objectifs : Le statut migratoire est vu comme un déterminant social de la santé. Les migrants à statut précaire (MPS) renvoient à une catégorie de personnes sans statut permanent ou garanti voire sans statut migratoire. Au Québec, certains immigrants possédant un statut temporaire valide et ceux qui sont sans statut légal ont des droits limités et ne sont éligibles à aucune couverture de santé publique. L’objectif de cette communication est d’examiner l’association entre le statut migratoire précaire et la santé. Notre discussion s’appuiera sur le volet quantitatif d’une étude mixte que nous avons réalisée à Montréal.

Méthodes : Nous avons effectué entre juin 2016 et septembre 2017 une enquête transversale à Montréal portant sur des immigrants originaires de diverses régions géographiques et sans assurance médicale publique. Les participants ont été recrutés dans l’espace urbain montréalais et dans une clinique non-gouvernementale. Un questionnaire couvrant les caractéristiques sociodémographiques, les déterminants sociaux, les besoins de santé, l’accès aux soins de santé et la perception de la santé leur a été soumis. Les facteurs associés à la perception de la santé ont été évalués à l’aide d’une régression logistique.

Résultats : 781 participants ont été recrutés pour cette étude: 421 (53,9%) avec statut migratoire (visiteurs, étudiants internationaux, travailleurs étrangers temporaires) et 360 (46%) sans statut légal. Dans notre étude, près de la moitié (44,6%) de ces personnes ont perçu leur santé de façon négative, et cette proportion atteint 54,4% pour les personnes sans statut légal. D’autre part, 68,9% ont déclaré que leurs besoins en soins de santé n’étaient pas comblés. Dans le modèle multivarié final, l’âge, la région de naissance, le statut socio-économique, la discrimination, et les craintes/stress sont parmi les variables associées de manière significative à une perception négative de la santé.

Discussion : Au Canada et ailleurs dans le monde, la classification migratoire produit des inégalités sociales de santé à cause d’un accès inéquitable aux ressources. D’autres formes de hiérarchie sociale telles que le genre, l’origine nationale et la classe sociale ont le pouvoir d’exacerber les défis auxquels sont confrontés les immigrants. La nécessité de mettre en place des politiques sociales garantissant l’accès aux ressources, aux soins de santé et aux services sociaux de façon équitable, avec ou sans statut migratoire légal, est une exigence absolue non seulement pour leur bien-être mais également pour la santé publique.

Co-Authors: Patrick Cloos, Université de Montréal, Canada; Josée Aho, Agence canadienne de santé publique, Canada; Malick Ndao, Université de Montréal, Canada; Magalie Benoît, Université de Montréal, Canada; Valéry Ridde, Institut de Recherche et de Développement (IRD), France
From Alma-Ata to Astana: a view from the Americas

To mark the 40th anniversary of the Declaration of Alma-Ata, the Pan American Health Organization (PAHO) convened the Regional Forum “Universal Health in the 21st Century: 40 Years of Alma-Ata” that took place in Quito, Ecuador, on December 11-12, 2017. At the end of the event, Dr. Carissa Etienne, PAHO Director, convened a homonymous High-Level Commission to further explore the legacy of Alma-Ata and its relevance in the context of the existential challenges we are facing at the beginning of the new millennium.

The Commission was chaired by President Michelle Bachelet, former President of Chile, and then, when President Bachelet was called to become United Nations High Commissioner for Human Rights, by Ambassador Nestor Mendez, Assistant Secretary General of the Organization of American States. Members of the Commission included an interdisciplinary group of regional experts, high-level political actors, including six former Ministers of Health, representatives of the civil society, and academics. The final report of the Commission was formally launched in April 2019 in Mexico City, with the participation of Ministers of Health and high-level political representatives from more than 30 countries in the region.

As a member of the Commission, the author will briefly describe the structure and methodology adopted, discuss the central themes and recommendations included in the Report, and reflect on the value of this initiative as an American contribution to the global debate on universal health.
Dathan, Anupama, Abdul Latif Jameel Poverty Action Lab (J-PAL), United States of America

Testing linkages between innovative cookstoves and improved respiratory health

Respiratory disease is a leading cause of disability and death worldwide. Research suggests that for women, cooking with solid fuels and in poorly-ventilated areas could cause smoke inhalation and increase risk of respiratory disease. In addition to their adverse health impacts, cookstoves that burn solid fuels emit soot, a pollutant that speeds up climate change.

To address these challenges, innovators have developed cookstoves that direct smoke away from users, use less fuel, or put off fewer harmful emissions. Increased adoption of such cookstoves could reduce incidence of respiratory disease and mitigate environmental impacts. However, research suggests that cookstoves programs have not been achieving these goals.

This finding is a critical one for governments that are focused on combatting respiratory disease and increasing uptake of clean fuel. Cookstove programs have been widely implemented, and this research suggests that policymakers may benefit from further testing of such interventions. This presentation will provide an overview of why these programs have had little demonstrable impact and highlight steps that governments and other policymakers could take to improve effectiveness.

Development economists conducted six randomized controlled trials in numerous countries across sub-Saharan Africa, Latin America, and South Asia. Conducted over the past decade, these studies rigorously evaluated whether providing these cookstoves improved women’s respiratory health and reduced pollution. The presentation synthesizes the main findings and highlights key policy insights from the experiments.

With one exception, cookstoves designed to reduce smoke exposure and improve health did not achieve their goals. In Senegal, the provided cookstoves were adapted to the local context and highly portable, and users reported lower incidence of respiratory disease and fuel use. In the other studies, the new stoves were not adapted to local cooking practices and/or individuals did not want to purchase and maintain the stoves or did not use them enough for benefits to materialize. As a result, there were few health or environmental impacts. Because this research took place across multiple continents, these findings may be relevant for policymakers working in numerous locations.

Research on the use and impact of innovative cookstoves indicates that providing them may not make lasting improvements to women’s health or to the environment. These studies also point to a need for more testing of new solutions. Governments and other decision-makers could invest in research that tests new and innovative interventions that encourage people to switch to electric stoves and/or improve ventilation and reduce indoor air pollution.
Di Ruggiero, Erica, Dalla Lana School of Public Health, University of Toronto, Canada

governing measurement in the SDG area: lessons learned from two case examples

In 2015, the United Nations released the 17 Sustainable Development Goals (SDGs) with a commitment to end extreme poverty and tackle global social, economic, gender and health inequities. Within this complex policy context, a number of public, private and civil society actors are competing for attention and resources - actions, which directly confront efforts to achieve health and develop sustainability globally. Scholars have argued that a paradigm shift will be required to make significant progress towards the 2030 global agenda. To get there, several challenges will need to be tackled, including the commercial determinants of health (i.e. actions employed by the private sector to promote practices and products that are detrimental to health), and the structural barriers to achieving concerted action across sectors.

Global and country-level efforts to assess progress against an extensive number of sub-goals, targets and indicators for each of the SDGs may inadvertently interfere with meaningful measurement of collective global impact through intersectoral action. Similarly, while increased dependency on public/private partnerships is on the rise, efforts to measure the unintended consequences arising from the commercial determinants of health are not keeping pace. Taken together, these two examples (intersectoral action and commercial determinants of health) bring to light several conundrums for global governance of the commons, including what gets measured, who decides what gets measured or not, as well as issues of transparency, accountability and conflicts of interest perceived or real. The purpose of this presentation will be to critically reflect on these issues, through an analysis of two case examples: 1) a World Health Organization-led effort to shift the gaze on monitoring intersectoral actions (i.e. governance, policy, or programmatic interventions) taken by governments and other actors to improve the social determinants of health and health equity; and, 2) a systematic effort to analyze different interactions between public and private sector actors to reduce non-communicable diseases through improved nutrition in various country contexts. Reflections on what measurement strategies and evidence are privileged and their implications for governance and accountability mechanisms will be discussed.
Global health curriculum as an intersectoral approach to global health governance

Issue:

Academic global health programs play an important role in educating leaders who will contribute to and sustain good governance for global health. However, research on global health education has focused mainly on pedagogical considerations for teaching international medical electives with little attention on strategies that develop students’ ability to think critically about the complex issues underpinning global health. The McMaster University Master of Science in Global Health program developed an innovative course that engages students in approaches to global health research that examine complex issues within the context of overlapping disciplinary boundaries and through an intersectional lens. We assessed the extent to which the content, design and delivery of the course content and learning strategies achieved the aim of developing students’ interdisciplinary critical thinking and research competencies.

Methodology:

We conducted a mixed-methods study with students enrolled in the Fall 2018 semester including focus groups to explore students’ perspectives of the course objectives, content and learning practices; student essays to examine students’ perspective on their personal learning processes; and instructor observations to examine instructors’ perspectives of the course and students’ learning processes. Data were analyzed thematically and examined alongside the theoretical and empirical literature to inform and situate the findings within wider discourses on education as an intersectoral approach to global health diplomacy and governance.

Results:

Results across all three methods demonstrated an overall effectiveness of the course in developing students’ interdisciplinary critical thinking and research competencies. This was evidenced through students’ engagement with critical concepts including an understanding of research as a function of the social world; a changing perception of the term “interdisciplinarity”; the importance of understanding theoretical orientation and epistemology to effectively work in an interdisciplinary environment; and the importance of authentic reflexivity throughout the entire global health research process. High impact learning practices supported students’ engagement with the course objectives as well as research examples drawn from a range of communicable and non-communicable diseases in a variety of geographic and social contexts.

Discussion:

Engaging with the complexities that underpin global health governance should be embedded in all areas of global health curriculum. Our study demonstrates that an interdisciplinary research methods course provided a means through which students developed the critical thinking skills necessary to engage with the themes that cross-cut good governance including gender, equity, evidence and sustainability. This pedagogical approach provides an example that can be applied to global health curricula more widely.

Co-Authors: Deborah DiLiberto, McMaster University, Canada; Talia Filler, McMaster University, Canada; Andrea Baumann, McMaster University, Canada
**Diop, Rosalie A, IPDRS, Senegal**

**Réorganisation de la mobilisation sociale autour de la santé maternelle et infantile au Sénégal et rapport sociaux de genre : cas du Programme des Bajenu Gox (PBG)**

**Enjeu/Objectifs :** Depuis les années quatre-vingt-dix, certaines transformations ont été apportées au système de santé mis en place au Sénégal. Les plus grandes modifications apportées sont l’implication des acteurs communautaires ainsi que la mise sur pied du Programme « l’Initiative Bajenu Gox » (PBG). Les “Bajenu Gox” (BG) marraines de quartier ont pris une place nouvelle et incontournable dans la santé reproductive. L’objectif de cette recherche est d’étudier comment une approche de développement communautaire peut renforcer la mise en œuvre du PBG de manière à ce qu’il puisse davantage améliorer la santé de la mère et de l’enfant.

**Méthodes/approche :** Utilisée se fonde sur une analyse de processus avec une approche mixte quantitative et qualitative. Elle intègre la définition d’un ensemble d’indicateurs pour mesurer les changements apportés par les initiatives mises en œuvre. Des interviews individuelles et des focus groups ont été menés auprès des professionnels de la santé, des “Bajenu Gox”, et autres membres communautaires. Des statistiques ont été collectées au niveau des registres de poste de santé.

**Résultats :** Les BG assument les trois rôles édictés par la société : les rôles de production, de reproduction et communautaire. La contribution sociale des BG dans le PBG peut être perçue comme accommodante. Les activités des BG s’établissent dans le prolongement de leurs activités habituelles qui leur sont traditionnellement confiées et qui sont socialement définies à travers la division sexuelle du travail. Il en résulte un élargissement de leur rôle, une augmentation de volume du travail et un accroissement de leur responsabilité.

**Discussion/conclusion :** les BG participent à des associations communautaires leurs permettant de sortir de leur sphère privée « sortir des maisons » pour prendre des décisions et d’opérer une certaine autonomie sociale. Reconnues, valorisées et capacités, les BG influent positivement sur les indicateurs de santé reproductive surtout ceux de la santé de la mère et de l’enfant, mais aussi apportent des changements sur les normes et coutumes qui constituaient des obstacles.

**Co-Authors:** Rosalie A diop, IPDRS, Senegal; Fatou Kebe, ACDEV, Senegal
Connecting climate change, poverty, and seasonal food insecurity among small-scale farming households in rural Honduras

Issue/objective: Seasonal food insecurity has been documented among small-scale farming households across Central America. In recognition of the ongoing challenge of seasonal food insecurity, particularly for rural populations, the Government of Honduras committed to achieving ‘zero hunger’ as part of broader plans to eradicate extreme poverty by 2038. While the connection between food insecurity and poverty is articulated within these plans, the role of climate change in exacerbating seasonal food insecurity is less understood. In the context of policy efforts to address food insecurity, this study investigated factors associated with seasonal food insecurity among small-scale subsistence farmers in rural Honduras.

Methodology/approach: Anchored by a partnership with the Fundación para la Investigación Participativa con Agricultores de Honduras (FIPAH) and the Yorito Municipal Health Centre, a cross-sectional household survey was administered in Yorito, Honduras in July 2014. The study population included 1263 individuals from 248 households across 22 rural communities. A multi-level negative binomial model that accounted for household- and community-level dynamics was built to investigate the relationship between the self-reported number of months without food from subsistence agriculture in the previous year (August 2013-July 2014) and demographic, socioeconomic, and agricultural production variables.

Results: Overall, 62.2% (95% CI: [59.52, 64.87]) of individuals experienced at least four months of food insecurity in the previous year. Individuals from poor and large households were more likely to experience seasonal food insecurity compared to individuals from wealthier and small households. Additionally, individuals from households that produced both maize and beans were less likely to experience compared to individuals that did not grow these staple crops (PR=0.83; 95% CI: [0.69, 0.99]). Receiving remittances from an internal or international migrant family member did not significantly reduce the prevalence of seasonal food insecurity among surveyed individuals.

Discussion/conclusion: This study found a lengthier ‘hungry season’ among surveyed individuals than previously documented by other studies in Honduras. As unpredictable crop yields linked to climate change and extreme weather events are projected to negatively influence the food security and nutrition outcomes of rural populations in Honduras, it is important to understand how demographic, socioeconomic, and agricultural production factors may modify the ability of individuals and households to respond to adverse shocks. Moreover, policy efforts to achieve ‘zero hunger’ in Honduras and throughout Central America need to include intersectoral action among the agricultural, health, social service, and environmental sectors to account for how climate change may disrupt or exacerbate seasonal food insecurity.

Co-Authors: Warren Dodd, University of Waterloo, Canada; Marvin Gómez Cerna, La Fundación para la Investigación Participativa con Agricultores de Honduras, HO|Honduras; Paola Orellana, La Fundación para la Investigación Participativa con Agricultores de Honduras, Canada; Sally Humphries, University of Guelph, Canada; Margaux Sadoine, Université de Montréal, Canada; David Zombré, Université de Montréal, Canada; Kate Zinszer, Université de Montréal, Canada; Amy Kipp, University of Waterloo, Canada; Donald Cole, University of Toronto, Canada
Eboreime, Ejemai, National Primary Healthcare Development Agency, Nigeria

Evaluating policy development and deployment across multi-level governance structures in Low- and Middle-Income Countries: A case study of a primary healthcare system improvement initiative in Nigeria

Background: Effective implementation processes are essential in achieving desired outcomes of health initiatives. Whereas many approaches to implementation may seem straightforward, careful advanced planning, multiple stakeholder involvements and addressing other contextual constraints needed for quality implementation are complex, particularly in decentralized health systems. This study applies the Quality Implementation Framework (QIF) developed by Meyers, Durlak and Wandersman to identify and explain observed implementation gaps in the development and deployment of a primary healthcare system improvement intervention across Nigeria’s multi-level governance system in 2012.

Methods: We conducted a retrospective process appraisal by analysing contents of 39 policy document and 15 key informant interviews. Using the QIF we assessed challenges in the implementation processes and quality of an improvement model across the tiers of Nigeria’s decentralized health system.

Results: Significant process gaps were identified which may have affected subnational implementation quality. Key challenges observed include inadequate stakeholder engagements and poor fidelity to planned implementation processes. Although needs and fit assessments, organizational capacity building and development of implementation plans at national level were relatively well carried out, these were not effective in ensuring quality and sustainability of DIVA at the subnational level.

Conclusions: Implementing initiatives between levels of governance is more complex than within a tier. Adequate pre-intervention planning, understanding and engaging the various interests across the governance spectrum are key to improving quality.
Egert, Amanda, Trinity Western University, Canada

Preparing nursing faculty for international experiences with students: moving beyond “trial-and-error”

Issue/Objective:
There is a long history of nursing faculty accompanying nursing students on international experiences (IE) and many Canadian nursing programs currently offer IE for their students varying in length, location, and types of placements. While there is evidence of pre-departure preparation for students going on IE, there is a gap in the literature about the preparation of faculty who accompany them. There is also minimal evidence on how preparation for these international experiences aligns with important global concepts of justice, equity, and relationships of power. Relating to governance, this gap raises the question of accountability by academic practitioners and their institutes for quality, equitable, relevant, and effective international experiences. Therefore, the objective of this study was to explore faculty preparation for accompanying nursing students on IE.

Methodology/Approach:
A qualitative interpretive description approach, informed by critical inquiry methods highlighting the global health concern of equity, was used to explore faculty preparation. Semi-structured interviews were conducted in late 2018 and early 2019 with nine novice-to-expert nurse educators across Canada who had accompanied nursing students on IE. Second interviews were conducted to confirm and extend the preliminary analysis. Interview transcripts were coded and NVIVO software supported an iterative and dynamic process of analysis.

Results:
Thematic analysis revealed four themes of faculty preparation including the overarching theme 'understanding preparation over time and experience' highlighting the progression of preparation, and the varied understanding of preparation. The first main theme 'how I prepared: learning 'on-the-job’’ indicated reliance on trial-and-error and informal strategies regardless of experiences, relationships, and personal attributes. The theme 'why I prepare: discovering the different nature of IE’ highlighted the nature of IE being different than any other nursing or teaching role. This discovery revealed the preparation strategy of 'trial-and-error' as insufficient. The final theme represented participants preparation recommendations through 'preparing differently: starting from what we’ve already learned' which including nine rights-of-preparation. Notably, not all participants indicated preparation in alignment with critical concepts of global health including justice, equity, and relationships of power.

Discussion/Conclusion:
Discussion and recommendations focus on the development of intentional preparation for nursing faculty when accompanying students on international experiences. Specifically, preparation strategies for nursing faculty should move beyond "trial-and-error" as a starting point for faculty new to the role. Faculty preparation strategies should also align with important global health concepts of equity, social justice, and relationships of power thus supporting accountability to the different responsibilities inherent to IE.

Co-Authors: Amanda Egert, Trinity Western University, Canada; Barbara Astle, Trinity Western University, Canada; Sheryl Reimer-Kirkham, Trinity Western University, Canada
Fahoum, Khalid, Weill Cornell Medicine, United States of America

Occupation, settlement, and the social determinants of health for West Bank Palestinians

Background/Significance: A contentious issue in the Israel-Palestine conflict is the ongoing construction of settlements in the occupied West Bank along with its related policies, both of which have had impacts on the lives of residing Palestinians. These impacts have been documented by various UN and non-governmental agencies but are understudied in the academic literature. This work aims to review the literature on the social determinants of health for West Bank Palestinians and elucidate how settlement construction and policy influence these determinants.

Methods: The first section of this work reviews the available literature on the short-and long-term impact of Israeli settlement-building and related policies on the daily lives of West Bank Palestinians. The second section is a review of the literature on the social determinants of health of West Bank Palestinians. Following a search of relevant MeSH terms and keywords of Ovid Medline and Embase, title and abstract screening produced 163 articles for full-text review. Inclusion criteria were primary studies examining how one or more social factors influence health outcome(s) of Palestinians in the West Bank, and 27 articles were included.

Results: Review of reports published by United Nations (UN) agencies and analyses by the World Bank and World Health Organization revealed impacts of settlements and related policies on access to healthcare, water, employment, agricultural livelihood and exposure to political violence mediated by three primary areas of government policy/action: 1. Military infrastructure and mobility restrictions; 2. Water resource allocation and waste management; and 3. Land appropriation and house demolition. Review of the literature on social determinants of health in the West Bank identified four main areas where sociopolitical factors have influenced health outcomes: 1. Access to healthcare and maternal/newborn health; 2. Political violence and mental health; 3. Economic factors; and 4. Water contamination.

Conclusion: This review of the literature examines how settlement construction and related policies influence various aspects of life in the West Bank, in particular those that have been identified as health determinants, such as access to healthcare and employment. This review also summarizes our current understanding of how social health determinants influence health outcomes, including those related and unrelated to Israeli government policy/action on settlements. This review also identifies various gaps in the literature, in particular on how social determinants are related to chronic diseases.

Co-Authors: Khalid Fahoum, Weill Cornell Medicine, USA; Izzeldin Abuelaish, Dalla Lana School of Public Health, University of Toronto, Canada
Utilisation des données communautaires pour informer la gouvernance et améliorer l’efficience des interventions contre la tuberculose (TB) au Sénégal

Contexte

Au Sénégal, malgré des efforts considérables dans la lutte contre la tuberculose, 30% des cas de tuberculose ne sont pas détectés par le système de santé. Cette situation a incité le gouvernement à mettre en place un mécanisme d’intervention communautaire pour améliorer la détection de la tuberculose. Entre 2012 et 2017, l’ensemble des activités communautaires était identique et harmonisé dans toutes les régions du pays. En 2018, une analyse des données épidémiologiques a été réalisée dans le but de développer une stratégie différenciée de gestion de la tuberculose basée sur les profils épidémiologiques et les spécificités géographiques des régions. Les ressources ont été allouées sur cette même base. Le rapport coût-efficacité des interventions communautaires pour ces deux périodes est analysé.

Méthodologie

Une comparaison du coût des interventions communautaires sur une période identique de 9 mois (Juillet à Mars) est faite, pour les régions de Dakar et de Thiès, qui concentrent respectivement 44% et 15% de la charge morbide au Sénégal, pour les années 2014-2015 et 2018-2019. Les coûts directement liés à l’activité des organisations communautaires de base (OCB) ont été pris en compte. L’étude s’est concentrée sur deux variables :
- Le nombre de tuberculose pulmonaire à bâscilloscopie positive (TPB +) détecté par OCB
- Les budgets alloués aux OCB pour dérouler leur paquet d’activité de détection de cas

L’indicateur coût-efficacité est basé sur le rapport budget mobilisé versus le nombre de TPB+ détecté durant les 2 périodes étudiées.

Résultats

Cette étude a montré une diminution de 32% des coûts directs liés à la détection d’un cas de TPB + par les OCB entre 2018-2019 par rapport à celle de 2014-2015 (645 USD par rapport à 437 USD). Ceci est associé à une augmentation de la détection, qui passe d’une moyenne de 1,7 TPB + détectée par OCB sur la période 2014-2015 à 4,1 TPB + détectée par OCB sur la période 2018-2019, ce qui équivaut à une augmentation de la détection de 2,4 TPB + par OCB.

Conclusion

La mise en œuvre d’interventions communautaires dans le cadre d’une approche utilisant des paquets différenciés basé sur le contexte épidémiologique, semble induire davantage de détection et à un moindre coût. L’exploitation des données pour informer les stratégies contribue à leur efficience et à une meilleure gouvernance.

Co-Authors: Astou Fall, Plan International Senegal, Senegal; Alpha Diallo, Plan International Senegal, Senegal; Bocar Diallo, Plan International Senegal, Senegal; Elhadj Dioukhane, Plan Canada, Canada; Magalie Nelson, Plan Canada, Canada; Fatou Fall, Plan International Senegal, Senegal; Cheikh Niang, Plan International Senegal, Senegal; Ndeye Diouf, Plan International Senegal, Senegal; Ndieme Ndiaye, Plan International Senegal, Senegal
**Femi-Pius, Yemisi, Pathfinder International, Nigeria**

**Building the capacity of Community Stakeholders to close gaps in emergency obstetric and newborn services through SMART advocacy: Lessons from SMGL experience in Cross River, Nigeria.**

**Issue/Objective**

Maternal and newborn deaths remain a major public health problem in Nigeria. In Cross River, health facility assessment done in 2015 revealed a maternal mortality ratio of 812/100,000 live births. The second delay to accessing life-savings emergency obstetric care is the delay in reaching services. Expanding access to emergency obstetric and newborn services as well as availability of emergency transport system are ways to address this delay. Community stakeholders and structures are key to driving sustainable strategies for emergency transport services to pregnant women.

**Approach**

Saving Mothers Giving Life (SMGL) Initiative collaborated with Ward Development Committees (WDCs) in Cross River state to facilitate community-driven emergency transport services (ETS) for pregnant mothers. However, the sustainability of ongoing ETS services is dependent on continued funding. SMGL trained WDC members on SMART advocacy using the AFP SMART approach, which is a 3-phased (build consensus, focus efforts and achieve change), 9 step approach that focuses on opportunities that have the highest potential for success in the near term. All the WDCs developed smart objectives and work plans that was focused on strategies to ensure sustained funding for emergency transport services for pregnant women in their respective communities. A common theme in the WDC objectives was to secure a mandate by respective community clan heads to diverse community groups. The mandate was to secure provision of regular funds for provision emergency transport services for pregnant mothers. A total of 408 community stakeholders from 58 WDCs cross 16 Local government areas of the state were trained.

**Results**

About 60% of WDCs were able to achieve their set objectives within 3 months of the training. Signed copies of mandates from the clan heads have been circulated to respective groups within the communities. The clan heads, who are the community leaders have established mechanisms to ensure timely collection of funds.

**Conclusion**

Community stakeholders are critical to sustainability of interventions to address maternal and newborn health. They are ready to take ownership of such efforts to save lives of their women and children and can drive the sustainability of these interventions if trained on right approaches.

**Co-Authors:** Yemisi Femi-Pius, Pathfinder International, Nigeria; Kazeem Arogundade, Pathfinder International, Nigeria; Yemisi Erhunmwunse, Pathfinder International, Nigeria; Farouk Jega, Pathfinder International, Nigeria;
Gurnani, Neeta, Health Standards Organization, Canada

**Developing a people-centred standard for governance of health and social services organizations**

Issue: Governing boards of health and social services organizations are a key mechanism for health systems governance at the organizational level. They provide oversight and demand transparency and accountability regarding the organization’s decisions and actions. They ensure that the organization is making decisions based on best evidence, and is delivering services in an ethical, equitable, inclusive, and sustainable manner, while maximizing value and patient satisfaction. For the governing boards to function optimally and fulfill their purpose, their precise nature, roles, and responsibilities must be clearly defined, evidence-informed, and inclusive of the perspectives of individuals and communities that are the beneficiaries of the organizations’ services. To address this need, Health Standards Organization (HSO) is developing a people-centred global standard for governance that will specify the responsibilities and expectations of governing bodies of health and social services organizations around the world and guide them in the achievement of good and effective health governance.

Approach: The process to develop actionable standards combines a review of literature with expertise from a technical committee composed of patients and family members, policy-makers, researchers, clinicians, administrators, and board members. For broader validation, the process includes a sixty-day public review period during which the draft standard is made available for qualitative comments from members of the public and other stakeholders. The complete standards development process is iterative and consensus driven, and takes approximately two years.

Results: The literature review and technical committee consultations revealed a number of key board functions for good governance in health and social services organizations, including but not limited to: a focus on organizational mission and values; policy development; stakeholder engagement; integrity and accountability to the community and stakeholders; evaluation and self-improvement; building collective intelligence; strategic oversight; legal, ethical, and financial oversight; and risk management. We also identified evidence regarding the ideal makeup and characteristics of governing boards, training for governing board members, and the role of governing boards in protecting the rights and safety of workers and clients, in promoting value creation, and in emergencies and crises.

Discussion: HSO’s Governance standard can be used globally by governing bodies of health and social services organizations to facilitate good governance practices and mechanisms that will hold organizations accountable for the quality and safety of their services.

Co-Authors: Neeta Gurnani, Health Standards Organization, Canada; Carolyn Wayne, Health Standards Organization, Canada
Critically mapping research addressing gender equity in Tanzania: approaches, gaps and future directions

Objective: This scoping review aimed to synthesize interdisciplinary literature which approached gender equity in Tanzania across two decades. Acknowledging the contested terminology of gender equity and equality over time, this study was framed around two research questions: 1) how have issues relating to gender equity and equality in Tanzania been approached in peer-reviewed literature to date, and 2) what is known about how gender inequities are experienced, negotiated and understood by Tanzanian women?

Methodology: Guided by a critical paradigmatic perspective and decolonial theoretical underpinnings, this scoping review followed a six-stage methodological approach to search and synthesize relevant literature from 1998 to 2018. The initial search yielded 285 peer-reviewed articles published in English, however after a two-stage review, 67 articles with a primary focus on gender equity or equality in Tanzania were included and critically analyzed. Women’s daily occupations within the included articles were also examined to better understand how women negotiate gender inequities with recognition that human occupation can both perpetuate and transform gendered oppression.

Results: Eleven articles were authored by Tanzanian researchers, 37 were collaborations by Tanzanian and foreign authors, and the remaining 19 were completed by authors outside of Tanzania. Methodologies ranged from survey-design (21), mixed methods (13), case study (10), ethnography (9), narrative (7), empirical analysis (3), participatory action (3) and communicative feminist (1). These were paradigmatically guided predominantly by positivist (40), critical theory (17), and constructivist/interpretivist (10) lenses. Issues relating to gender equity and equality in Tanzania were addressed through the following topical categories: reproductive health (20), physical or sexual violence (13), labour or entrepreneurship (12), agriculture (11), empowerment (7), social or political inequities (3), and climate change (1). Trends across the inclusion timeframe of 1988-2018 were linked with socially relevant global development goals established during that period, such as the United Nations Millennium Development Goals and Sustainable Development Goals.

Discussion: The results highlight the diverse and dynamic ways women experience and navigate gender inequities in Tanzania. However, significant limitations in the literature remain in how women actually understand these inequities, both conceptually and in the context of their daily lives. Gaps within existing the approaches included qualitative space for Tanzanian women’s voices and culturally appropriate approaches to research, the limited use of a critical perspective, and finally the uptake of an occupational lens.

Conclusion: Advancements towards gender equity in Tanzania first requires critical and contextual understandings from multiple perspectives, most importantly from Tanzanian women themselves.
Jeyabalan, Vyshnave, Western University, Canada

Context-specific challenges, opportunities, and ethics for drones in healthcare delivery in the eyes of program managers and field staff: a multi-site qualitative study

Background: There is an increasing interest in implementing drones for healthcare in order to reduce healthcare disparities by improving healthcare accessibility and efficiency. UAVs can be used for telemedicine, public health surveillance, laboratory diagnostic testing, and to deliver medical supplies and patient samples. Though UAVs have the potential to revolutionize healthcare, it is important to consider and reflect on the ethical and practical challenges that may arise such as privacy concerns, safety concerns, how locals feel about the use of drones, and whether the community has the infrastructure to support this sophisticated technology. The aim of this project is to explore practical and ethical experiences of introducing drones for health in remote regions across the world, from the perspective of Flying Lab personnel.

Methodology: This qualitative study involves conducting semi-structured interviews [N=12] with individuals responsible for bringing drones to remote communities for health purposes and for the first time: drone health program coordinators, community engagement officers/trainers for drone projects, and community leaders in communities receiving a drone. Individuals are recruited through drone Flying Labs in Nepal, Peru, Dominican Republic, and Fiji. Semi-structured interviews are conducted via Skype, Viber, or phone. Interviews are transcribed and coded using NVivo 12.0 (QSR) and both directed thematic and grounded theory approaches.

Results: Discussed are various uses of drones, including for the delivery of anti-dengue mosquitoes, public health system payloads, and blood samples. While technical challenges loom large with the introduction of these new technologies to remote communities, there is optimism amongst Flying Lab staff that these can be resolved locally and in the near future. Less clear in the eyes of participants and of concern to some are best practices for ensuring true engagement of local communities in ownership and use of these technologies in the long term, and how collective informed consent process may be inappropriate due to local dynamics in some communities.

Discussion: Findings will help stakeholders understand context-specific ethical and practical concerns, which will then allow them to develop best practices for integrating drones into healthcare services in diverse settings.

Co-Authors: Vyshnave Jeyabalan, Western University, Canada; Elysée Nouvet, School of Health Studies, Western University, Canada; Lorie Donelle, Arthur Labatt Family School of Nursing, Western University, Canada
Canada’s participation in global governance: competing interests in feminist agendas, mining development, and women’s health?

Issue:
In regions experiencing large-scale mining development there exists a clear gender bias in the unequal distribution of risks and benefits experienced by women. Health and human rights effects include deepening economic inequality, increased risk of physical and mental health impacts, sexual violence, exploitation and harassment, as well as increased risk of HIV and other infections. Yet considerations of gender have often been neglected in mining governance efforts. Canada, ‘The World’s Miner’, has an obligation to consider these inequities. 2017’s Feminist International Assistance Policy (FIAP) presents an opportunity to transform the way gender is addressed in Canadian companies’ mining developments overseas. This project aims to explore how a feminist agenda is affecting global mining governance, and what this means for women’s health.

Methods:
Between June 2018 and June 2019, 24 interviews were conducted with mining officials in Toronto and Zambia representing large-scale Canadian mining companies active in Zambia’s Northwestern Province, development experts representing the Government of Canada, and women-focused non-governmental organizations (NGO). Researchers also attended the Prospectors and Developers Association of Canada Convention, and the Northwestern Province and Zambian Alternative Mining Indabas as observers.

Results:
The Government of Canada is still in the process of integrating a feminist agenda into its global policies. FIAP is being incorporated into an ‘inclusive trade agenda’ that highlights women’s businesses and participation in the workforce. In development, the government has stepped away from previous commitments that linked aid to mining development at a country level, instead focusing efforts to transform global norms to include greater consideration of gender. While mining companies are attentive to gender issues in their corporate social responsibility and employment programs, they attribute this attention to shifts in the public discourse, e.g. #MeToo, and to economic drivers, e.g. company losses attributed to gender-based violence and lending institutions’ requirements, not government policy. NGOs, both local and international, continue to actively promote gender considerations within government, mining companies, and international standard-setting institutions, and may be alone in highlighting how structural issues affect women’s health.

Conclusions:
FIAP is contributing to a global governance shift, yet these efforts predominantly focus on strengthening women’s economic participation in a system that continues to privilege industrial development in Zambia. This approach often neglects the most marginalized. Where Canada is benefiting from overseas mining development, direct efforts to support host governments, public institutions, and NGOs in addressing mining impacts on women’s health and wellbeing should be made.

Co-Authors: Lesley Johnston, University of Waterloo, Canada; Jennifer Liu, University of Waterloo, Canada; Colleen Davison, Queens University, Canada; Kitty Corbett, University of Waterloo, Canada; Craig Janes, University of Waterloo, Canada
Kabanda, Geoffrey, African Research Center 4 Ageing & Dementia, Uganda

Citizens’ outcry, a trigger to public health institutions responsiveness: Exploring the roles of accountability mechanisms on local health system performance in Uganda.

Background:

Health systems governance is recognized as a vital element in achieving a resilient and functional health care systems as well as a panacea for UHC. Because of their contribution towards offering a platform to respond to different feedbacks at various level of service delivery within the different levels of health system (bureaucratic) or community (external accountability), accountability mechanism ranks high on the global agenda especially in developing countries with fragile health systems. Existing oversight and accountability structures have not produced the desired results. In many instances, it has stopped at providing a voice with no power to influence implementation of the desired innovations and yet investigations into the underlying causes of suboptimal functionality remains understudied. This study aimed to explore the roles of accountability mechanisms and how they affect performance of the Local health system in Uganda

Methods:

This was a single embedded case study design. Twenty four key informant interviews were conducted with political leaders, advocacy groups and district health team officials. In addition, 4 focused group discussion (FGDs) were conducted with residents in Mukono district. Analysis was undertaken following the thematic network analysis framework. This process was aided by the atlas.ti7 software for qualitative data analysis.

Results:

Four themes emerged from this study. (1) Resource rationalization, (2) performance monitoring, (3) participatory planning and (4) bureaucratic reporting. Most participants revealed that, amidst merger resource allocation for health, accountability mechanism would aid in rational allocation of resources and provide a check at different points of service delivery. Citizen’ voices are vital in the monitoring and evaluation of the Local Health System (LHS) performances and also offers a platform for community participation in priority setting in LHS. However, bureaucratic accountability was largely driven by set targets per different indices within LHS and its achievement majorly depended on the organizational culture.

Conclusion:

Accountability efforts exist but still weak to cause desired changes hence a call for action to strengthen existing structures with an aim of equipping them with power to cause change. However, existing strategies such as community score cards should be incorporated as part of the accountability tools in order to harmonize the gaps between bureaucratic and community accountability mechanisms.

Co-Authors: Geoffrey Kabanda, African Research Center 4 Ageing & Dementia, Uganda; Herbert Nyanzi, African Research center 4 Ageing & Dementia, Uganda; Isaac Ddumba, Mukono district local government, Uganda
Kakolo, Jediael, JSI, Democratic Republic of the Congo

l’évaluation et renforcements des capacités organisationnnes des écoles et ordres professionnels de la santé: République Démocratique du Congo, un projet mis en œuvre par JSI

L’objectif de cette présentation sera de démontrer comment le renforcement organisationnel, particulièrement en matière de procédures et de normes financières et administratives, a eu un impact sur deux écoles et un ordre professionnels en République Démocratique du Congo (RDC). L’investissement dans ces types de renforcement devrait aller de pair avec le renforcement des capacités techniques pour une gouvernance durable et transparente dans les systèmes de santé.

Méthodologie : Un pays en conflit et en transition gouvernementale, le secteur de la santé en RDC est vulnérable à la corruption. Ce dernier risque à affaiblir les infrastructures et avoir des effets négatifs sur la population congolaise. Le renforcement de la capacité organisationnelle des structures professionnelles de la santé et des cadres du ministère de la Santé est une solution indispensable pour responsabiliser et former des leaders locaux pour une gouvernance transparente. Le projet « Resilient and Responsive Health Systems » (RRHS) vise à renforcer le système de la santé publique pour soutenir la mise en œuvre des stratégies nationales de santé et des plans de rétablissement, pour répondre aux épidémies émergentes, pour prévenir, gérer et contrôler le VIH et d'autres maladies, et améliorer les résultats en matière de santé de la population.

Dans le cadre de RRHS, M Jediael Kakolo, expert financier et administratif congolais et consultant de JSI, a effectué une évaluation de la capacité organisationnelle, ou en anglais « organizational capacity assessment » (OCA) de l’institut supérieur de technique médicale (ISTM) à Lumbubashi, la faculté de médecine de l’université de Lubumbashi (UNILU) et de l’ordre national des infirmières en RDC.

Cette présentation pragmatique décédera les lacunes organisationnelles typiquement retrouvées, et les plans d’actions créer par les organisations professionnelles qui identifie les domaines dans lesquels ils peuvent eux-mêmes développer leur capacité en fonction des domaines explorés. L’implémentation des simples procédures administratives et financières est critique pour responsabiliser les professions de la santé et pour diminuer une tendance à corruption. La renforcement organisationnelle ne doit pas être négligé lors de nos discours d’une bonne gouvernance surtout dans des pays en conflit. Grâce au succès de ces renforcements, JSI continu à soutenir les professions sous-mentionner pour impacter la capacité du système de santé publique en RDC.
**Kassam, Fazila, McMaster University, Canada**

**Addressing road traffic injuries in low- and middle-income countries: A Kingdon policy analysis**

Issue: Road traffic injuries (RTIs) are a leading cause of morbidity and mortality worldwide. Unfortunately, this burden disproportionately affects Low and Middle-Income Countries (LMICs) due to inadequate institutional capacity development for road safety. Despite global initiatives for reducing RTIs, two nations that continue to suffer most are Nepal and Uganda.

Objective: To identify the tools necessary to get RTI prevention/road safety on the policy agenda of LMICs.

Methodology: The Kingdon Multiple Streams Framework is applied to Nepal and Uganda to identify successful and damaging elements to prioritization of RTI prevention/road safety on the national policy agenda.

Results: Nepal lacks RTI evidence, limiting its ability to define a prominent road safety issue. Accordingly, governmental efforts have been minimal and the issue is largely being addressed by non-governmental organizations. The introduction of the Decade of Action for Road Safety 2011-2020 functioned as a brief policy window for Nepal, but due to political instability and absence of a policy entrepreneur, the streams have not aligned and road safety remains a low priority. Akin to Nepal, Uganda's RTI evidence is insufficient. However, the 2018 Road Safety Performance Review can be understood as strengthening Uganda's problem definition and opening a policy window. The problem, defined as the worst RTI fatality rate in the African region, has converged with existing (inter)national policy solutions, a favorable political climate as well as the presence of a pivotal policy entrepreneur, propelling efforts to improve Uganda's road safety sector.

Conclusions: Political stability is a fundamental necessity before any progress can be made for agenda item prioritization. If this is fulfilled, the greatest likelihood for success will arise when there is a well-defined problem accompanied by existing policy solutions and a policy entrepreneur to connect the three streams. However, even if a LMIC has a weak problem definition, a prominent policy entrepreneur can increase the likelihood of its recognition as long as feasible and valuable solutions are available to address the issue and policymakers are receptive.

Co-Authors: Fazila Kassam, McMaster University, Canada; Hasan Merali, McMaster University, Canada
Kassim, Said Abasse, southeast university, China (People’s Republic of)

The Effects of Political Instability on Healthcare System in Comoros, 1975-2015

Issue/objective: Good health is the bedrock on which social progress is built. A nation of healthy people can do those things that make life worthwhile, and as the level of health increases so does the potential for happiness. However, political instability has dramatic impacts on societies, and it is often considered as one of the main obstacles for economic, social and political progress in the world today. There is an ongoing scientific evidence pointing out the adverse effects of conflict on population health and development. Union of Comoros has experienced nearly two decades of political instability and military rule. This comprehensive review was carried out to ask whether the health crisis in Comoros is attributable to the consequences of the chronic political instability.

Methodology/approach: This study involved a series of semi-structured interviews with key informants complemented by a comprehensive search of secondary information sources and databases, assessing some key health status indicators related to Comoros’ political situation at that time.

Results: The analysis demonstrated that political instability and lack of proper leadership from the Government undermine the establishment of health policies which contributed dramatically to the decline in the health performance. Additionally, the resurgence and emergence of old and new diseases such as cholera, chikungunya, malaria, HIV/AIDS, as indicators of inadequate health services were most likely during political turmoil. Data also showed an out-migration of health workforce and an increased overseas medical treatment demands at that period, which indicate less-attractive working conditions and weak health systems in the country. Meanwhile, an increasing performance of health status indicators was observed after the comprehensive peace process of 2000-Fomboni Declaration.

Discussion/conclusions: The chronic political instability in Comoros has contributed to the health crisis facing the Union of Comoros. It has hampered the implementation of proper institutions and macroeconomic policies, which might guarantee the socioeconomic development and prosperity of the population. Further studies in fragile states are needed to confirm our findings.

Co-Authors: Said Abasse Kassim, southeast university, China (People’s Republic of)
Les « Bajenu Gox » (BG) (acteurs de santé communautaire) contribuent-elles à l’utilisation des services de santé maternelle et infantile (SMI) par les femmes en âge de procréer (FAR) au Sénégal ?

Enjeu/Objectifs : De récentes initiatives ont été élaborées à l’échelle mondiale pour réduire la mortalité maternelle et infantile. En Afrique, la prise de conscience de l’enjeu de la santé maternelle et infantile (SMI) se traduit depuis quelques années par une augmentation des efforts visant une amélioration de la santé des femmes et des enfants. Au Sénégal en 2009, le Ministère de la santé a mis en place « l’Initiative Programme Bajenu Gox » qui est une approche communautaire qui s’inscrit dans l’amélioration de la santé maternelle et infantile.

Notre étude a documenté et analysé l’expérience des cibles de cette approche qui sont des agents de santé communautaire appelés “Bajenu Gox” (BG) ou marraine de quartier et de leur rôle dans l’amélioration de la SMI.

Méthodologie / approche : La méthodologie de cette recherche est une analyse continue d’une collecte périodique pour observer le changement. Des données statistiques ont été collectées à partir des registres des structures de santé pour observer le rôle des BG dans l’utilisation des services SMI. Des groupes de discussion ; des entretiens individuels ont été menés auprès des BG, des femmes en âge de procréer (FAR), du personnel de santé, des communautés (familles, jeunes, autorités locales) dans les sites de Dakar, Kaolack, Fatick et Louga.

Résultats : Les BG ont amélioré la fréquentation des structures de santé par les FAR. Les BG sont membres intégrantes du dispositif communautaire des structures de santé. Elles constituent l’interface entre la communauté et le système de santé. Elles sont perçues par le personnel de santé comme des femmes leader d’utilité capitale pour améliorer la santé de la mère et de l’enfant. Les BG appuient beaucoup le personnel de santé dans la recherche et la remobilisation des FAR perdues de vue dans le cadre des vaccinations et la planification familiale.

Discussion / conclusion : Les autorités administratives (selon le niveau) doivent mieux s’impliquer dans le travail des BG pour qu’il y ait plus de crédibilité dans leur mission. Le travail qu’effectue les BG au niveau communautaire a augmenté le taux de fréquentation des services de santé maternelle et infantile (SMI). Et participé à la prise de conscience de certaines femmes de leur capacité à prendre des décisions relatives à leur santé et à celle de leur enfant.
Khalid, Ahmad Firas, McMaster University, Canada

Supporting the use of research evidence in decision-making in crisis zones in low- and middle-income countries: A critical interpretive synthesis

Issue: Decision-makers in crisis zones are faced with the challenge of having to make decisions under limited time constraints and in light of the many factors that can influence their decisions, of which research evidence is just one. To address a key gap in the research literature about how best to support the use of research evidence in such situations, we conducted a critical interpretive synthesis approach to develop a conceptual framework that outlines the strategies that leverage the facilitators and address the barriers to evidence use in crisis zones.

Methodology: We systematically reviewed both empirical and nonempirical literature and used an interpretive analytic approach to synthesize the results and develop the conceptual framework. We also purposively sampled additional papers to fill in conceptual gaps. We used a “compass” question to create a detailed search strategy and conducted electronic searches in CINAHL, EMBASE, MEDLINE, SSCI and Web of Science. A second reviewer was assigned to a representative sample of articles. We identified 21 eligible papers to be analyzed and an additional 6 purposively sampled to fill conceptual gaps.

Results: The synthesis resulted in a conceptual framework that focuses on evidence use in crisis zones examined through the lens of four systems - political, health, international humanitarian aid, and health research. Within each of the four systems, the framework identifies the most actionable strategies that leverage the facilitators and address the barriers to evidence use.

Conclusion: Our conceptual framework identifies and helps explain the strategies that can be employed to integrate the use of evidence more systematically in crisis zones.

Key messages:

1. Presents a new conceptual framework that outline strategies that leverage the facilitators and address the barriers to evidence use in crisis zones within different systems.
2. Systems include political, health, international humanitarian aid, and health research.
3. Outlines strategies that are systematic and directed at the appropriate end-user within different systems.
4. Expands on the literature pertaining to evidence-informed decision-making.
5. First time a CIS has been applied to this topic.

Co-Authors: Ahmad Firas Khalid, McMaster University, Canada; John N. Lavis, McMaster University, Canada; Meredith Vanstone, McMaster University, Canada; Fadi El-Jardali, American University of Beirut, Lebanon;
The First 1,000 Days approach to nutrition through a rights-based lens: gaps and opportunities for gender and health equity

Background: The second Sustainable Development Goal (SDG) ambitiously aims to achieve a world without hunger by the year 2030. Latest findings show that global rates of hunger increased more than 2% from 804 to 821 million people between 2016 and 2017. The First 1,000 Days approach seeks to improve nutrition between a woman’s pregnancy and her child’s second birth since it is a critical period of growth and development in a child’s life, with far-reaching effects on learning and working capacities, risk of developing non-communicable diseases later in life and intergenerational effects on their own offspring.

Objective: The objective is to explore the development and limitations of the First 1000 Days approach in order to highlight and subsequently expand beyond its gaps. Understanding theory is important to the governance of global health because how we think about global health problems frames priorities and how we act on them. Critically examining influential theories is a means of accountability to ensure inclusiveness and reduce replications of gender and health inequities in evidence-based research.

Methodology: A landscaping literature review was conducted on Medline Ovid, PubMed, JSTOR, Google Scholar and reference lists reviewed to investigate the theory development, implications, and critiques of the First 1000 Days approach. The review used a gendered human rights-based approach to health and considered findings with the World Health Organization (WHO) Gender Responsive Assessment Scale from gender exploitative to gender transformative policies and programs.

Results: A focus on child health benefits of maternal diet interventions neglects health outcomes for women, which reflects an injustice within human rights based frameworks to health. The relative gap in knowledge on the impacts of maternal diet interventions on the women themselves makes the topic hard to discuss and advocate for, which then contributes to lower prioritization and less research. The research-advocacy gap thus replicates and reproduces existing gender-based disparities in both research and health.

Conclusion: While the importance of maternal nutrition for the mothers may be implicitly understood in interventions within the First 1000 Days approach, the missing explicit focus has led to a lack of data on the relationship between nutrition and maternal health outcomes, which in turn hampers the ability to move maternal nutrition into the global health and development agendas. Women-centred research into marginalized topics has the potential to be transformational and disrupt implicit gender inequities in health.

Co-Authors: Mai-Lei Woo Kinshella, Department of Obstetrics and Gynaecology, University of British Columbia, Canada
Kohler, Jillian Clare, WHO Collaborating Center for Governance, Accountability and Transparency in the Pharmaceutical System, Canada

how corruption can undercut universal health coverage and how anti-corruption, transparency and accountability mechanisms can reduce its risk

I will highlight findings from a rapid literature review that illuminates how corruption can undercut Universal Health Coverage (UHC) and how anti-corruption, transparency and accountability (known as ACTA) can reduce its risks. The health system, as a result of its fragmentation, technical complexity, and the vast sums of money involved in the purchase of health products and its operations, is an optimal space for corruption to thrive. Corruption is found throughout the health system; from petty corruption at the health facility level to corruption that takes place at the highest level of the state. There is indeed a growing body of evidence which is documenting the pernicious effect corruption has had on health systems, particularly in terms of health equity goals. For instance, Vian’s comprehensive article on corruption and the consequences for public health and the European Commission’s Study on Corruption in the Healthcare Sector. Health system corruption certainly has been found to harm the poor and most vulnerable population groups, threatening equity. A 2015 study by Transparency International on corruption in Africa reported that the poor are often forced to pay bribes for access to “free” public services. As countries globally strive towards achieving the Sustainable Development Goals, more specifically, Goal # 3 Ensure healthy lives and promote well-being for all at all ages, policy makers need to understand how corruption can undercut UHC goals and how to integrate ACTA into health policy to reduce its risk. Accordingly, I will review how the various mechanisms of UHC – namely revenue raising, pooling, purchasing and benefits are vulnerable to corruption and provide examples why. I will then speak about what ACTA mechanisms can best reduce the risk of corruption drawing on country examples, where possible. Ultimately, countries with political leaders committed to reducing corruption, held accountable by mobilized and well-informed citizens, supported by strong institutions, with well-paid and trained personnel, formal and timely processes, and effective mechanisms to regulate the pharmaceutical industry and enhance overall transparency, oversight, evaluation, and accountability are more likely to effectively mitigate risks.

Co-Authors: Jillian Clare Kohler, WHO Collaborating Center for Governance, Accountability and Transparency in the Pharmaceutical System, Canada
Kola, Lola, WHO Collaborating Centre for Research and Training in Mental Health, Neurosciences and Drug and Alcohol abuse. Department of Psychiatry College of Medicine, University of Ibadan, Nigeria., Nigeria

Responding to the challenges of adolescent perinatal depression with patient- centered mobile health

Background

Perinatal depression is more prevalent among adolescents than older perinatal women and associated with poor maternal and child outcomes particularly among adolescents. Despite the effectiveness of psychosocial intervention for perinatal depression in Nigeria, evidence suggest that a combination of age related and structural factors exacerbate feelings of ostracization in young mothers and limit their use of available service. Mobile technologies are ubiquitous and can be leveraged as therapeutic tools to complement face to face mental health care in a ‘Blended care’ approach to improve adolescent mothers contact with care. Using mobile technologies/IT in health advances Grand Challenges in Global Mental Health to improve access to care.

Method

A Mixed-method approach of qualitative and quantitative research data collection is used to address study aims. Study population are consecutive adolescent attendees aged 16-19 years ; and non-specialist MCHC clinicians in purposively selected primary care clinics in Ibadan, Nigeria. A User-Centered Design (UCD) is used to develop and construct a mHealth system for the treatment of Adolescent Perinatal depression. Laboratory based usability test with real users is utilised to refine and enhance the mHealth system and to determine it acceptability and feasibility in real-world conditions. Following appropriate modifications, 15-week community field trial is conducted among 15 participants recruited in blocks to evaluate the usability of the mHealth system after which changes will then be made to the mHealth system.

Results

Perinatal adolescents with depression in Nigeria are engaged in a unique opportunity to design an intervention that has the potential of improve their health outcomes and informing health policy.

A user entered design produces a culturally informed and age-appropriate mHealth system, for the treatment of APD within routine care to improve the current intervention delivered for the condition in primary care. The mHealth system has the potential of being feasible, useful and acceptable based on users’ rating.

Discussion /Conclusions

This research contributes to the scale up efforts for Perinatal Depression and provide unique information on mHealth acceptability and feasibility in LMIC. The work advances Grand Challenges in Global Mental Health to increase access to evidence-based care (Goal F). Integration of mental health into primary care and improved access to healthcare based on the principle of equity are goals of the WHO Action Plan 2013-2020.

Co-Authors: Lola Kola, WHO Collaborating Centre for Research and Training in Mental Health, Neurosciences and Drug and Alcohol abuse. Department of Psychiatry College of Medicine, University of Ibadan, Nigeria.,Nigeria
Kulkarni, Manisha, UNIVERSITY OF OTTAWA, Canada

Subnational-level variation in maternal health care service use and implications for equity in Jimma Zone, Ethiopia: cross-sectional spatial analysis

Issue/Objective

To appropriately monitor progress in improving maternal health outcomes, subnational-levels need to be examined as national-level indicators often mask local differences. Furthermore, to promote equitable use of health services, it is important to identify communities marginalized due to lower educational attainment or household wealth. This study combined statistical and spatial methods to explore variations in maternal health service utilization at the primary health care unit (PHCU)-level in rural Ethiopia.

Methodology

Data were obtained from a baseline household survey (n=3,784) conducted between October 2016 and January 2017 as part of an on-going cluster-randomized controlled trial in three districts in Jimma Zone, Ethiopia. The proportions of women reporting use of antenatal care (ANC), maternity waiting homes (MWHs), facility delivery services and postnatal care during their last pregnancy were calculated for 24 participating PHCUs. Differences in service utilization levels between PHCUs were examined using chi-square tests in STATA version 15. Spatial patterns in service utilization were mapped and explored using Moran’s I analysis in ArcMap version 10.6.1.

Results

Overall, 84% of women reported attending at least one ANC visit, 6% used MWHs, 49% gave birth at health facilities and 39% reported receiving PNC. However, at PHCU-level there was significant variation in ANC use (48%-93%, p <0.001), MWH use (0%-21%, p <0.001), facility deliveries (19%-74%, p <0.001) and PNC use (13%-68%, p <0.001). Spatial clustering of regions with higher and lower service utilization were identified for all services except MWH (p<0.05). Spatial correlation was observed between PHCUs with low service use and higher proportions of less educated women. Similar patterns were observed between PHCUs with high service use and high household wealth.

Discussion

We demonstrate significant variation in utilization levels along the continuum of maternal health care service use at PHCU-level in three rural districts of Ethiopia. Inequities exist despite reported improvements in access to services, particularly for vulnerable communities. Further integration of local level service utilization indicators in routine monitoring and national level reporting may assist in promoting inclusiveness, equity and more effective policy formulation and implementation.

Co-Authors: Jaameeta Kurji, University of Ottawa, Canada; Lakew Abebe Gebretsadik, Jimma University, Ethiopia; Sudhakar Morankar, Jimma University, Ethiopia; Muluemebet Abera, Jimma University, Ethiopia; Gebeyehu Bulcha, Jimma Zone Health Office, Ethiopia; Kunuz Bedru Haji, Jimma Zone Health Office, Ethiopia; Ronald Labonte, University of Ottawa, Canada; Manisha Kulkarni, University of Ottawa, Canada
**Kyomuhangi, Teddy, Healthy Child Uganda, Uganda**

**Medium-term effect of an intervention to strengthen capacity of Health Facility Governance Committees in rural Uganda: A qualitative perspective**

Background: Improving global health outcomes requires strengthening health systems, which involves increasing governance capacity. In Uganda’s decentralized health system, ‘Health Unit Management Committees (HUMCs)’ comprised of volunteer community and facility representatives at every health centre, are described in national health policy. However, how to best operationalize HUMCs at scale is not well understood and there are few practical examples. During 2012-2014, a Ugandan-Canadian partnership (Healthy Child Uganda) supported HUMC capacity development throughout a full rural SW Ugandan district as one component of a larger maternal health intervention.

Objectives: A qualitative evaluation conducted five years post intervention aimed to understand HUMC experiences with and since the intervention.

Methods: HUMC activities involved reaffirming HUMC membership in every facility, providing orientation (to roles and responsibilities including governance, community liaison and support for decision-making) according to government guidelines which were provided in writing in local dialect. Next, management and leadership training was provided during a participatory workshop (i.e. human resources, planning, budgeting, quality improvement). Mentorship and refresher training were led by district health management teams. In 2018, skilled facilitators used semi-structured interview guides to collect experiences through focus groups with selected HUMC member participants and one-on-one interviews with selected health facility and district managers. Interviews were recorded, transcribed and coded. Thematic content analysis extracted main and sub-themes and representative quotations.

Results: HUMC trainings were remembered and viewed as relevant and timely. HUMC members reported current roles including as community representatives, service advocates, planners and financial and general overseers. Participants described capacity to handle issues at the facility due to knowledge and skills acquired during trainings. Significant initiatives undertaken included savings schemes, placenta pit and canteen construction, and gardens.

Conclusion: Mobilizing and training HUMCs district-wide in rural Uganda is feasible and may have long-term benefits including those which are sustainable. Investment in scale-up of HUMCs should be considered when considering value-add programming in governance and health system-strengthening.

Co-Authors: Teddy Kyomuhangi, Healthy Child Uganda, Uganda; Samuel Maling, Mbarara University of Science and Technology, Uganda; Kimberly Manalili, University of Calgary, Canada; Jerome Kabakyenga, Mbarara University of Science and Technology, Uganda; Jennifer Brenner, University of Calgary, Canada; Nalini Singhal, University of Calgary, Canada; George Muganga, Bishop Stuart University, Uganda
Lang’at, Evaline, Kilifi County Government, Department of Health, Kenya

Accelerating reduction of maternal and perinatal death in Kenya through a community social responsibility model: Kilifi County-AKDN partnership model

Kilifi County is one of the 15 out of 47 counties in Kenya that contributes to 98% of maternal mortality in the country. To address this challenge, Kilifi County Government has made significant and purposeful efforts geared towards improving maternal and child health. However, despite political commitment, the County government is faced with funding deficits. Aga Khan University and the Aga Khan Hospital in Mombasa (together referred to as AKDN) operate as private education and health institutions in Kilifi county. A shared commitment to structural change which leads to improvements in health and well-being has served as a platform for establishing a public-private partnership (PPP) between AKDN and the Kilifi County Department of Health (CDoH). Through iteration and application of good governance principles, this partnership has contributed to real and sustained change in Kilifi county. It is a model for exploring how to strengthen the public health system and tackle preventable maternal and perinatal mortality.

Transparency and accountability were critical dimensions which facilitated the success of this PPP. The leadership of these institutions at multiple levels agreed in writing on the terms of engagement. These terms supported the alignment of AKDN objectives with the CDoH annual workplan and laid down a foundation where both partners’ resources were aligned to meet the needs of Kilifi County whilst achieving individual institutional goals. This partnership is also continually improved through regular CDoH-led forums fostering communication.

Through this collaboration, Kilifi County has brought meaningful improvements to health service delivery, including prioritizing evidence-based, high-impact interventions and a 30% increase in the number of health facilities using data systematically to inform service delivery. One example is the establishment of eHealth Communities of Practice where health professionals from both institutions collaborate virtually. This builds capacity of health workers within CDoH by leveraging specialist expertise at AKDN institutions, while also engaging in mutual knowledge exchange. In addition, the AKDN team has organised a health research forum that has facilitated streamlining other stakeholders’ research foci on the needs of CDoH and Kilifi County.

The most striking element of this partnership is the continuous and deliberate efforts by both parties to jointly plan, allocate resources, manage operations, analyse progress made and tailor responses promptly, with a clear focus of improving the health of women and children. This approach is one that CDoH has since replicated with other partners and is demonstrative of how good governance principles can facilitate productive PPPs.
Lauber, Kathrin, Tobacco Control Research Group, University of Bath, United Kingdom of Great Britain and Northern Ireland

Global NCD governance in the SDG era: a qualitative analysis of ultra-processed food and beverage industry framing

Background: The UN system’s shift towards multi-stakeholder governance, now enshrined in the Sustainable Development Goals (SDGs), invites not only civil society but also the private sector to the table. Although the tobacco industry is formally excluded from engagement, this approach provides opportunities for other unhealthy commodity industries to influence the non-communicable disease (NCD) agenda of the World Health Organization (WHO). Focusing on the ultra-processed food and beverage (UPFB) industry, this research critically examines actors’ governance preferences and the strategic framing they use to promote these preferences.

Methods: A qualitative frame analysis was conducted on all written responses from UPFB actors to all publicly available NCD policy-relevant WHO consultations held after the SDGs came into force in January 2016 and before 2019. From five consultations, we identified 46 submissions from 24 trade associations (no individual companies), twelve of which directly represented two or more of the four largest global corporations in the processed food and soft drinks market.

Findings: Respondents overarchingly promoted public-private collaboration and self-regulation, and opposed statutory regulation and conflict of interest (COI) safeguards or, more generally, reduced engagement with industry. To this purpose, they framed the UPFB sector as a legitimate and necessary partner in NCD policymaking, differentiating themselves from the tobacco industry and referencing a history of successful collaboration while also invoking multi-stakeholder norms to portray collaboration as a must. Respondents contrasted this with the limits of WHO’s mandate and expertise, further framing policy and governance decisions as matters of national sovereignty. In the context of regulation they invoked principles of good governance and evidence-based policymaking to promote an economically oriented policy environment, including business impact assessment, which identifies a clear role for industry and its evidence in the policy making process.

Conclusion: These preliminary findings not only confirm existing research on national-level UPFB framing, they also highlight similarities with tobacco industry arguments on the supranational level. Our observation that the UN’s call for partnerships to support the SGDs is invoked to defend corporate access to NCD policy highlights the need for more cautious approaches which are mindful of the commercial determinants of health. Systematic opposition to regulation and to governance approaches which may compromise commercial actors’ insider role in global health by UPFB actors shown here raises questions about the value of collaboration from the perspective of international health agencies such as WHO.
Lencucha, Raphael, McGill University, Canada

Policy paradigms, institutional legacies and intersectoral tensions: How neoliberalism is shaping product supply and what it means for NCD prevention

Issue/objective: Alcohol, tobacco and unhealthy foods contribute greatly to the global burden of non-communicable disease (NCD). The 2013-2020 WHO action plan identifies the need to engage economic, agricultural and other relevant sectors to establish comprehensive and coherent policy. To date one of the biggest barriers to action is not so much identifying effective policies, but rather how a comprehensive policy approach to NCD prevention can be established across sectors. Much of the research on policy incoherence across sectors has focused on exposing the strategies used by commercial interests to shape public policy in their favor. Although the influence of commercial interests on government policy remains an important issue for policy coherence, here we argue that what is often neglected is how the dominant neoliberal policy paradigm has shaped the supply of agricultural commodities often to the detriment of population health.

Methodology: This presentation draws from interviews with representatives from government, civil society, industry and intergovernmental organizations (n~100) from five countries (Kenya, Malawi, Zambia, Brazil and Philippines) and the literature on agricultural supply and health. These data sources are used to analyze how the neoliberal paradigm has shaped product supply.

Results: This analysis illustrates that two dominant patterns of governance have shaped the supply of harmful commodities such as tobacco, alcohol and unhealthy foods. First, governments have largely relinquished control over the supply chains leaving companies to manage product supply. This policy approach has implications for the ability of governments to intervene on the basis of health objectives. Second, governments often institute programs to stimulate the processing and manufacturing of unhealthy products with little regard for the implications for population health. Underpinning these two patterns are a certain set of implicit assumptions about the proper relationship between government, market and society informed by the neoliberal paradigm.

Conclusion: Work to establish policy coherence across sectors, particularly to ensure a healthy product environment, will require systematic engagement with the assumptions that continue to structure institutions that perpetuate unhealthy product environments.

Co-Authors: Raphael Lencucha, McGill University, Canada; Anne-Marie Thow, University of Sydney, Australia
Little, Matthew, University of Victoria, Canada

The double burden of under- and over-nutrition in rural South India: A cross-sectional study assessing social and policy determinants

Issue: Low- and middle-income countries (LMICs) around the globe are undergoing a ‘nutrition transition’, characterized by marked dietary transformation and shifting physical activity patterns related to globalization of food and economic systems. In rural India, the nutrition transition is manifest as a shift of diets toward increased intakes of vegetable oils, refined grains, and processed foods, as well as a reduction in the consumption of legumes and coarse cereals. These changes have contributed to the double burden of malnutrition, defined as the co-occurrence of over-nutrition (e.g. obesity, type 2 diabetes, and cardiovascular disease) and undernutrition (e.g. underweight, stunting, and micronutrient deficiencies) at the population, household, and/or individual level. Including abrupt increases in the prevalence of obesity and associated diseases. This double burden is becoming a serious public health concern in many regions of India; however, studies examining the interconnected social and policy determinants of this crisis are scarce.

Methodology: We undertook a cross-sectional study of adults (n=753) that assessed socio-demographic factors, physical activity levels, and dietary intake. A variety of health outcome measures were examined, including overweight, obesity, diabetes, and anemia. Multivariable logistic regression analyses were employed to determine associations between risk factors and two co-morbid double burden pairings: (1) anemia and overweight, and (2) anemia and diabetes. Explanatory qualitative interviews were conducted with an additional 121 individuals to explore how social and policy environments may be contributing to the double burden of malnutrition.

Results: Prevalence of co-morbid anemia and overweight was 22.6% among women and 12.0% among men. Prevalence of co-morbid anemia and diabetes was 5.6% among both women and men. Female sex, high caste, higher socio-economic status, urbanicity, non-agricultural occupation, and meat intake were associated with double burden co-morbidities. Interviewees identified the Public Distribution System (PDS), a large-scale food rationing program that provides subsidized rice, as an important driver of dietary consumption that may impact risk of the double burden of malnutrition.

Discussion: Several areas of interest for policy, practice, and research in determining proximate and distal factors driving the nutritional double burden were identified. Women in rural regions of India may be particularly vulnerable to co-morbid under- and over-nutrition. The PDS is an important policy driver of food availability and consumption, and may represent an opportunity for nutrition intervention to address the double burden of malnutrition.
Loureiro, Maria Carolina, School of Public Health, University of São Paulo, Brazil

The building of the global governance for health and the access to medicines in emerging countries Brazil and India: economic liberalization, foreign policy strategy or universalization of the right to health?

Health has acquired a relevance on the international arena, integrating countless foreign policy and cooperation agendas. Despite the progress of health in foreign relations, the interdependence fueled by contemporary globalization still reflects the existing power dynamics and inequities that severely affect the health realm. An example is the tension between intellectual property and the access to medicines. This study is divided into 2 parts. Firstly, it presents a brief history of the link between health and international relations, stressing the role of infectious diseases and security at the genesis of this interchange. To do so, we approach three waves of “disease globalization” and the consequent transformations in health global governance taking place respectively: a) in the 19th century in the epidemics of cholera, plague and yellow fever; b) in the 20th century in the AIDS advent and c) in the 21st century in the epidemiological transition to chronic non-communicable diseases.

Considering the current world political conjuncture, particularly the complex multilateral diplomacy and the diversity of state and non-state actors, health issues have come to relate more closely to economics and trade. If, on the one hand, the access to medicines was fundamental to guarantee the right to health, on the other, to tackle AIDS in developing countries demanded the import of patented and unaffordable antiretroviral (ARV) medicines. Therefore, in a second step, this article intends to clarify the similarities and discrepancies between the Brazilian and Indian internal and foreign policies, in the pursuit of access to medicines, for both infectious diseases and the control of increasing chronic non-communicable diseases. To this end, three approximation factors between health and international relations described by Stuckler and Mckee, are applied to each country regarding: a) the right to health; b) the health economics with the development of pharmaceutical industries, c) the foreign policy strategies to health. The main questions to be answered by this study are: since Brazil and India struggled for the right to access to medicines, mainly in international forums and multilateral international organization (WHO, WTO), with a quite similar humanitarian discourses, what are the similarities and discrepancies between the foreign and domestic policies of those countries, with regards to the medical control of diseases? Which of the three studied factors (right to health, economic interests and foreign policy in health) was the most influential in the history of access to medicines in those countries?
the case of disability and policy: using intersectionality theory to unpack the perceptions of health providers in Northern Uganda

Issue/objective: Uganda is considered a disability rights pioneer in sub-Saharan Africa. It adopted pro-disability legislation and policies to address issues of inclusion and human rights. Yet, little empirical evidence is available to understand the relationships between policy adoption and utilisation of health services by people with disabilities (PWD) in the country. Our research objective was to explore the perceptions of policy actors, including health providers, about the relationships between legislation and policy, and utilisation of sexual and reproductive health (SRH) by PWD.

Methodology/approach: We conducted 45 in-depth interviews with PWD, organisational representatives and decision-makers, nine focus groups with PWD and health providers, and non-participant observations of seven health facilities in the Northern region and capital of Uganda. Based on the interview data, we then developed a 2-day orientation training on disability-friendly health service provision for the senior and clinical staff of the health facilities. A disability researcher and five PWD co-conducted the training. Intersectionality was used as the analytical framework. We report on the analysis of structured participant observation and proceedings of the training.

Results: Five major themes emerged. 1) Most of the health providers were not cognizant of disability inclusion, policy content and accessibility standards. 2) Healthcare providers learned that they needed to be more humble to better meet PWD needs, and that PWD can be change-makers, role models and collaborators. 3) Providers also realised PWD were experiencing multiple structural and interpersonal access barriers when using SRH services. They reported being ashamed of their negative attitudes toward PWD. 4) To translate policy to action, disability inclusion must actively include both the community and health system actors and requires the establishment of specific policy implementation tools, such as the inclusion of disability budget lines. 5) Many healthcare providers and managers planned to bring back the acquired knowledge to their district and incorporate the learnings into their programme planning and monitor changes over time.

Discussion/conclusion: These findings shed light on the often invisible health service access inequalities experienced by PWD and crucial views of policy implementors, such as health providers. Using intersectional lens can promote the implementation of more disability-sensitive health services, through more continuing education of health providers and critical awareness-creation among decision-makers, for instance. Intersectionality also calls for more accountability from health providers and decision-makers alike, while encouraging more interactions between health providers and PWD and their associations and raising the issue of equitable healthcare access by vulnerable populations.

Co-Authors: Muriel Mac-Seing, Université de Montréal, Canada; Emmanuel Ochola, Lacor Hospital, Uganda; Martin Ogwang, Lacor Hospital, Uganda; Kate Zinszer, Université de Montréal, Canada; Christina Zarowsky, Université de Montréal, Canada
Maleko, Cécile, CCISD, Canada

Les barrières à l’accès et à l’utilisation des services de santé sexuelle et reproductive par les femmes dans la province de Kinshasa (RDC), une analyse socio-écologique

Les services de santé sexuelle et reproductive (SSSR) jouent un rôle essentiel pour les femmes, dans l’exercice du droit à la santé, notamment en favorisant leur libre choix au nombre d’enfants qu’elles désirent en temps voulu, ainsi que l’accès une maternité sans danger, et à une vie sexuelle saine, à l’abri du VIH et d’autres infections sexuellement transmissibles. En République démocratique du Congo (RDC), les femmes sont parmi les plus vulnérables au monde (128e sur 129 pays au classement de l’indice d’égalité de genre). La RDC fait partie des quatre pays avec la plus forte mortalité maternelle (846 décès maternels/100 000 naissances vivantes; 20% chez des adolescentes [15-19 ans]). La prévalence contraceptive est de 8,1% et les besoins non satisfaits sont estimés à 28%. L’accès et l’utilisation des SSSR de qualité, soutenus par une bonne gouvernance des acteurs de tous les niveaux, pourraient certainement améliorer la situation.

Cette étude visait à explorer les barrières rencontrées par les femmes et les adolescentes pour accéder aux SSSR dans la province de Kinshasa, en RDC.

Des entrevues semi-dirigées ont été menées et audio-enregistrées dans sept zones de santé de la province de Kinshasa (1er Mai - 31er Septembre 2018), auprès d’un échantillon de 112 femmes (incluant 54 adolescentes) issues de groupes et de milieux socio-économiques et communautaires divers. Une analyse thématique guidée par le modèle socio-écologique a été réalisée.

Des barrières ont été identifiées aux cinq niveaux de ce modèle. Au niveau individuel: l’absence de connaissances sur le rôle d’information des établissements et du personnel de santé, et le manque de responsabilisation/autonomisation des femmes dans la gestion de leur santé; au niveau interpersonnel: le manque de confiance envers le personnel de santé, qui ne respecte pas forcément la confidentialité, émet des jugements de valeur, et ne communique pas toujours adéquatement, notamment avec les adolescent.e.s; au niveau organisationnel: la qualité de l’accueil, notamment pour les personnes vulnérables, les horaires d’ouverture et la faible adaptation des services aux besoins sont les barrières les plus fréquemment évoquées; au niveau communautaire : la stigmatisation des adolescentes qui ont des rapports sexuels et le cas échéant, des grossesses; au niveau structurel: les ruptures de stocks en intrants, les contraintes financières, notamment l’accès aux mutuelles de santé.

L’étude avance donc que l’accès et l’utilisation des services de SSR sont influencés par divers facteurs, desquels il faut tenir compte via des stratégies multifactorielles, intersectorielles et intégrées.

Co-Authors: Sophie Bourdon, CCISD, Canada; Patrice Ngangue, CCISD, Canada; Geneviève Blouin, CCISD, Canada; Marie-Jeanne Tusey, CCISD, Democratic Republic of the Congo; Cécile Maleko, CCISD, Democratic Republic of the Congo
McKague, Kevin, Cape Breton University, Canada

Gender and health social enterprises in Africa

Issue: This oral presentation will report the findings from the first study to examine gender equality as it relates to social enterprises for maternal and child health in Africa. Although health social enterprises are expanding rapidly in Africa, gender issues are highly important but under-addressed. Our results are based on a major three-year CDN$500,000 study funded by the Canadian Institutes of Health Research, Global Affairs Canada and the International Development Research Centre.

Methodology: Our findings are based on 36 interviews and 21 focus group discussions with managers, community health workers and their spouses from multiple social enterprises working across Uganda and Kenya including BRAC Uganda, Access Afya, Healthy Entrepreneurs and LifeNet International. Findings are also informed by a Rapid Evidence Assessment literature review of 57 studies at the intersection of gender equality, CHWs and health social enterprises in Africa.

Results: Based on our data and analysis we developed a conceptual model of how gender influences health social enterprises, finding that important gender dynamics are at play in four areas: 1) between the social enterprise and the CHW, 2) between the CHW and their spouse/partner, 3) between the CHW and their patients and 4) between the patients and the social enterprise.

Analyzing the interactions between these four groupings of actors, findings demonstrate that gender can be integrated intentionally by social enterprises through four primary strategies: 1) equitable systems and structures, 2) gender responsive training, support and incentives, 3) appropriate partner involvement and 4) gender responsive sales, design and marketing of health products and services. Each of these four primary strategies includes a number of specific actionable activities that can help improve the lives of women and girls.

Discussion: There are a number of strategic actions that health social enterprises can take to simultaneously improve health outcomes while enhancing the gender equity of their employees, CHWs and patients. Emerging findings are solutions-oriented and relevant for social entrepreneurs and researchers working across the fields of gender equality, social entrepreneurship and maternal and child health in Africa.
Mekonnen, Wubegzier, School of Public Health, College of Health Sciences, Addis Ababa University, Ethiopia

Challenges and opportunities to capture cause of death in Ethiopia

Background: Since there is an infant civil registration and vital system (CRVS) in Ethiopia, most of the deaths have not been registered. Moreover, there is no procedure to identify causes for deaths happening at home without medical care attendance. The present study aimed at exploring challenges and opportunities on capturing cause of death data in Ethiopia.

Method: A qualitative study was conducted with purposefully selected 24 key informants. The key informants were individuals working in Federal Ministry of Health and Vital Event Registration Agency and Central Statistics Agency, referral and regional hospitals. In addition, informants from City Administration, regional Health Bureaus and District Vital Events Registration officers were interviewed.

Semi-structured interview guide was used to collect the data between August 6 and 4 September 2018. Verbatim transcribed data were coded and analyzed using ATLAS ti qualitative data analysis software and the findings of the study were presented thematically.

Result: The main system related challenges in the health and vital event registration sector includes problems related to leadership and management, lack of integration, coverage and access, lack of electronic recording system and resources, attention to service and awareness and absence of feedback Some of challenges related to service provision includes low value and perception related to vital event registration by lower level leadership, lack of awareness, workload, and lack of skilled human resources and data quality. At the community level awareness, cultural norm, service inaccessibility and long waiting time, unlinked death registration with social services could be cited as challenges. Also, opportunities for the system includes presence of CRVS bylaws, increased understanding of the health system on the value of data in its information revolution agenda, and the presence of well-established administrative structure to the lower level. Increasing education coverage, high concern for data quality and motivation to support the infant CRVS were some of the opportunities related to death registration service provision. Availability of social institutions in the community could be considered as opportunities to strengthen the death registration system

Conclusion: Cause of death registration and notification is a complex procedure which involve multilevel and multisector performers. Challenges and opportunities related to the system, service provision and community are extremely interconnected. Therefore, working on the challenges and using the existing opportunities along with persistent awareness creation and linking death registration with other social services need to be considered as a way forward.

Co-Authors: Wubegzier Mekonnen, School of Public Health, College of Health Sciences, Addis Ababa University, Ethiopia; Damen Hailemariam, School of Public Health, College of Health Sciences, Addis Ababa University, Ethiopia
Milot, David-Martin, Réseau francophone international pour la promotion de la santé (RÉFIPS), section des Amériques, Canada

Improving governance with integrated and intersectoral planning of health promotion actions in school health in Haiti

Enjeux/objectifs

Face au constat de chevauchements et manquements dans l’éventail de services de santé offerts à la population, et ce, dans un contexte de ressources limitées – le Ministère de la Santé Publique et de la Population (MSPP) d’Haïti a inclus, dans ses plans directeurs et politiques, le besoin de planifier de façon intégrée lesdits services entre ses directions centrales et avec ses partenaires intersectoriels. Cette orientation est particulièrement importante pour les actions en promotion de la santé afin de pouvoir agir plus optimalement sur les déterminants de la santé et sur l’équité en santé. L'objectif du projet est donc de développer, à l'aide d'un projet pilote, des mécanismes et des processus qui appuient un système de gouvernance intrasectoriel axé sur une planification intégrée entre les directions du MSPP et le renforcement de la collaboration intersectorielle favorisant une planification intégrée entre l’ensemble des acteurs concernés par un domaine d’action.

Approche

Vu la collaboration avérée entre la Direction de Promotion de la Santé et de Protection de l’Environnement (DPSPE) du MSPP et la Direction de santé scolaire (DSS) du Ministère de l’Éducation Nationale et de la Formation Professionnelle (MENFP) et le fait que ces deux partenaires identifiaient le besoin d’une planification intégrée en santé scolaire, il a été convenu de débuter par cette thématique. À partir de données colligées lors d’entretiens individuels puis discutées en ateliers, des mécanismes et des processus à mettre en place ont été identifiés pour parvenir à une planification opérationnelle intégrée à l’intérieur du MSPP, puis entre les ministères et partenaires concernés en santé scolaire. Ensuite, ceux-ci permettront d’améliorer l’efficience des actions dans d’autres domaines du Plan directeur du MSPP.

Résultats

Un état de situation a permis d’identifier divers facteurs facilitants, tels que des succès vécus en intersectorialité au sein du MENFP et la présence de leaders soutenant l’importance d’une planification intégrée basée sur les données probantes, et divers obstacles politiques, techniques et organisationnels, tels que le roulement des élus, l’absence d’une plateforme officialisée d’échanges et la planification en silos des activités découlant des modes d’intervention de plusieurs organismes subventionnaires. Des modèles organisationnels et un plan d'action ont été discutés et le processus d'identification de solutions est en cours.

Conclusion

Ce projet a requis une réflexion critique à plusieurs niveaux afin d’en optimiser les bénéfices. Il vise à agir au niveau de la culture organisationnelle et des pratiques du MSPP et de ses partenaires intersectoriels.

Co-Authors: David-Martin Milot, Université de Sherbrooke/Réseau francophone international pour la promotion de la santé (RÉFIPS, section des Amériques), Canada
Préférences et perceptions des adolescent.e.s sur les interventions en santé sexuelle et droits sexuels et reproductifs (SDSR) au Benin

Au Benin, les adolescentes (15-19 ans) constituent un groupe particulièrement vulnérable en matière de fécondité : 20% des adolescentes ont commencé leur vie reproductive, 15% ont eu une naissance vivante et 5% sont enceintes d’un premier enfant (EDS-V). La mise en place de services en SDSR de qualité, équitables, efficaces et adaptés aux besoins des adolescent.e.s est essentielle pour renverser la tendance. Cette étude visait à explorer les préférences et perceptions des adolescent.e.s sur les modes d’intervention en SDSR dans les régions du Mono et de l’Atlantique, au Bénin.

7 entretiens de groupe semi-dirigés ont été menés au Bénin (1er Mai -20 Août 2018) auprès d’un échantillon de 124 adolescent.e.s, répartis dans les zones rurales, semi-urbaines et urbaines. Une analyse thématique des données selon l’approche descriptive interprétative de Thorne a été conduite.

Les préférences et perceptions des adolescent.e.s béninois se déclinent en quatre groupes de stratégies.

Les stratégies basées sur les technologies de l’information: les adolescent.e.s utilisent les nouvelles technologies, applications et médias sociaux, comme sources d’information rapides et efficaces. Toutefois, ils déplorent la faible possibilité d’y poser des questions et soulèvent les inconvénients des coûts d’accès à Internet ainsi que le niveau d’alphabétisation/littératie nécessaire pour en profiter.

Les stratégies à base communautaire : les adolescent.e.s priorisent les interventions permettant de se regrouper. Les filles favorisent les tontines, les randonnées et les cuisines collectives. Les garçons mentionnent les matchs de soccer et les séances de thé. Autant les filles que les garçons sont friands de stratégies d’intervention incluant les loisirs passifs (projections de films, théâtres) et les loisirs interactifs (jeux).

Les stratégies au sein des structures de santé : pour être attractives, les interventions de SDSR en centre de santé devraient inclure une activité ludique (jeu de babyfoot) et se dérouler selon des horaires de services améliorés/adaptés.

Les stratégies de paire-éducation : les adolescent.e.s ont exprimé le besoin d’éviter de miser sur la famille ou l’entourage immédiat pour accéder à l’information en SDSR, afin d’éviter les risques de stigmatisation. La pertinence de tenir des séances de paires-éducation en contexte non mixte est réelle pour certains sujets.

Les résultats de l’étude mettent en exergue la nécessité de tenir compte des préférences et d’impliquer les adolescent.e.s dans le développement et la mise en place des interventions en SDSR les concernant.

Co-Authors: Sophie Bourdon, CCISD, Canada; Patrice Ngangue, CCISD, Canada; Camille Schoemaker-Marcotte, CCISD, Canada; Hortense Lokossou, CCISD, Benin;
Molakhail, Ahmadullah, UNFPA-Afghanistan, Afghanistan

ensuring equity for the essential RMNCAH services by midwives-led community health centers called family health houses (FHHs) in remote and hard-to-reach areas of Afghanistan through strategic partnerships – and involving of local authorities and commun

Issue/objective: 10-15% of the Afghan population lives in remote areas called “white areas” with no access to essential RMNCAH services. Access to RMNCAH services is further constrained by costs, few female health workers and cultural dictates. The purpose of the FHH Model, which is a community-based intervention is to increase access to quality essential RMNCAH services for every 1,500 – 3,000 catchment populations living in “white areas”. The project addresses the HR need for midwives.

Methodology/approach: The model was piloted from 2012-2018, and has five components: (a) coordination with local authorities, and communities-through PAPSL methodology in which unserved areas are identified, (b) 26-month community midwife education –through bonded scholarships for identified female students, (c) community engagement – to provide land, building materials and labor for FHH construction, (d) Provision of 24/7 RMNCAH services supported by home visits and referrals. (e) social mobilization-through health education/public awareness.

Results: 121 FFHs constructed and staffed with community midwives in “white areas” of four provinces increasing national health-care coverage by 15%- serving ~260,000 people. With annual operations cost of $6,500/year. Each FHH was constructed at US $5,000 with the community contributing 27% of the cost. In 6-years, no drop-out at midwifery school and only 0.0125% attrition rate of community midwives deployed in FHHs.

Female members in catchment areas are empowered and now move-out of their homes without seeking male permission. The community midwives as role models for girl-child, influencing girl child enrolment and retention in schools. Evidence shows that annually, there is an increase in uptake of RMNCAH services, with an average of 8,087 deliveries, and the same amount of neonatal care per year. Main lesson learned: Strategic partnerships—developing projects/programmes that are community-based, and community-led involving local authorities and communities in decision process for the project has increased community acceptance and support for the project. Collaboration between community leaders, and FHH midwives permitted “learning by doing” —adjustments of the plan according to new evidence, and community advice.

Discussion/conclusion: FHH Model offers an opportunity to increase equity in access to RMNCAH services in Afghanistan. Its community acceptance and linkage with the public health system for referral, and reporting offers opportunities for integration into a government-led health service delivery strategy called BPHS. Its planned expansion into five additional provinces--through funding from GAC and its replication throughout the country will ensure the sustainability of the concept, and ensure UHC, Leave-No-one-Behind, and the Furthest the First-the principles of SDG.
**Moroz, Nicholas, University of Toronto, World Health Organization Collaborating Centre for Governance, Accountability and Transparency in the Pharmaceutical Sector, Canada**

**An exploratory study: Assessment of national governance of promotion and advertising of medicines in Brazil**

Objective: The rational promotion of medicines is of great importance, as inappropriate promotion of medicines contributes to health problems globally. This study explored the national governance of medicines promotion in Brazil, aiming to identify any gaps or risks for inappropriate promotion of medicines, including promotion that is misleading or breaching regulations. In the past decade, Brazil has experienced political crises and high-profile cases of corruption, while its pharmaceutical industry remains the largest in Latin America. With this in mind, this paper explores the governance of medicines promotion to determine if measures are in place to limit inappropriate promotion.

Methodology: This study used a set of structured indicators to compile publicly available documents to provide evidence for governance of medicines promotion. Two existing tools were adapted to create a single hybrid tool. This resulted in a set of 66 indicators (64 positive and two indices), grouped by six categories. This hybrid tool was used to identify public documents and establish if evidence of governance to satisfy each indicator was available. Following the use of indicators to compile laws, regulations, and codes to determine evidence of governance, a rapid review of the literature on medicines promotion in Brazil was conducted.

Results: Brazil met 54 of 64 positive indicators, signalling that Brazil may be meeting governance expectations. The research identified key policies governing medications, including the existence of a national medicines policy, an essential medicines list, a national health surveillance agency, and codes of conduct specific to regulating the promotion of medicines. However, Brazil ranked 105th out of 180 countries on the Corruption Perceptions Index (2018) and breaches of legislation were identified. The rapid review identified 13 articles that described violations of pharmaceutical promotion/advertising regulations, spanning 10 years.

Conclusion: Brazil has national legislation, regulations, and institutions, meeting the majority of the structured indicators used to compile evidence of medicines promotion governance. However, cases of corruption were identified, and it appears that many pharmaceutical advertisements in Brazil have not been fully compliant with regulations over the last 10 years, suggesting problems with policy implementation and enforcement. This study contributes to global health by exploring national medicines governance in Brazil, which could be replicated in other countries. This research directly relates to the theme of Governance for Global Health: Power, politics, and justice, and to Sub-theme (2.), Accountability, transparency and mechanisms for governance, by focusing on regulations for increased healthcare transparency in Brazil.

Co-Authors: Nicholas Moroz, University of Toronto, World Health Organization Collaborating Centre for Governance, Accountability and Transparency in the Pharmaceutical Sector, Canada; Marvin Chang, University of Toronto, Canada; Jillian Kohler, Leslie Dan Faculty of Pharmacy, University of Toronto, Canada
Mumtaz, Zubia, University of Alberta, Canada

Sweepers providing childbirth care in health facilities: a sign of a fragile health care system?

Issue: Contemporary discourse on health system strengthening centers on building and measuring resilience. It recognizes that the foundations of a resilient health system are strong leadership and a well-trained, committed workforce. One sphere where this need is becoming evident is the human-resource challenge of providing high-quality maternity care in resource-poor settings following the recent surge in demand for facility-births. The skilled birth attendant literature has tended to focus on improving provider performance, motivation and supervision. The present study sought to provide deeper insight in the role of the health workforce on the resilience of the health system, and contribute to the development of indicators to measure it.

Methods: We conducted a six-month institutional ethnography in two government Rural Health Centers, one District Hospital and three private practices in rural Pakistan. We observed facility functioning, 69 patient-provider interactions, and 24 births. We conducted interviews with 18 women postpartum, 25 providers, 5 managers, and 67 villagers. A theory-driven analysis focused on the role of providers in delivering quality care.

Results: Despite the availability of women physicians, nurses, and midwives, most births in our study facilities were attended by female sweepers, ostensibly employed to clean the premises. We observed sweepers conducting vaginal examinations with dirty, ungloved hands, attending births during which they applied violent fundal pressure, making two episiotomy cuts and forcing patients’ legs apart to hasten birth. This poor quality care by untrained sweepers negated the basic premise of facility-based safe childbirth. More importantly, they were often the de-facto key birth attendants, aggressively competing with existing skilled providers. They openly defied the authority of women physicians, who are ostensibly the team leaders. It is worth noting that the sweepers were, without exception, members of the Kammi caste, a chronically poor, marginalized group that is socially constructed to perform menial tasks.

Discussion: The fact that unauthorized, untrained members of a socially marginalized group had managed to create a space for themselves in the government’s health facilities to successfully provide poor quality maternity care, is we argue, a sign of a fragile health care system. It is both a reflection of weak leadership and an uncommitted trained workforce. There is a need to develop strategies to support the trained workforce and address the underlying reasons for the lack of health worker commitment. Simultaneously, there is a need to change the structures of employment that provide sanitary workers power over highly trained health care providers.
Murphy, Kathleen, University of Toronto, Joint Centre for Bioethics, Canada

AI for all? The ethics of artificial intelligence in global health

Issue/Objective: Artificial intelligence (AI) has been described as the “fourth industrial revolution” with transformative and global implications, including within healthcare, public health, and global health. AI technologies are enhancing diagnostic support, disease surveillance, gene editing, and more, highlighting its promise for improving individual and population health outcomes. While the Sustainable Development Goals are founded on values of equity, inclusion, and global solidarity, the advent of AI could, however, exacerbate existing health inequities, both within and between countries. There is currently a dearth of research at the intersection of ethics, AI, and global health, yet gaining clarity on the ethical implications of AI within global health, and on the role of global health governance in mitigating ethical challenges, is critically important if we wish to leave no one behind. To address this research gap, we conducted a scoping review to better understand what ethical issues have been identified in relation to the application of AI within health, from a global health perspective.

Methodology: Eight electronic databases were searched for peer reviewed literature using the overarching concepts of health, ethics, and AI, and related terms, following which a search of the grey literature was conducted between April and September 2018. Identified records were independently screened by two reviewers based on the inclusion criteria that (1) records reported on AI in direct relation to ethics and health, and (2) were written in English. Data was charted on a piloted data abstraction form, and analyzed using an inductive, thematic analysis.

Results: Upon reviewing 12,722 articles from the academic and grey literatures, 103 met the predetermined inclusion criteria. The major ethical themes of privacy, trust, accountability, and bias were identified from the literature, with a significant focus on the ethics of AI in robotics, diagnostics, and precision medicine. Largely missing from the reviewed literature was attention to the ethics of AI in public health and global health, particularly in the context of low- and middle-income countries (LMICs), as was a collectively agreed upon model of global governance.

Discussion/Conclusion: The dearth of literature on the ethics of AI within LMICs and public health, points to a critical need to devote further research into the ethical implications of AI within both global and public health. So too does it indicate the necessity for good governance and accountability mechanisms for mitigating these ethical challenges, to ensure the development and implementation of AI is ethical for everyone, everywhere.

Co-Authors: Kathleen Murphy, University of Toronto, Joint Centre for Bioethics, Canada
Mwaikambo, Magdalena, Agreteam health Tanzania, United Republic of Tanzania

Institutionalizing effective supportive supervision practice in district health systems in Mwanza region, Tanzania

Issue:
In Tanzania, many MNCH projects emphasize improving clinical practice within health facilities, with less emphasis on interventions at the district health system level. Yet, for primary health care systems to deliver equitable health services to all, continuous support to improve accountability and performance is required. Supportive supervision is an important accountability mechanism for managers to monitor and provide technical support to facilities. However, adoption of truly supportive supervision practices has been inconsistent because they conflict with the top-down and directive management approach commonly applied within the health system.

The GAC-funded Mama na Mtoto project in Mwanza Region, Tanzania, strengthens district supervision through a combination of training, mentoring, modeling and on-the-job coaching approaches to build hands-on skills, change attitudes and practices, address accountability and institutionalize best practice within the district management team. This relationship-based approach has yielded positive results in a low-resource context.

Methodology:
The project facilitated joint supervision visits, feedback and reflection sessions with two district health management teams using the national supportive supervision guideline. Through these sessions, the management teams identified performance challenges including poor relationships between supervisor and facility teams, interpersonal skills, conflict resolution, effective planning, and accountability. Continued coaching was provided to address relationship skills and consolidate new skills and approaches.

We implemented a qualitative study to assess the effectiveness of this supportive supervision capacity-building approach. Purposive sampling was used to select facilities for interview, using key informant and focus group discussions.

Results:
District managers reported that the supportive approach to supervision enables them to listen and solve problems more effectively, and reduces workload in monitoring facility performance. Mentoring and modeling helped them to put the supervision guidelines into practice more effectively than training alone. Health facility staff reported that after project interventions, supportive supervision visits have improved; visits often help to recognize and motivate staff, reinforce clinical trainings and best practice, and increase accountability. When supervision is supportive rather than punitive, staff are empowered to share challenges, ask for support, and develop accountability systems to address their own challenges.

Discussion:
Supportive supervision is a critical tool for ensuring good clinical practice and effective facility management. However, these skills are difficult to apply based on training only. The project approach combining training with on-the-job mentoring, coaching, modeling, and reflection has helped district management teams to consolidate and institutionalize more effective practices as per national guidelines. These new practices are feasible and sustainable within a resource-constrained setting.

Co-Authors: Magdalena Mwaikambo, Agreteam health Tanzania, United Republic of Tanzania; Erica Stillo, Agriteam Health Canada, Canada; Tanya Salewski, Agriteam health Canada, Canada
Mwamba, Dieudonné, Université de Montréal, Canada

facteurs explicatifs du manque de contrôle de la dixième épidémie de la maladie à virus Ebola en République démocratique du Congo

Facteurs explicatifs du manque de contrôle de la dixième épidémie de la maladie à virus Ebola en République Démocratique du Congo

Contexte

Contrairement aux 9 précédentes épidémies de la Maladie à Virus Ebola (MVE) en République Démocratique du Congo (RDC) qui avaient été toutes contrôlées dans les trois mois, l’épidémie actuelle au Nord Kivu et en Ituri, déclarée depuis le mois d’Août 2018, reste non maîtrisée 10 mois après en dépit d’importantes ressources humaines, financières et logistiques mobilisées. La RDC demeure de ce fait, sous la menace d’une urgence de santé publique de portée internationale. C’est ainsi que Le Président de la République a décidé de mettre sur pied un groupe d’experts nationaux devant faire un état de lieux sur la gestion de l’épidémie.

Objectif

L’étude avait pour objectif d’évaluer la gestion de l’épidémie de la MVE en cours afin de proposer les voies et moyens pour y mettre fin.

Méthodes

La méthodologie de l’étude a consisté en l’observation participante, la revue documentaire, les entretiens semi structurés avec les différentes parties prenantes et l’évaluation des indicateurs de la riposte.

Résultats

Ce qui a marché :

(i) Cette riposte a bénéficié d’une attention particulière des autorités politiques nationales et des partenaires techniques et financiers avec l’utilisation des innovations en termes de diagnostic, de traitement, de nutrition et de vaccination.

Ce qui n’a pas marché :

(i) La gestion de l’épidémie est hyper centralisée au niveau du cabinet du ministre de la santé, entrainant ainsi une faible gouvernance et un déficit de leadership.

(ii) Les dépenses ostentatoires qualifiées de riposte arrogante (d’Ebola business) par la population.

(iii) La gestion de l’épidémie se fait en dehors du système de santé existant, sans l’implication de la société civile, ni des communautés locales et sans tenir compte du contexte socioculturel. En plus la gestion financière est non coordonnée, donc peu rationnelle.

Tout ceci a comme principale conséquence la méfiance et l’agressivité de la population contre toute initiative de la riposte.

Conclusion

Au terme de cette évaluation, il a recommandé : (i) la création d’un comité national multisectoriel de coordination placé au plus haut niveau de l’État pour renforcer la gouvernance et le leadership national étant donné que l’épidémie dépasse le cadre du seul ministère de la santé ; (ii) le renforcement de l’engagement communautaire en impliquant davantage les communautés locales (iii) l’ancrage des activités de riposte dans le système de santé existant.
Mweteni, Wema, Bugando Medical Centre, United Republic of Tanzania

Adolescent vulnerability in the health system, rural Tanzania

Background

The health systems worldwide are faced with an increasing challenge of providing reproductive, maternal, newborn and child services (RMNCH) to more younger women aged between 15-19 years. Tanzania has a 17th highest adolescent fertility rate in Africa. According to Tanzania Demographics Health Survey (TDHS) there is an increasing trend in adolescent pregnancies from 23% to 27% from 2010 to 2015-16 respectively. A well-managed health system achieves more accessible, equitable and sustained improvements and health outcomes for maternal, newborn and child services among others. The health system is not well suited to handle adolescents’ unique biological and socio-cultural characteristics hence make adolescent more vulnerable while accessing RMNCH services.

Objective: This study aimed to explore adolescent vulnerability in the health system that become barriers to accessing MNCH services in Misungwi district, rural Tanzania.

Methodology: Using a socioecological framework, we conducted 22 In-depth Interviews (IDI) in 2018 with adolescent women who were pregnant or parenting a child under five years old to explore adolescents’ barriers to accessing RMNCH services in Misungwi District and nine Key Informant Interviews (KII) with health care providers. We conducted Eight focus group Discussions (FGDs) involving young husbands, elder men and women. We used purposive sampling to recruit participants for IDIs, KIIs and FGDs. All Interviews were audiotaped, transcribed, translated and analyzed thematically.

Findings

We identified 3 main themes: Difficulty entry to the health system (Adolescents delay or denied services due to the absence of partner, Failure to afford ANC and delivery service cost, Use of abusive language); limited ability to provide quality services to adolescents at the health facilities (Unfavorable environment to provide RMNCH services to adolescents, Inadequate medical equipment and supplies at Health facility); Inadequate provision of RMNCH services health education relevant to adolescents.

Conclusion

To improve MNCH services provision to adolescent women there should be an easy entry environment to the health system to mitigate adolescent vulnerability that they already have. The health system needs to strengthen adolescent friendly policies, guidelines and protocols, adolescent friendly facilities that offer safe environment, privacy and information, and train health care providers on adolescent friendly services.

Co-Authors: Wema Mweteni, Bugando Medical Centre, United Republic of Tanzania; Girles Shabani, Catholic University of Health and Allied Sciences, United Republic of Tanzania
Nobrega, Raphael, University of Waterloo, Canada

Air quality monitoring platform using data mining, big data, and machine learning

Issue: The WHO stated that exposure to outdoor air pollution is responsible for 4.2 million premature deaths every year. Studies have shown that exposure to increasing levels of air pollution is related to infant mortality as a result of respiratory deaths in the postnatal period, linked to low birth weight, premature births, and intrauterine growth retardation. Also, air pollution is addressed to cardiovascular diseases, childhood asthma and atopic dermatitis. The number of remote sensors collecting air pollution data 24/7 at high velocity has contributed to the increasing volume of data and literature available using this data to understand the impact of air pollution on human health. At the same time, these sensors can collect a variety of data types due to the complex mixture of airborne pollutants. Although traditional epidemiological or environmental health models to analyze these types of data have been used for decades, the increasing amount and complexities of the data require new methods for data analysis. The authors emphasize that prediction-based or knowledge discovery methods present in data mining algorithms and machine learning can help epidemiologists, scientists and governments better understand the data.

Approach: Develop a platform capable of collecting particulate matter, CO2 and air quality index data from different air quality units, as well as non-sensors data, such as hospital admissions. This approach will focus on aggregating data and generating a unique, informative and synthetic new raw data sources that will be used for future analysis. The platform will be developed using data fusion, a process recommended for IoT solution that aggregates heterogeneous data from different data sources and generating new raw data for further analyzes. Additionally, data mining algorithms and machine learning will be applied to hypotheses generation, prediction and forecasting.

Results: The platform will be used for knowledge management and knowledge exchange of air pollution monitoring, and maternal and child health data. This platform will allow healthcare practitioners to access up to date and reliable data, which will provide the knowledge they need to deal with the short, medium and long term public health consequences of air pollution.

Discussion: Overall, the platform will provide state-of-the-art data and information that will enhance the understanding of the effects of air pollution on maternal and child health. This additional knowledge can motivate the creation of policies, practices and innovations to reduce the health risks related to air pollution and improve maternal and child health outcomes.

Co-Authors: Raphael Nobrega, University of Waterloo, Canada; Nadia Somani, University of Waterloo, Canada; Plinio Morita, University of Waterloo, Canada
Nsangi, Allen, Makerere University College of Health Sciences, Uganda

Effects of the Informed Health Choices primary school intervention on the ability of children in Uganda to assess the reliability of claims about treatment effects, a cluster-randomised trial

Background

Claims about what improves or harms our health are ubiquitous. People need to be able to assess the reliability of these claims. We aimed to evaluate an intervention designed to teach primary school children to assess claims about the effects of treatments (ie, any action intended to maintain or improve health).

Methods

In this cluster-randomised controlled trial, we included primary schools in the central region of Uganda that taught year-5 children (aged 10–12 years). We randomly allocated a representative sample of eligible schools to either an intervention or control group. Intervention schools received the Informed Health Choices primary school resources (textbooks, exercise books, and a teachers’ guide). Teachers attended a 2 day introductory workshop and gave nine 80 min lessons during one school term. The lessons addressed 12 concepts essential to assessing claims about treatment effects and making informed health choices. We did not intervene in the control schools. The primary outcome, measured at the end of the school term, was the mean score on a test with two multiple-choice questions for each of the 12 concepts and the proportion of children with passing scores on the same test. This trial is registered with the Pan African Clinical Trial Registry, number PACTR201606001679337.

Findings

Between April 11, 2016, and June 8, 2016, 2960 schools were assessed for eligibility; 2029 were eligible, and a random sample of 170 were invited to recruitment meetings. After recruitment meetings, 120 eligible schools consented and were randomly assigned to either the intervention group (n=60, 76 teachers and 6383 children) or control group (n=60, 67 teachers and 4430 children). The mean score in the multiple-choice test for the intervention schools was 62·4% (SD 18·8) compared with 43·1% (15·2) for the control schools (adjusted mean difference 20·0%, 95% CI 17·3–22·7; p<0·00001). In the intervention schools, 3967 (69%) of 5753 children achieved a predetermined passing score (≥13 of 24 correct answers) compared with 1186 (27%) of 4430 children in the control schools (adjusted difference 50%, 95% CI 44–55).

Interpretation

The results show that it is possible to teach primary school children to think critically in schools with large student to teacher ratios and few resources. Future studies should address how to scale up use of the resources, long-term effects, including effects on actual health choices, transferability to other countries, and how to build on this programme with additional primary and secondary school learning resources.

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31226-6/fulltext
Women as protagonists of maternal health: experience of community women identifying and solving their health problems in Northern Uganda

Issue: An alarming number of mothers and children still suffer and die from life threatening but preventable conditions related to pregnancy and childbirth, albeit multiple efforts for maternal and child health. In Uganda, the high maternal mortality ratio of 336 deaths per 100,000 women requires interventions at policy, health facility, and community levels for better outcomes. The Mother Child Health Lacor South Sudan (MoCHELaSS) project aimed to improve maternal health by engaging women groups in communities to identify and improve their health problems using a participatory action learning cycles. This report highlights some problems that women chose to solve and how they went about solving them.

Approach: In January 2018, twelve existing women money savings groups in Gulu, Amuru and Nwoya districts of Northern Uganda were selected and their leaders trained on group facilitation, as well as a phased multiple step process of maternal and problem identification, prioritization, root cause analysis, solution generation and community engagement for implementation. They thereafter started implementing these participatory meeting cycles.

Results: Some of the key health problems identified by the women groups included poor access to health care services, prevalent teenage pregnancies, malaria in pregnancy, poor child spacing, unskilled deliveries, lack of transport to health facilities, bleeding in pregnancy or at birth, and HIV. Underlying poor support from spouses was noted, as well as high rates of poverty. One women’s group in Amuru district engaged the community and constructed a simple bridge to cross the river which would usually floods blocking passage to health facilities. Another group targeting teenage pregnancy are seeking out teenage pregnant girls or mothers, sensitizing them and linking them to livelihood programs. Many groups are doing community sensitization and education, with innovative drama on various health problems. Many groups have engaged subcounty leaderships, health facilities, and local non-governmental organisations to support measures that they have initiated like water source cleaning, clearing of roads.

Conclusion: Women in groups are able to identify their health problems and take action with available resources in the community, when empowered to do so. Community perceived health problems may not be diagnostic group related, and health workers should become responsive to them. Communities are capable to engage high levels of leadership and partners for health. Embedded community members are better health mobilisers.

Co-Authors: Emmanuel Ochola, St. Mary's Hospital Lacor, Uganda; Loubna Belaid, McGill University, Canada; Pontius Bayo, Torit State Hospital, South Sudan; George Alii, St. Mary's Hospital Lacor, Uganda; Christina Zarowsky, Montreal University, Uganda; Gasthony Alobo, St. Mary's Hospital Lacor, Uganda; Elijo Omoro, Tahir Torit State Ministry of Health, South Sudan
Olufemi, Olusola, Society for Good Health, Sustainable Development and Environmental Awareness, Nigeria

“no place to pee or poo”: gendered indignities and health corollaries of open toileting in Nigeria

Issue/Problem: Globally, approximately 2.3 billion people lack access to basic sanitation, unshared household facilities that hygienically separate human excreta from human contact (UNICEF, 2017). Of these, 892 million people lack access to any sanitation and practice open defecation (UNICEF, 2017). Poor or non-existent sanitation facilities faecal pathogen exposure, which is associated with multiple infectious disease outcomes, including diarrhoea, soil-transmitted helminth infection, trachoma and schistosomiasis (Prüss-Üstün et al, 2008; Guerrant et al, 2013). Nigeria is an under-toileted country with a high prevalence of open urination and defecation. About 46 million people still practice open defecation, using open fields, forests, bushes and bodies of water as convenience in Nigeria and the country has been ranked third in the world among countries (This Day, 2018). Whether off-street or on-street, or private, toilets are inaccessible, of poor quality or non-existent.

Objective: The differential toilet and sanitary insecurities, needs, requirements and lived experiences of both men and women are examined in this paper. The pervasiveness of open toileting practices (open urination/defecation) when nature calls is discussed using lived experiences of women. The toilet needs of women for urination, defecation, menstruation and child birth is very important. Women go through agonising efforts and indignities to access toilet facilities that are clean, safe and waterised in the public and private spheres.

Methodology: This paper adopts a qualitative approach using stories and lived experiences of women and men obtained through formal interviews. An ecological perspective and advocacy planning theory was adopted to understand the indignities (health, social and environmental) and inequities associated with open toileting (toilet and sanitary insecurities).

Lessons Learned: Access to clean, safe, usable toilet and sanitary facilities is both a practical (survival, health, immediate) and strategic (intentional, policies) gender interest. Multi-level forms of governance that emphasizes inclusionary argumentation (participatory approach) that combines both hard (physical) and soft (lived experiences) and the rights of women and men to safe, clean and accessible toilets is germane to the achievement of 2030 Urban Agenda.

Conclusion: A health-centric lens that promotes behavioural change, advocacy, engagement, and land use regulations that enforce designing healthy toileting spaces should be mainstreamed into planning and health policies. This would minimise continuing exposure to vector-borne diseases, odour and indignities experienced and could be achieved through public-private partnership in provision of clean, safe and accessible toilets.

Co-Authors: Olusola Olufemi, Society for Good Health, Sustainable Development and Environmental Awareness, Nigeria; Oluwasayo Olatunde, Dalhousie University, Canada
Panday, Sarita, Stanford University, Nepal

The use of participatory research approaches to understand and mitigate health impact after disasters among grass-roots level populations in Nepal

Issue/objective: Poor governance remains a key issue in the effective delivery of healthcare services during disasters in Nepal. In 2015, when two massive earthquakes struck Nepal, more than 9000 people were killed and around 22,000 were injured, with severe damage to populations in rural regions compared to urban areas of Kathmandu valley. We seek to bring grassroots level voices from rural Nepal to understand their perceptions of health risks during disasters, and compare those views with the members of governing bodies, such as health policymakers, health managers, non-governmental workers at different levels of governance.

Methodology/approach: Working in partnership with the local organisation PHASE Nepal, we conducted a community–based participatory study followed by policy workshops in 2018. Data were collected using participatory videos, focus group discussions and key informant interviews. We facilitated a 10-day participatory video project in each of the three rural villages of Nepal – Hagam and Jalbire in Sindhupalchok District, and Kerauja in Gorkha District. Eight community participants in Hagam and Jalbire and nine in Keraunja were trained to make short videos (5-10 minutes) focused on issues of disaster and their impact on health. The community participants first screened the videos at their communities followed by Districts, Center and Provinces, all of which involved participatory workshops.

Results: Our participatory research project provided opportunities for people at grass-roots level to understand and advocate about risks and its impact on health. The participatory policy workshops created a dialogue between grassroots population and various governing bodies (health, education, women welfare groups), who had not had that chance before. We noted a huge disconnect in understanding of health risks among members of grass-roots level and policymakers. Communication gap across different layers of governance was noted, when the workshop participants questioned the governing authorities for their inability to take actions in villages and demanded accountability from them.

Discussion/Conclusions: Participatory research is more likely to benefit populations at grass-roots level through increased understanding of disasters and their impact on population health. The participatory process is useful to initiate a dialogue between the members of grass-roots level and the members of governing bodies, and the later groups are more likely to work to address the health needs of the former. Yet, success of participatory research relies on involving local partners and relevant stakeholders from early stage of research with inclusion of governance from local through central.
Plamondon, Katrina, University of British Columbia & Interior Health, Canada

Combining global health governance, integrated knowledge translation, and power analysis to advance better responses to persistent health inequities

Issue/Objective: Global health inequities are caused by the maldistribution of power, resources, and money within and between countries. Despite readily available evidence and plausible policy solutions, meaningful action remains elusive and embroiled in power structures designed to maintain paternalistic and colonial systems that unfairly distribute power and resources. In this presentation, we highlight results of dialogue about how our respective global health fields, integrated knowledge translation (IKT) and global health governance (GHG), are engaging in health equity action.

Methodology/Approach: This study involved critically reflective inquiry informed by Freire & Shor’s dialogic table. As one among a series of dialogues with experts in IKT, health equity, and ethics, this particular ‘table of dialogue’ brought the results of three literature reviews to a between two women immersed in the field of health equity. Drawing on feminist, relational, and critical pedagogy, we used critically reflective questions to examine findings in the context of our practice experience and leadership in global health.

Results: Reviews of the theoretical and scientific literature the fields of IKT and GHG identified complementary strengths and limitations in these fields. IKT models were found to lack consideration of issues of power, providing little direction for how to support cohesive efforts toward a common goal. GHG literature and processes were found to lack attention to evidence, creating spheres politically-driven governance. Yet, emerging evidence about the benefits of IKT highlights approaches and strategies that can guide collaborative processes of generating, refining, and applying knowledge. In both fields, we found a critical need for re-examining roles, responsibilities, power, and voice in processes of connecting knowledge with action. We identified shared experiences of desire to find ways to overcome barriers to meaningful health equity action. And we shared disappointment with frequent incongruency in our field, where we found equity intentions articulated alongside distinctly inequitable action. Leaning into an optimistic resistance and considerations of complexity and power, our dialogue examined the strengths (and limitations) of IKT and GHG. We challenged tendencies toward reductionism and propose strategies for creating equity- and evidence-informed processes that blend IKT with GHG.

Discussion/Conclusion: Bringing governance into IKT science, theory, and models could strengthen leadership for health equity action. Health equity action, whether pursued through IKT or GHG, requires reimagining of how policy arenas work through the complex decision making processes that determine contexts of power, resource, and wealth distribution.

Co-Authors: Katrina Plamondon, University of British Columbia & Interior Health, Canada; Julia Pemberton, McMaster University, Canada
Popoola, Oyindamola, International Development Research Centre, Canada

**Engagement between academia and medical professionals in the health and nutrition field and corporate actors in the food and beverage industry**

Ethical dilemmas are a judgment call, but when this call has the potential to affect the health outcomes of large population groups, it is pivotal that such decisions are made in the interest of the greater good. These dilemmas are faced by researchers and medical professionals in the health and nutrition field, especially as diet and nutrition are important determinants of Non-Communicable Diseases (NCDs).

However, resource constraints, as well as the mandate for multi-stakeholders and public-private partnerships in Sustainable Development Goal (SDG) 17, demands the diversification of funding for research and programs on NCD Prevention and Control, especially in resource-poor settings. This therefore raises the need to understand the challenges and proffer viable solutions to conflicts of interest that arise when actors in the commercial sector and experts in health and nutrition engage. Some of these challenges include; the plague of resource limitation and unclear ethical boundaries exacerbated by the lax policy environment in low and middle-income countries. This research therefore, focuses on how medical experts in the health and nutrition field in Nigeria can ethically interact with corporate actors in the food and beverage industry. It also examines how these ethical dilemmas may be addressed, managed and/or mitigated under alternative scenarios to tackle nutrition-related chronic diseases and health challenges.

This research explores these issues by executing a literature review, analyzing the principles and code of conduct that guide these experts in Nigeria. It also seeks their opinions and experiences on their engagement with corporate actors in the food and beverage industry; in their capacity as professionals working in either the primary, secondary or tertiary health institutions in Nigeria. Expected results of this research will show specific factors these professionals consider when deciding to engage with the commercial sector. It will also highlight strategies that can be used to minimize, manage or eliminate the ethical issues that may arise in these engagements, and the opportunities that exist as well. This research contributes to the body of knowledge on issues of ethics, governance and conflict of interest in health and nutrition, as the commercial sector is a major stakeholder in the prevention and control of NCDs.
Punjani, Neelam, University of Alberta, Canada

CREATE: A Cascade Training Approach to Enhance Peoples’ Knowledge, Attitude, and Practice to Address Sexual and Reproductive Health and Rights Issues: Train the Trainers

Background

Sexual and reproductive health (SRH) awareness in the Pakistani context is a challenging notion as it is an extremely sensitive topic. In Pakistan, adolescents make up 29% of its total population. However, the subject of human sexuality is considered a societal taboo and remain unaddressed. Purpose

The aim of this project was to enhance the knowledge, attitude, and practice of the trainers to address SRHR issues and to enhance the knowledge and positive experiences of the community while addressing the SRHR issues through advocacy.

Methodology

30 healthcare providers, teachers, and community workers were recruited and trained to provide sexual health education to communities. The three-day training was conducted through a cascade training approach titled as CREATE (Clarify, Reflect, Examine, Aim, Transfer, Evaluate). Pre-test and post-test were conducted to assess change in the knowledge level of participants. Attitude and practice of the youth participants were assessed through an observational audit of the replicated modules. Moreover, focus group discussion was conducted with the two group of at least 5-6 trainers after one replication of the training in the community.

Results

69% were female and 31% were male. 11 participants were health care professionals, 10 were school teachers, and 8 were social workers. All the participants who attended the training showed a significant increase in knowledge level including health care professionals, teachers, and social workers. With the effective mentorship, 86% of the CREATE participants replicated the training modules in different communities i.e., out of 29 participants 25 replicated the modules. These replications were observed by the facilitators and in total 21 replications happened in just two months. Approximately, 800 community people were benefited by the training modules. However, the master trainers of CREATE project conducted hundreds of more independent replications in which approximately more than 5000 participants were benefited.

Conclusion

CREATE trainers have gained knowledge and achieved a comfort level in addressing SRHR matters after attaining the training regardless of their professional expertise. Through CREATE project the community people gain language skills related to sensitive issues, build positive relations with their children, and enhanced comfort in initiating the conversation on SRHR.

Co-Authors: Neelam Punjabi, University of Alberta, Pakistan; Nausheen Salim, University of Manitoba, Canada
Universal health coverage meets the localization agenda: Partnering with communities to increase access to health.

Background

The decision by United Nations Members states to try and achieve Universal Health Coverage (UHC), the idea that everyone, everywhere should have access to essential health services whenever they need it, without facing financial hardship by 2030, invites us to explore how UHC impacts people’s health, both in Canada and abroad.

This symposium will look at UHC from the humanitarian lens, particularly how local actors within marginalized and underserved populations can appropriately position themselves as credible, reliable and effective implementers, and how the ways resources are allocated, and partnerships are formed will position to better meet their health needs. This intersection of UHC and the localization agenda will also apply an intersectional analysis that examines how gender, ethnicity and geography shape the role of power and the inequalities in health care systems related to access.

Main Messages

- Marginalized populations often have different access to health care and may receive different treatment from healthcare professionals, resulting in unwanted barriers to access. Understanding these power dynamics is essential to ensuring equal access and universal health coverage for all.

- Universal health coverage in vulnerable and often contexts a deeper understanding of gender and power-based dynamics shaping the experiences of these communities which affect the ability to access and build health systems for all within these communities.

- It is important to realize that different societies and cultures have different way to assess risk including in health and that there must be minimum standard of care provided, so there is no discrimination - however, it’s also important to let communities and individuals decide for themselves.
Raphael Oujowgah, Cheabum, Effective Basic Services (eBASE) Africa, Cameroon

Community Participation and Voice for Decision Making in Healthcare in Conflict Settings: Experiences with Facilitating Research, Practice and Policy in Cameroon

Participation and voice play a key role in health governance and promotes equity. In Africa, health systems ensure community participation through community health workers (CHWs) grassroots mobilization. Because health systems are unable to pull all health data through the DHIS2 data due to its limitation to health facilities, equitable data representation is compromised due to the inability of poorer segments of community to access health facilities. Trustworthy data is needed for reliable decision making at local and global level.

We trained CHWs on collecting qualitative data for poor DHIS2 health outcomes data in the 9 health areas in the district of Bali where a project with the university of Ottawa funded by Grand Challenges Canada, GAVI-WHO-UNICEF immunization programs, Ministry of health HIV and TB programs, were being implemented. Qualitative interviews focused on SDG related indicators on underserved populations including women, children, people with disability and indigenous populations. A set of tested open-ended questions was posed to households around key diseases of high burden including malaria, TB, HIV, and maternal mortality. We used MaxAPP to collect interviews and Magpi to collect GPS locations and time. We used an innovative approach to process DHIS2 data, evidence on what works, and CHWs qualitative data to guide decision making at district level to improve health outcomes and increase equity in service provision and access. Conflict poses a challenge to data collection for measuring global health indicators and outcomes, however working with CHWs who live within same communities increases systematization, ownership and reduces physical exposure to harm for development agencies staff.

We report on an innovative approach for community mobilization for evidence-informed decision making (EIDM). We report an increase of 40% (R: 15-98%) in data completeness for health programs and a 12 days reduction in district data promptitude. Mean 2.8 new evidence-informed decisions per quarter between January 2017 and March 2019. 6 (sexual and gender-based violence, family planning, malaria, waste disposal, access to energy for women and indigenous groups, and medical abortions) 3-Dimensional Qualitative data complemented with existing evidence from the evidence ecosystem (Cochrane, Campbell, JBI and EBPracticeNet Africa) were generated and used to guide decision making.

Conflict affects global health outcomes and further worsens measurement of these outcomes. Several development agencies are currently active in conflict areas and Cameroon in particular. Using CHWs and DHIS2 is through our innovative 3D Qualitative data approach is an approach that could facilitate measurement of global health outcomes.

Co-Authors: Cheabum Raphael Oujowgah, Effective Basic Services (eBASE) Africa, Cameroon; Patrick Mbah Okwen, Effective Basic Services (eBASE) Africa, Cameroon
Riddle, Alison, University of Ottawa, Canada

A conceptual framework of empowerment-based nutrition interventions to improve adolescent girls’ nutritional status

Issue/objective: The nutritional status of adolescents has important consequences for their health and development. Adolescent girls face particular challenges in achieving optimal nutrition due to gender inequities that limit their ability to access a nutritious diet, practice healthy behaviours, and access essential health services. We hypothesized that incorporating empowerment strategies into nutrition interventions for adolescent girls in low- and middle-income countries would improve intervention effectiveness by addressing the gender inequities that contribute to their malnutrition. In support of a systematic review of empowerment-based nutrition interventions for adolescent girls in low- and middle-income countries, we developed a conceptual framework to depict the pathways through which the incorporation of empowerment strategies in nutrition interventions lead to improved nutrition outcomes for adolescent girls.

Methodology/approach: We conducted a literature review to identify how empowerment is currently integrated into existing nutrition-related conceptual frameworks for women, children and adolescents. Based on the literature review findings, we developed our own conceptual framework that integrates women’s empowerment theory along the causal chain for adolescent girls’ nutrition.

Results: Our conceptual framework builds on the UNICEF Conceptual Framework for Malnutrition and the WHO Framework of Interventions and Determinants of Adolescent Nutrition to describe the elements of an empowerment-based nutrition intervention and depicts the pathways through which each program element facilitates adolescent girls’ empowerment, mitigates the negative consequences of gender inequalities on the underlying drivers of malnutrition, and leads to improved nutrition outcomes for adolescent girls. Implementation and contextual factors that can moderate the effects of an intervention are also described.

Discussion/conclusion: Our conceptual model describes the elements of an empowerment-based nutrition intervention for adolescent girls in low- and middle-income countries and describes the pathways through which the incorporation of empowerment strategies in nutrition interventions leads to improved nutrition outcomes for adolescent girls. This model can be used by nutrition program implementers to design and implement adolescent nutrition interventions that address gender inequities in nutrition outcomes, and to assess equity effectiveness of interventions.

Co-Authors: Alison Riddle, University of Ottawa, Canada; Abigail Kaplan-Ramage, Independent, Canada; Cynthia Kroeger, University of Sydney, Australia; Carol Vlassoff, University of Ottawa, Canada; Elizabeth Kristjansson, University of Ottawa, Canada; Zulfiqar Bhutta, The Hospital for Sick Children, Canada; Vivian Welch, The Campbell Collaboration, Canada; George Wells, University of Ottawa, Canada
Samalie, Musenero Samalie, African Research Center 4 Ageing & Dementia (ARCAD), Uganda

Evaluation of new HIV/AIDS policy implementation in Uganda: Comparison between public and private health centers

Background

In 2015, Uganda adopted the World Health Organization ‘HIV testing and treat” policy and rolled it out in 2016. Early diagnosis and treatment of HIV infected clients is essential in averting HIV-related morbidity and mortality. While the adaptation is these policies are essential to mitigate the escalating number of new HIV infections, its implementation in the health facilities is hardly understood.

Methods

A cross section design with mixed method data collection tools were employed. We assessed the implementation of the new “test and treat policy” in four high volume public and private health facilities in Uganda. The 2016 ministry of health HIV policy document were reviewed and pre-determined indices were extracted in relation to the content as per HIV service provision policy guidelines.

A structural questionnaire was used to assess the facility based policy implementation and was administered to ART In-charges of each facility. Implementation was classified as high, median and low and stratified by ownership of the facility (Public or Private). The semi-structured interviews were conducted with key informants (policy makers, district health team members, Health facility in-charges and HIV/AIDs implementing partners), to identify factors that influenced HIV test and treat policy implementation. Data was analyzed using thematic content analysis.

Results

Most of the test and treat policy guidelines were implemented in both Public and Private health care facilities (Free HIV testing, Option B+, Free highly active Antiretroviral Therapy (HAART) and Post exposure prophylaxis). Both had a notable implementation gap relating to retention in care but were more common among the private health care setting. Public health facilities highly implemented policies related to care and treatment than private and performed better on quality of care indicators such as; availability of drugs.

Factors that facilitated the implementation included; availability of lead HIV implementation partner, content of the policy guideline, district partner coordination structures, availability of scientific evidence and strong data management structures.

Barriers in implementation of policy in private health facilities included; weak coordination, lack of logistics and commodities, poor supervision, few health workers orientated with new policy guidelines, health information system and poor referral systems that threatens the successful implementation of this policy.

Conclusions

Most HIV policies were highly implemented in the public health facilities; however, gaps in implementation coverage prevail and exist in the private setting. Strategies to ensure high implementation of HIV policies in private setting against adaption of any new policy.

Co-Authors: Stephen Joloba, African Research Center 4 Ageing & Dementia (ARCAD), Uganda; Herbert Nyanzi, African Research Center 4 Ageing & Dementia, Uganda; Daniel Ssentamu, Kalungu District Local Government, Uganda; Geoffrey Kabanda, African Research Center 4 Ageing & Dementia, Uganda; Isaac Ddumba, African Research Center 4 Ageing & Dementia, Uganda
Sarasua, Irene, McGill University, Ingram School of Nursing, Canada

Building global citizenship – threading global and Indigenous health competencies throughout graduate nursing curricula

1. Issues/Objective:

Nurses comprise the largest health workforce and arguably have the greatest impact on health outcomes worldwide (ICN 2018). With a broad understanding of health and well-being, significant involvement in institutional governance structures, and recognized public trust, nurses are ideally positioned to exert influence – at all levels and across systems. While nurses have a history of actively advocating for healthy public policy, they are rarely formally trained to do so. With ever-growing global interconnectedness, nurse educators are called upon to develop curricula that foster the development of skills to enable nurses to engage more fully with evidence to influence public policy across boundaries and systems, in areas such as climate change, Indigenous health and gender equity, among others. Through careful addition of key Global, Indigenous and Environmental Health competencies within our Master’s of Nursing Curriculum, we hope to develop a nursing workforce that harnesses its power to mobilize individuals, communities and governments toward healthier more equitable resource utilisation and allocation. We believe that the development of such competencies is vital to a comprehensive nursing education.

2. Methodology/Approach:

Our Master’s of Nursing ‘Global and Indigenous Health’ curriculum sub-committee (comprised of nursing Faculty with interest and experience in global health education) reviewed the literature to identify key articles on recommended competencies for nurses and/or health care professionals in ‘global health’, ‘public health’, ‘Indigenous health’ and ‘environmental/sustainability’. Following an in-depth review of the competencies, we selected a number of them and incorporated them into our existing nursing competency framework (CNA 2015). The selected competencies will be ‘mapped out’ across courses within the curriculum to ensure that they are adequately addressed and explored. The revised Master’s of nursing curriculum, which includes the new Global and Indigenous Health competencies, will be implemented in the fall of 2019.

3. Results:

Strategies used for identifying appropriate competencies as well as challenges and lessons learned associated with linking them to our National Nursing Educational Framework and mapping them throughout the curriculum will be described. The logic behind chosen competencies will be discussed and supported by the rationale of educating nurses to face global health challenges and crisis in environment, Indigenous health and population health.

4. Discussion/Conclusion:

The inclusion of Global and Indigenous Health competencies in Graduate nursing curricula is vital to the creation of a more ‘action-driven’ and ‘globally accountable’ healthcare workforce. We foresee including Global and Indigenous Health competencies in our undergraduate degrees programs.

Co-Authors: Irene Sarasua, McGill University, Ingram School of Nursing, Canada; Jodi Tuck, McGill University, Ingram School of Nursing, Canada; Catherine-Anne Miller, McGill University, Ingram School of Nursing, Canada; Françoise Fillion, McGill University, Ingram School of Nursing, Canada; Maria Di Feo, McGill University, Ingram School of Nursing, Canada
Savelli, Carmen Joseph, World Health Organization, Switzerland

The (FAO/WHO) International Food Safety Authorities Network (INFOSAN): Looking inside this global community of practice

Issue/objective: The International Food Safety Authorities Network (INFOSAN) is a global network of national food safety authorities, managed jointly by FAO and WHO. Since 2004, INFOSAN has enabled the rapid exchange of information during food safety emergencies to stop the spread of contaminated food from one country to another. INFOSAN also facilitates the sharing of experiences and tested solutions in and between countries and across sectors to optimize future interventions to improve food safety and protect the health of consumers around the world.

However, INFOSAN has never been examined as a functional community of practice and its value, according to members, has not been determined in a systematic or rigorous way.

A three-phased, mixed-method study is ongoing to explore the experiences of INFOSAN members with respect to their participation in network activities to improve global food safety and prevent foodborne illness. Details related to phase 1 are presented here and relate specifically to how the INFOSAN Community Website (ICW) is being used to support network activities.

Methodology/approach: Registration data has been collected for each member on the ICW since 2012. Anonymized data was analyzed using descriptive summary statistics and stratified by several variables including type of member, geographic region, and length of membership. Records of access to the ICW were also downloaded from the site.

Results: As of January 2019, the ICW has 524 registered members from 183 WHO Member States; 186/524 (35%) are Emergency Contact Points, 338/524 (65%) are Focal Points; 241/507 (48%) are female. The majority of these INFOSAN members, 290/524 (55%), have been registered on the ICW for 3 or more years and 270/524 (52%) have logged on to the ICW within the preceding 6 months.

Discussion/conclusion: In a complex global landscape, INFOSAN has emerged as the only network of its kind with a truly global mandate to connect food safety authorities around the world for exchanging information during food safety emergencies. The ICW helps to facilitate the work of the Network. The results from phase 1 of this study provide objective, foundational information about engagement of all members and will be triangulated with data from phases 2 and 3 of the ongoing study to determine if members’ reported attitudes and experiences reflect their online behaviours. This information can be used by the INFOSAN Secretariat to increase active participation and improve international information exchange to mitigate the impact of food safety emergencies and prevent foodborne diseases globally.
**Shahrin, Afifa, Simon Fraser University, Canada**

**The commission-based health care marketing mechanism: The role of middlemen in the obstetric and gynecological health care sector in Bangladesh**

Bangladesh, made remarkable progress in a number of health indicators such as in reducing fertility and mortality. However, the health system in Bangladesh is weak, specially in terms of governance, accountability and regulation (Chowdhury et al., 2013; Ahmed et al., 2013). The existing corruption and inefficiency within the regulatory and statutory bodies, failed to ensure quality and to limit quantity of ‘for-profit’ private health care sector (Rashid, Akram & Standing, 2011; Ahmed S. M., 2015). In this era, a group of middlemen has arisen in the Bangladeshi health care system, who have been involving in the patients’ referral procedure to certain health care providers and/ or health care facilities in exchange for commission (Bay, 2018).

This research identified the role of the middlemen in the obstetric and gynecological health care services in Bangladesh. This research interviewed 63 Bangladeshi women who recently (within year 2013-2019) went through obstetric and gynecological treatment, 26 health care providers (includes who work as middlemen) and 13 maternal health policy makers in Bangladesh. Face-to-face in-depth qualitative interviews were conducted in between December 2018-April 2019 in Dhaka and in Tangail, Bangladesh. Thematic analysis was conducted using N-Vivo software.

This paper found that, although public health sector is inexpensive and provide better quality health care compared to private sector, women from lower middle class and middle class families do not seek treatment public health facilities. They remain fearful to go to public health facilities, due to inefficiency and corruption. The upper-scale private health care facilities which are efficient, are too expensive for them. To receive affordable and efficient health care services, these group of population depends on middlemen, who often live in their neighborhoods and are known as experts regarding health care services. Generally, the middlemen involve in the negotiation procedure regarding the total cost of treatment in between the administration of health facilities and patients’ families. However, the women often receive poor quality of treatment in referral of middlemen. They do not often cure though treatment and through surgeries and develop morbidity later. Women often remain unaware about their true health status. That ultimately results more hassle and financial loss for women and their families.

In Bangladesh, with the expansion of ‘for-profit’ private health care sector, it became challenging to ensure quality health care for all. Through ensuring governance, regulation and accountability, the harmful practices of middlemen in Bangladeshi health care sector should be restricted.
Sharma, Vandana, Harvard T.H. Chan School of Public Health, United States of America

Unite for a Better Life: Piloting a Culturally Appropriate Behavioral Intervention to Decrease Intimate Partner Violence and HIV in among Somali Refugees in Dollo Ado, Ethiopia

Issue/Problem: A growing body of evidence has linked Intimate Partner Violence (IPV) with HIV risk. Culturally appropriate, community-based interventions that address inequitable gender norms and other social and cultural factors underlying IPV risk have the potential to prevent IPV and in turn, HIV transmission. The study piloted a gender-transformative, group-based IPV and HIV prevention intervention comprising 16 participatory sessions that were adapted for the Somali refugee context in order to assess the intervention’s feasibility, acceptability and participation rates. The program sessions were led by trained, same-sex facilitators during tea talks, and were designed to help participants identify and transform power imbalances within their relationships and build skills for healthy, non-violent and equitable relationships.

Methods: The study was implemented in Bokolmanyo refugee camp in Dollo Ado, Ethiopia in 2018. Households (n=180) with married couples in 6 camp zones were randomly selected for participation in a baseline survey to assess IPV and HIV knowledge and attitudes as well as experience of IPV. Households were randomly assigned to one of four groups: 1) women receive the intervention, 2) men receive the intervention, 3) couples receive the intervention, or 4) a control group. The 16 intervention sessions were delivered to groups of 20 individuals in each arm over 6 weeks. A post-intervention survey was administered to assess acceptability of the intervention and changes in knowledge and attitudes.

Results: In total, 120 individuals (60 women, 60 men) participated in the intervention and 135 women completed the post-intervention questionnaire. At baseline, 81% of women (mean age=33 years) reported experiencing physical and/or sexual intimate partner violence in their lifetime. The frequency of specific acts of IPV was reported to be higher within the camp than prior to displacement. Of participants, 78% in the women’s arm, 68% in the couples arm and 55% in the men’s arm completed at least 70% of sessions. Among participants, 92% were satisfied with the program, 85% would recommend it to a friend, and none reported spousal conflict or violence as a result of participation. Follow-up data also suggest improvements in IPV and HIV knowledge and attitudes.

Conclusions: IPV is pervasive among married couples in this context and IPV prevalence is higher after displacement. Unite for a Better Life is a culturally acceptable and feasible intervention and has the potential to reduce IPV and HIV transmission in this population. A more rigorous evaluation of the intervention to assess longer-term outcomes is warranted.

Co-Authors: Vandana Sharma, Harvard T.H. Chan School of Public Health, USA; Jennifer Scott, Harvard Medical School, USA; Samuel Tewolde, Women and Health Alliance International, Ethiopia; Negussie Deyessa, Addis Ababa University School of Public Health, Ethiopia;
Silva, Erika E., Plan International Canada, Canada

Investments in ASRHR to reduce pregnancies and HIV incidence through a multisectoral approach: learning from RESA & LA.

Background:

Adolescent girls and young women account for half of new HIV infections in Sub-Saharan Africa while an estimated 21 million girls aged 15 to 19 years and 2 million girls aged under 15 years become pregnant in developing countries every year. Latin American and the Caribbean region continues to be the second only to Sub-Saharan Africa with the highest pregnancy rates in the world, due in part to limited access to adolescent friendly sexual reproductive health services, including to relevant sexuality information, to help them fully enjoy their sexual and reproductive health and rights. While many countries have enacted legislation and rolled out health policies, some gaps persist keeping adolescents at higher risk and more vulnerable to HIV infection, GBV and early or unintended pregnancy.

Plan International is mid-way into the implementation of adolescent -targeted HIV or SRHR projects in Bolivia, Malawi, Mozambique, Peru, Tanzania and Zimbabwe, and key lessons are emerging on how the different policy frameworks are catalyzing or retarding progress in improved sexual and reproductive health outcomes for adolescents in these countries.
Peer Victimization among School Age Children with Disabilities in Pakistan and Afghanistan

Background: Children with disabilities are highly vulnerable, excluded, and marginalized in society. They face discrimination, negative behaviours and abuse from parents, siblings, peers and other community members. WHO (2011) suggests that the estimated number of people with disabilities in Pakistan is around 5 million and the National Disability Survey (2005) suggested that the prevalence of severe disability in Afghanistan was 2.7% of the population.

Methods: As part of the What Works to Prevent Violence Against Women and Girls Global Programme, two baseline studies were conducted in Pakistan and Afghanistan. In Pakistan, the study design was a Cluster Randomized Controlled Trial (RCT) with 40 schools sampled in the urban city of Hyderabad and data collected from youth aged 12-14 years. In Afghanistan, the study design was cross-sectional, with data collected from students aged 11-19 in 11 schools in Jawzjan province. In both countries, baseline prevalence data of youth with a disability and associated experiences of peer violence was collected. A modified version of the Washington Group Disability questionnaire was used.

Results: In Pakistan, 6% of children reported any kind of disability. In Afghanistan, 17.92% reported any kind of disability. The prevalence of disability in Afghanistan was much higher for girls (22.14%) than boys (12.86%). There were no differences in the prevalence of disability between boys (6.02%) and girls (5.99%) in Pakistan. In both Pakistan and Afghanistan, disability is significantly associated with higher depression scores. Hunger is strongly associated with disability in Afghanistan. In Pakistan, disability is also associated significantly with experiences of corporal punishment in school, although this finding only holds when not adjusting for age and gender. Perpetration of peer violence is not associated with disability; however, the experience of peer violence victimization is strongly associated with disability, particularly in Afghanistan among girls, with the effect dissipating in Pakistan when adjusting the regression model for age and gender.

Conclusion: Understanding how violence in schools impact on children with disabilities’ is needed to ascertain support needs. Risk factors and protective factors for violence in schools need to be shared with parents, school staff and all children, with a specific focus on inclusive and accessible approaches for children with disability. Parental and teacher training for early violence detection and intervention should be a priority. School-based policies, curriculums and interventions need to be inclusive and should be modified in accordance with the needs of children with disabilities.

Co-Authors: Rozina Somani, University of Toronto, Canada; Julienne Corboz, NA, Afghanistan; Rozina Karmaliani, Aga Khan University, Pakistan; Judith Mcfarlane, University of Texas, USA; Hussain Maqbool, Aga Khan University, Pakistan; Nargis Asad, The Aga Khan University Hospital, Pakistan; Yasmeen Somani, Aga Khan University, Pakistan; Ingrid Heijden, South African Medical Research Council, South Africa; Rachel Jewkes, South African Medical Research Council, South Africa; Esnat Chirwa, South African Medical Research Council, South Africa.
Sonogo, Ouassa, Aga Khan Foundation Mali, Mali

Rôle des organisations de la société civile dans la résilience de la santé communautaire en situation de crise : cas des maternités rurales de mopti et djenné

La crise politique et sécuritaire a perturbé le système de santé malien surtout au nord-centre du pays où les services de santé sont rapidement devenus non fonctionnels. Dans ce contexte, c’est souvent les organisations communautaires qui s’engagent à répondre aux besoins essentiels. Cependant, malgré le rôle central que jouent ces acteurs en période de crise, ils peuvent être rapidement écartés dans les réformes politiques majeurs après les crises. Promouvoir une plus grande participation et une inclusion des organisations au niveau local, et la reconnaissance des efforts fournis par la communauté, pendant les phases critiques de la reconstruction et de reformulation des politiques est essentiel pour un système de santé plus équitable.

Le présent travail vise à décrire le rôle de ces organisations communautaires dans la résilience durant la crise de 2012-2013 et les efforts d’AKF Mali pour renforcer l’inclusion de ces institutions communautaires essentielles dans le système de santé formelle. De 2012 à 2013, 36 maternités ont été construites dans un contexte de crise multidimensionnelle au Mali. Pour y parvenir, les communautés avec l’appui d’AKF Mali ont mis en place de fortes organisations villageoises dans la gestion des maternités sous la supervision des centres de santé fonctionnels. La mise en place des maternités a été l’occasion de instaurer des espaces de dialogue permanent entre les communautés dont les besoins ne cadreraient pas toujours avec les politiques de santé; partager les actions communautaires en santé et les résultats obtenus afin d’améliorer leur acceptation; et faire la promotion de politique de santé plus globale en afin de couvrir les besoins du couple mère enfant.

Dans un pays aussi vaste avec une grande partie du territoire d’accès difficiles, l’implication des communautés dans la gestion des services sociaux de base sont les gages de leur disponibilité et de leur accessibilité. Ainsi, quand tous les services de santé fermaient car le personnel de santé quittait la zone, les services gérés par les structures communautaires ont pu continuer à offrir les soins aux femmes. Et finalement l’un des plus grands résultats actuellement est l’intégration future des maternités dans le système de santé suite à la réforme lancée par le Président.

Les structures communautaires peuvent jouer un rôle important dans l’accès aux soins et services des populations des zones reculées si elles sont gérées par des communautés engagées. La pérennité des structures communautaires est fortement liée à leur acceptation et intégration dans le système de santé.
Production and use of Evidence to translate Global Campaigns into National policy priorities to address stillbirth in Uganda.

Introduction

Despite tremendous progress in reduction of maternal and child mortality during the MDG era, close to 2.6 million stillbirths still occur annually. Global campaigns which drew attention towards this public health challenge gained momentum with the 2011 Lancet series “call to action” calling upon global players to the large stillbirth burden which was at the time absent in the global maternal and newborn health agenda. Subsequent campaign highlighted areas that required redress with a call to country level actors to draw strategies of addressing those gaps among which alignment with existing policy frameworks that were at the time missing. This paper analyses how evidence from global stillbirth campaigns was produced and used to translate into national policy priorities for Uganda.

Methods

This was a cross sectional descriptive study conducted in Uganda among policy networks that were key in translating these global campaigns. Qualitative interviews were conducted on a purposively selected sample of 20 key informants augmented with a snowball method to follow up on key leads identified during the interview process. Data was collected using an interview guide and a digital audio recorder and transcribed verbatim with content analysis done using Atlas ti a qualitative data management software to produce themes and subthemes.

Results

Overall, identifying and sieving of relevant evidence was done by the global campaigns and national level tasks included prioritizing of identified evidence in policy making. Three actions were taken on this evidence which included adoption into policy making without trial, piloting to assess health system compatibility, and direct application to justify prioritization of already ongoing policy endeavors. Skepticism about available evidence was prevalent and mainly due to the health systems ability to adapt to the new evidence where some health systems building blocks were trusted more to adapt than others. Known weaker health system building blocks however did not deter use of evidence for policy modification.

Conclusion

Different approaches to use of evidence to inform policy adaptation from global campaigns suggests that policy makers choose aspects based on their understanding of the health systems ability to adapt to that evidence and not because they doubt the credibility of the evidence. This calls for a framework for translation of foreign generated evidence to inform local policy prioritization of such evidence to facilitate translation of global campaigns into national policy.
Engaging the experiences of mothers impacted by albinism in Tanzania: An ethnographic study towards health equity

Issue/Objective: Persons with albinism, an inherited genetic condition that reduces the amount of melanin pigment formed in the skin, hair and/or eyes, face difficult lives in many parts of sub-Saharan Africa, including Tanzania. Beyond the extreme risk of developing skin cancer, persons with albinism deal with various threats to their human rights because of their physical appearance. In certain regions of Africa, deeply rooted spiritual and cultural beliefs about albinism persist, such that they are ostracized, excluded, and fear violent attacks. Women and children disproportionately bear the burden of these beliefs. Yet, little research exists specific to mothers impacted by albinism and how they navigate parenting within this gendered context. Addressing the United Nation’s Sustainable Development Goals on equality, poverty, gender, and health and well-being, research is needed on the intersectionality of life as a woman and as a mother of a child with albinism. The purpose of this study is to explore the social constructs around gender and disability in Tanzania and their impact on mothering and albinism.

Methodology/Approach: Focused ethnographic fieldwork was completed over 6 weeks in Tanzania, with semi-structured interviews and participant observation alongside a cultural liaison. Twenty-six mothers impacted by albinism and twenty-one key informants (e.g., nurses, social workers, teachers, government officials) were interviewed individually or in focus groups. Data analysis focused on producing rich narrative descriptions and key themes.

Results: Findings reveal the remarkable demands on women to ensure the security and well-being of their children; the long term impact of family separation following relocation of children with albinism to government or private boarding schools; the challenge of accessing appropriate services, especially in low-resource regions; and the resilience and innovation that can be fostered by community support groups.

Discussion/Conclusion: Good governance cannot be fully realized without the voices of the women carrying the burden of this largely misunderstood condition. The global significance of this study lies in the centrality of these voices sharing their experiences for the express purpose of creating change and developing channels for accountability. The results of this ethnographic study will assist policy makers at local, national, and global levels to ensure that health and social programs are driven first by the explicit needs voiced by mothers impacted, utilizing their articulated experiences in developing overall strategies to address inequities and promote accountability – all in an effort towards ensuring good governance and health equity.

Co-Authors: Emma Strobell, Trinity Western University, Canada; Sheryl Reimer-Kirkham, Trinity Western University, Canada; Barbara Astle, Trinity Western University, Canada;
Tekuyama, Kumba, Partners in Health Sierra Leone, Sierra Leone

Engaging government leadership from the top to the bottom: The experience of Partners in Health Sierra Leone’s Community Health Workers program

Sierra Leone has 15 districts, which are further delineated by chiefdoms. While national policies and some funding comes from the central government, day-to-day decisions around what programs can take place, how these programs are funded, and even who gets to partake in them are primarily taken by local chiefs, as well as leaders at a district level. Recognizing this hierarchy, Partners in Health (PIH) Sierra Leone works with leaders at every level, from the Ministry of Health and Sanitation (MOHS) in Freetown to chiefs in small villages. This intense, continued focus on working with leaders has resulted in robust participation in PIH’s HIV/TB Community Health Worker (CHW) program and buy-in from all levels of the government. The program serves 14 chiefdoms in Kono, a rural eastern district, and supports 1736 of HIV patients and 270 TB patients. PIH has seconded technical advisors to the MOHS’ national HIV and TB programs, in an effort to support a national HIV/TB CHW program modeled off PIH’s in Kono. This has resulted in a national framework for HIV/TB CHWs and initial funding for the program. In Kono, PIH works with the HIV and TB sections of the District Health Management Team. Initially seen as a “threat” who would “take away government patients,” PIH and the district team now work together to identify new patients, ensure they are attached to a CHW, and receive in-community follow-up care. The CHW program also has strong relationships with local chiefs, who in many cases have been skeptical not only of CHWs, but of the existence and importance of HIV and TB. PIH has held continuous consultative meetings with chiefs across the district to ensure that they know the basics of the diseases and how they impact their community, understand the importance of the CHW program, and encourage the communities to accept CHWs. Many chiefs now welcome PIH to give sensitization talks on HIV and TB, which has resulted in a significant increase in HIV and TB testing at local health centers; one chief has been so impressed that local funds have been contributed to nutritional support for vulnerable patients. This talk will discuss initial barriers to PIH collaboration with government at all levels; steps taken to remove these barriers; how collaboration has positively impacted the number of patients in the program, and patient outcomes; and the impact of collaboration on government’s understanding of HIV, TB and CHWs.

Co-Authors: Kumba Tekuyama, Partners in Health Sierra Leone, Sierra Leone; Fodei Daboh, Partners in Health Sierra Leone, Sierra Leone; Bawel Thomas, Partners in Health Sierra Leone, Sierra Leone
Thieba Bonane, Blandine, Société des gynécologues du Burkina, Burkina Faso

Contribution de la SOGOB et de MDM France à l'amélioration de la santé sexuelle et reproductive chez les adolescentes de moins de 18 ans reçues dans 5 centres de santé de la ville de Ouagadougou

Titre : Contribution de la SOGOB et de MDM France à l'amélioration de la santé sexuelle et reproductive chez les adolescentes de moins de 18 ans reçues dans 5 centres de santé de la ville de Ouagadougou

Objectifs Etudier les aspects épidémiologiques, cliniques et pronostiques de la grossesse et de l'accouchement chez les adolescentes de moins de 18 ans dans 5 maternités de la ville de Ouagadougou du 1er janvier au 31 décembre 2017.

Patientes et méthode : Il s'est agi d'une étude transversale descriptive sur 12 mois du 01 janvier 2017 au 31 décembre 2017 dans les maternités du CHU Yalgado OUEDRAOGO, le CMU de Nagrin et le CMU de Pogbi. 797 adolescentes ont été incluses

Résultats : les grossesses des adolescentes de moins de 18 ans représentaient 2,1% des admissions dans ces 5 centres de santé. L'âge moyen était de 16,5 ans. 94,2% étaient nullipares. 58,2% de ces adolescentes étaient mariées et 74,1% musulmanes. Elles étaient scolarisées dans 25,6% des cas. 79% étaient référencées/évacuées. L'accouchement était par voie haute dans 23,9%. Vingt-cinq pourcent (25%) de ces grossesses ont abouti à un avortement. La mortalité maternelle était de 1,7%. La morbidité était de 7,2%. Les prématurés représentaient 11,8% des naissances vivantes.

Conclusion : Malgré la gratuité des services de santé pendant la grossesse, les conséquences des grossesses précoces dues principalement aux mariages précoces sont graves. Ces conséquences sont pour nous un outil de plaidoyer et de sensibilisation des populations pour une amélioration de la santé des adolescentes.

Mots clés : adolescente, grossesse, accouchement, pronostic. Plaidoyer

Authors : B.Thiéba-Bonané ,CThiombiano-Yougbaré, A.Ouédraogo, S Kiemtoré ,

Corresponding author : Pr Thieba Blandine Immediat Past President Société des Gynécologues et Obstétriciens du Burkina (SOGB) E mail : thieblan@yahoo.fr

Co-Authors: BLANDINE THIEBA née BONANE, Société des gynécologues du Burkina,Burkina Faso; Cecile THIOMBIANO née YOUGBARE, Medecin du Monde France, Burkina Faso
Tondeur, Mélody, Canadian Partnership for Women and Children’s Health (CanWaCH), Canada

“Building Something Together”: Strengthening public and civil-society partnerships to enhance global health and gender equality impact

Issue: Communication, trust, responsiveness, and transparent information-sharing are all critical components of effective and efficient partnerships between local governments, donor governments, and civil society actors working in global health and gender equality. Starting in 2018, the Canadian Partnership for Women and Children’s Health (CanWaCH), began the coordination of a Country Working Group in Haiti, that works with all of these actors to enhance accountability, mobilize action, and improve programming. Groups leverage digital communication and data-sharing platforms, mapping, inter-sectoral collaboration, and other strategies to enhance their impact. Building on the initiative’s successes, a new group has been established in Mozambique, and others are being explored in new countries.

Approach: In February 2018, an official Call to Action brought Canadian partners working in Haiti together to better coordinate Canada’s interventions in strengthening the Haitian health system. The Call to Action was a result of a dialogue between Global Affairs Canada, CanWaCH and Canadian actors working in Haiti, that began in April 2017 in Sherbrooke, Quebec. A total of 30 Canadian organizations and academic institutions endorsed the call and made a commitment to work together.

Results: A network was created to connect staff members who are responsible for monitoring, reporting and analyzing the work being done in Haiti by Canadian organizations; this network now includes more than 50 staff based in Canada or Haiti. In-person meetings are taking place in both Canada (one per year) and Haiti (two per year). Each year, online surveys and individual interviews are being conducted to identify the priorities and the needs. Online tools were created from the start to facilitate communication between partners, including the coordination of activities with the Haitian government, access to national reports, statistics, and protocols. A cartography of Haiti showcasing the health-related work of Canadian actors is updated yearly and all data shared are added to CanWaCH’s Project Explorer. The network is creating an enabling environment for improved coordination and collaboration amongst Canadian actors, local partners and governments (Haitian and Canadian), in order to create more and better partnerships, reduced duplication of efforts and increased impact.

Discussion: Technology and in-person communication should be jointly leveraged to ensure the transparent sharing of timely information on programming and data from all partners, in order to strengthen trust and improve results. Collaboration between civil-society and government (both local and Canadian-based) must be made a priority in order to achieve national health objectives and global health goals. Trust and transparency are essential for effective partnerships between governments and civil society (Canadian and local). Experiences with, and potential of, a new model of global health Country Working Group (piloted in Haiti and Mozambique) are being explored. The model enhances accountability and programming through digital communication and inter-sectoral collaboration.
U. Mukangwije, Pulchérie, France

Diplomacy for health in action to reach SDG3 in Africa: dynamics of power at macro, meso and micro levels for health systems strengthening

Background

The Sustainable Development Goal 3 (SDG3) is 'Ensure healthy lives and promote well-being for all at all ages'.

There is intersection between diplomacy for health, good governance and health outcomes that play a key role in making impact in lives of children, youth, adults and the elderly.

In Africa, most countries face great challenges in terms of health inputs, processes, results and outcomes. However, different opportunities to develop public-private partnerships exist between the North and the South, and within the South.

In the past, bilateral and multilateral diplomacy have played a key role in addressing major public health concerns, such as the HIV epidemic, malaria, etc. Even localized crises like the most recent Ebola outbreaks have shown that diplomacy for health is crucial in order to achieve tangible results.

If SDG3 is to be achieved by the set timeframe, there is an obvious need to explore diplomacy for health under various angles: traditional diplomacy vs soft power, implications of digital diplomacy and how to best take advantage of the multiple opportunities it is offering as well as its cost effectiveness in the context of limited resources,... Without sound diplomacy, the world in general, and Africa in particular, cannot expect to achieve ambitious goals in terms of universal health coverage, non communicable diseases, child and maternal health,... The evidence from experience on the fight against HIV, tuberculosis and malaria, has shown that the huge gaps in health infrastructures, human resources and policies can greatly benefit from a well coordinated diplomacy for health action.

When diplomacy for health is put into action, decision makers, donors and investors are mobilized at high level and meet drivers of change which work in synergies in various dimensions. Who are they, where are they, and what can be done with them for better investing in human resources for health through education in order to bridge the gap?

Co-Authors: Pulchérie Mukangwije U., Humanity & Inclusion / Humanité & Inclusion, France; Jacques Sindayigaya, West East Junction, Senegal;
The lived experience of women and girls who engage sexually with UN peacekeepers: Lessons from Haiti

Issue/Objective: Peacekeeping operations (PKO) address international threats to peace within failed states. However, unintended consequences arise from the influx of male peacekeepers in countries with compromised governance. During the UN's longest peace operation in Haiti, Mission des Nations Unies pour la Stabilisation en Haïti (MINUSTAH), enough children were conceived by peacekeepers that a new term has been coined, labeling such children "Petit MINUSTAH". Using the MINUSTAH as a case study, this research explores the lived experiences of Haitian women/girls who conceive children with peacekeepers.

Methodology: This research was implemented through the Commission of Women Victims for Victims from October to December 2017. Eighteen semi-structured interviews across 8 cities/towns in Haiti were conducted by trained Haitian research assistants. Snowball sampling was used to recruit Haitian women who had engaged in sexual intercourse with a MINUSTAH peacekeeper, resulting in the birth of a child. The audio recorded interviews were translated from Haitian Creole to English and transcripts were analyzed using phenomenology.

Results: Adverse socio-economic conditions experienced by women/girls were key contextual factors that underlined sexual relations with peacekeepers. In addition, proximity to UN bases was perceived as being a factor that increased familiarity with peacekeepers. Three themes emerged related to the nature of the sexual interactions between UN peacekeepers and Haitian women and girls: sexual violence, transactional sex, and long-term transactional relationships imbedded in perceptions of love. Sexual violence was identified among girls who lacked the capacity to consent due to age, in addition to instances of sexual abuse. Most sexual interactions were transactional and nuanced since the peacekeeper often assumed the role of romantic and material provider. Sexual consent was conceptualized as the ability to weigh the benefits and consequences of engaging sexually with UN peacekeepers.

Discussion/Conclusion: So long as women and girls face adverse socio-economic conditions and live in proximity to peacekeeping bases, transactional sex with peacekeepers is likely to continue. A harm reduction approach that aims to: improve income generation, raise awareness for peacekeeper codes of conduct, and provide comprehensive sexual reproductive health education should be considered. This harm-reduction approach recognizes the socio-economic context of sexual interactions with peacekeepers and proactively aims to protect women and girls from sexually transmitted infections and unplanned pregnancies, while not condoning sexual exploitation and violence perpetrated by peacekeepers.

Co-Authors: Luissa Vahedi, Queen's University, Canada; Susan Bartels, Queen's University, Canada; Sabine Lee, University of Birmingham, Canada
Towards a more ethical global health research: A case study of knowledge translation within the ACPH implementation research project

1. Issue/Objective: The ACPH maternal and child health implementation research project, funded by the IDRC, aims to reduce maternal and child mortality in the Natikiri district of Nampula, Mozambique. This 3.5 year research project has seven different strategies which range from community based programming to hospital based interventions. Community needs were consulted during the design stage through focus group discussions, meetings with community stakeholders, and the application of questionnaires. Additionally, there continue to be community consultations and questionnaires as a part of ongoing monitoring and evaluation. However, data collection itself is not always associated positive or even neutral outcomes. When communities are exposed to many different research projects or data collection cycles, they may experience a phenomenon called “research fatigue”, where communities become exhausted by the research process. A protective factor against research fatigue is for the community to see benefit or impact from having shared their knowledge. Thus, for the community to be able to see an impact from sharing their knowledge with the CAHP project, the CAHP research team should successfully incorporate the feedback/data into the project’s knowledge translation process. Thus, the purpose of this project is to assess this process, and look at how the community feedback is being incorporated into project implementation. By assessing this, we can use the findings to optimize the knowledge translation process and to ensure knowledge is used in an ethical manner. This case has implications for how all knowledge is used within health governance and policy development.

2. Methodology/approach: To look at this problem, I decided to use a case study methodology. Data collection included a document review of project materials and reports, semi-structured interviews with research team members, a focus group, and participant observation at project activities and meetings. Data was collected between September 2018 and March 2019.

3. Results: Analysis is ongoing, and results are expected to be finalized summer 2019.
**Wallace, Lauren J., University of Ghana, Ghana**

**Communication and coordination between development partners and the ministry of health in national priority setting for maternal health in Ghana**

Issue/objective: Despite concerns about malalignment between development partners (DPs) and governmental actors in the health sector in low resource settings, studies have rarely examined the nature of communication and coordination processes between DPs and national policymakers, and few have taken a holistic approach that considers the perspectives and experiences of both DPs and government actors.

Methodology/Approach: This study, conducted from 2018-2019, uses institutional ethnography (including more than 150 hours of meeting observations, 35 interviews with both DPs and policymakers involved in priority setting for maternal health, desk review of relevant health sector strategies and plans and media review) to examine the impact of power asymmetries between DPs and the Ministry of Health on national priority setting for maternal health. Institutional ethnography is a unique approach particularly well placed to address questions delineating governance processes, power relationships, and the micro politics of organisational practice.

Results: We identified several power imbalances between DPs and the Ministry of Health (MoH) that lead to communication and coordination challenges which negatively impact priority setting for maternal health. DPs control of financial resources are a common route to influencing both policy formulation and implementation. Additionally, a lack of technical capacity at the MoH, relative to that of other sector agencies, negatively impact their ability to coordinate priority setting, including articulating clear priorities and delineating clear mechanisms for the participation and reporting of DPs and other actors. This has created entrenched institutional and interpersonal conflicts and path-dependent communication, and impairs the relevance and success of strategies for improvement.

Discussion/Conclusion: Despite the availability of structures that promote harmonisation between DPs and the government, and political will to move 'Beyond Aid', challenges in communication and coordination between DPs and government actors in national priority setting for maternal health remain, mediated by both the financial power of DPs as well as the lack of technical power at the Ministry of Health. Contextual factors, such as low government investment in health, and the technical power of other health agencies relative to the MoH, contribute to the power imbalances underlying poor communication and coordination. This study unpacks the nuances of DP-MoH relations to pinpoint key areas that require attention in order to increase the ownership of domestic actors over priority setting in maternal health, offering lessons for Ghana and similar low-resource settings.

Co-Authors: Lauren J. Wallace, University of Ghana, Ghana; Philip Adongo, University of Ghana, Ghana; Lydia Kapiriri, McMaster University, Canada
Ensuring equity and sustainability of data governance

Background:

Inequities in data governance act as barriers to discovery and impede research through power asymmetries and inefficiencies. From the point of data collection to data utilization, data management must be conducted in an equitable manner that ensures all parties benefit and that none are placed at a disadvantage. This requires that all data users are aware of the risks surrounding data. Researchers can improve the quality and integrity of their data by practicing responsible data governance. On account of sustainability, how we treat data will affect the ways in which we can utilize data for future studies and yield its application. Bearing in mind the four cross-cutting themes of the conference, this symposium calls for an enhanced understanding of how data must be approached in order to conduct high-quality evidence-based research.
Power, politics and tackling injustices associated with lung disease acquired by a migrant labour force for South African mines

Objective: South Africa’s mineral resources have produced, and continue to produce, enormous economic wealth; yet decades of colonialism, apartheid, capital flight, and challenges in the neoliberal post-apartheid era have resulted in high rates of occupational lung disease and low rates of compensation for ex-miners and their families. Coercive policies and legislation restricting access to land and means of production in these countries were among measures forcing male labourers to migrate to become mine workers, often disrupting family ties and undermining the rural black agricultural economy in order to maintain sources of cheap labour. Health concerns across the region were then compounded when these migrant miners returned home ill, putting other household or community members at risk of transmission of undetected or inadequately treated tuberculosis. Given growing advocacy, activism and class action law suits, initiatives were launched by the South African government to begin to address the legacy of injustice. This study aimed to assess developments over the last 5 years in providing compensation, quantify shortfalls and explore underlying challenges.

Methodology: Using the database with compensable disease claims from over 200,000 miners, the medical assessment database of 400,000 health records and the employment database with 1.6 million miners, we calculated rates of claims, unpaid claims and shortfall in claim filing for each of the southern African countries with at least 25,000 miners who worked in South African mines, by disease type and gender. We also conducted interviews in Johannesburg, Eastern Cape, Lesotho and a local service unit near a mine site, supplemented by document review and auto-reflection, adopting the lens of a critical rights-based approach.

Results: A myriad of diverse systemic barriers persist, especially for workers and their families outside South Africa. Calculating predicted burden of occupational lung disease compared to compensable claims paid suggests a major shortfall in filing claims in addition to the large burden of still unpaid claims. Many (28.4%) compensable claims are from Mozambique, Lesotho, Swaziland, Botswana and elsewhere in southern Africa, a large proportion of which have been longstanding.

Conclusion: Despite progress made, our analysis reveals ongoing complex barriers and illustrates that the considerable underfunding of the systems required for sustained prevention and social protection (including compensation) needs urgent attention. With class action suits recently settled, the globalized mining sector is now beginning to be held accountable. A critical rights-based approach underlines the importance of ongoing concerted action by all.

Co-Authors: Annalee Yassi, University of British Columbia, Canada; Barry Kistnasamy, Department of Health, SF|South Africa; Jessica Yu, University of British Columbia, Canada; Samuel Spiegel, University of Edinburgh, UK; Andre Fourie, IP Capital, South Africa; Stephen Barker, University of British Columbia, Canada; Jerry Spiegel, University of British Columbia, Canada
Sustainable, healthy cities: protocol of a mixed methods cluster randomized controlled trial for Aedes control in Brazil (COESA)

Issue: Dengue is increasing in its global presence with an estimated 4 billion people at-risk of infection in at least 128 countries. The only preventive measure of dengue infection is through mosquito vector control and there is increasing resistance to insecticides and larvicides and growing evidence of their negative environmental and health impact. In a context of sustainable healthy cities promoted the sustainable development goals, environmentally friendly approaches to Aedes control are needed to attain permanent reductions in mosquito populations. Despite the promising results of EcoHealth and community mobilization approaches for Aedes reduction, more evidence of their effectiveness on reducing dengue risk is needed.

Methodology: The principal research question is to determine if interventions based upon community mobilization reduce the risk of dengue virus infection among children 3 to 9 years old compared to usual dengue control practice in Fortaleza, Brazil. The study will follow a pragmatic cluster RCT design with randomization at the census tract level with equal allocation to the control and intervention arms. There will be 34 clusters in each arm of 80 children (3 to 9 year olds) for an expected total of 5,440 children enrolled in the study. Household visits will occur every six months for a total of six visits over a 3-year period to cover both dry and rainy seasons. There will be nested qualitative studies included within the cRCT to evaluate the process, acceptability, fidelity, and sustainability of the intervention. The intervention is based upon a participatory health research approach, Socializing Evidence for Participatory Action (SEPA), and critical to SEPA is the socialization of research evidence to foster community engagement and ownership of the health issue. There are five main strategic elements of SEPA including: 1) community volunteers; 2) house-to-house visits; 3) simple intervention tools accessible to every household; 4) visits to schools, churches, local businesses, shops and clubs; 5) wide variety of collective events and media approaches.

Results: Baseline results will be available by November 2019.

Discussion: The results of our study will provide evidence on community mobilization as an intervention for dengue control. Our study contains several innovative aspects including embedded qualitative research and a biomarker of individual exposure to Aedes saliva. We anticipate that if community mobilization is effective in Fortaleza, through broad and active dissemination, the results of this study will help develop evidence-based vector control programs in Brazil, and also in other countries struggling with Aedes-transmitted diseases.

Co-Authors: Kate Zinszer, Université de Montréal, Canada; Valery Ridde, Research Institute for Sustainable Development, France; Antonio Lima, Fortaleza Public Health Department, Brazil; Neil Andersson, McGill University, Canada; Monica Zahreddine, Université de Montréal, Canada; Kellyanne Abreu, Universidade Estadual do Ceará, Brazil; Andrea Caprara, Universidade Estadual do Ceará, Brazil
Zivot, Chloe, Department of Population Medicine, University of Guelph, Canada

A scoping review on the state of gender-centred research in the context of refugee health literature in Canada

Issue

Gender is considered a key social determinant of health in Canada, and is experienced differently across individuals of all sex and gender identities. The impact of gender (identities, roles, and inter and intra-household relations) as a determinant of health is not static, nor is it experienced uniformly by all Canadians. In the Canadian refugee health research landscape, gender is commonly incorporated as a variable in the analysis of physical and mental health outcomes in recently resettled refugee populations. Yet, interdisciplinary gender and health research that prioritizes gender as a key focus in study design and analysis is necessary to better understand gender as a determinant of refugee health in Canada, in order to facilitate a safe and health resettlement process for incoming refugees.

Methodology

This article reports on the results of a scoping review conducted to explore the range, nature, and extent of published research examining gender in relation to refugee health during resettlement in Canada. An initial search of six databases yielded over 6000 articles published before May, 2019. All articles identified in the initial search were subject to two levels of screening by independent reviewers at the University of Guelph.

Results

Existing gender and health research in the context of refugee resettlement in Canada suggests a predominant focus on women’s access to health services during pregnancy, childbirth, and the postpartum period. Mental health outcomes, particularly PTSD, were widely investigated with many studies having examined the role of gendered experiences and gender-based violence on refugees’ mental health. As a result of the review process we identified several gaps in the literature, largely pertaining to a dearth of research investigating the impact of gender roles, relations, and expectations on the health of refugee individuals as well as family units.

Discussion

The evidenced lack of interdisciplinary research investigating the relationship between social aspects of gender and refugee health should be addressed in order to inform policy design and service implementation related to refugee resettlement in Canada. This review, resulting from an in-depth and systematic search of existing literature, can be used as a tool to encourage and direct further interdisciplinary research examining gender and refugee health. Further research in this area is required to provide decision-makers with evidence supporting the important relationship between gender and health during refugee resettlement in Canada, which in turn can support context and gender-sensitive governance of health and support services for newcomers to Canada.

Co-Authors: Chloe Zivot, Department of Population Medicine, University of Guelph, Canada; Cole Heasley, Department of Biomedical Sciences, University of Guelph, Canada; Matthew Little, Department of Population Medicine, University of Guelph, Canada