MISSION

The attainment by all peoples of the highest possible level of health
Effect of Cell Dose and Dose of Infectious Agent on Expression of Protection Against *Listeria monocytogenes* and Ectromelia Virus in Cell Transfer Models

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Received for publication 9 December 1974

Two parameters (immune cell dose and dose of infectious agent) influencing the expression of protection by transferred immune spleen cells in *Listeria monocytogenes* and ectromelia virus infection in mice were investigated. First, when recipient mice were infected with a constant dose of ectromelia virus, a linear relationship between log_{10} cells transferred and the protection obtained expressed as log_{10} decrease in virus plaque-forming units per spleen was obtained, as has been described previously for the *Listeria* system. Second, the detectable protection was greatly affected by the number of viable bacteria or virus plaque-forming units relative to the number of transferred cells. An otherwise very effective number of transferred immune cells became ineffective when too great a dose of infection was used. Mouse strain differences could also have influenced the results. The impact of these and other parameters on the experimental outcome and its interpretation are discussed.

Transfer of immune lymphoid cells is established as a revealing analytical method in cellular immunology and in the study of immune mechanisms in infectious diseases (7). Dramatic transfer of protection against viral or bacterial infection has been achieved in a number of model infections (2, 6), but there are examples of failure of immune cells to protect both the number of immune cells transferred and the dose of infectious agent given to cell recipients. There are also minor differences due to the strain of mouse used. If the dose of infectious agent is increased above a certain threshold, an otherwise effective dose of immune cells becomes ineffective. These data
Global Perspectives on Health Policy Development: From Evidence to Practice

Tikki Pang
Research Policy & Cooperation
World Health Organization
Geneva, Switzerland
World Health Organization 2007–2011
Six Item Agenda

STRATEGY
- Strengthen health systems
- Evidence & Research

MEMBER STATES
- Health security
- Health development

OPERATIONS
- Improve performance
- Partnerships
MISSION

The attainment by all peoples of the highest possible level of health
UN Millennium Development Goals (MDG's) (2000-2015)

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Global partnership for development
• What are the major global health problems and how does WHO shape policy recommendations to help tackle them?

• How do developing countries deal with strengthening leadership and evidence-informed health policy development in the context of primary care reforms?
WHO declares swine flu pandemic

The World Health Organization (WHO) declared a pandemic after holding an emergency meeting.

It means the swine flu virus is spreading across the world with rising cases being seen in places like Chile.

WHO chief Dr Margaret Chan said the virus was causing more severe illness or death than originally thought.

The swine flu (H1N1) virus first emerged in April and has since spread to 74 countries.
Pandemic (H1N1) 2009,
Number of laboratory confirmed cases as reported to WHO

Status as of 06 July 2009
09:00 GMT

Total: 94,512 cases
429 deaths

Chinese Taipei has reported 67 confirmed cases of pandemic (H1N1) 2009 with 12 deaths. Cases from Chinese Taipei are included in the cumulative totals.

Data Source: World Health Organization
Map Production: Public Health Information and Geographic Information Systems (GIS)
World Health Organization

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IHR is a legally-binding international agreement to prevent, protect against, control and respond to the International spread of disease.

First version in 1969

IHR 2005 enters into force on June 15, 2007
Indonesia’s avian flu holdout

Indonesia sent a chill through the World Health Organization recently when it refused to supply any more samples of the avian flu virus that has killed scores of its people. The move, which seemed aimed at gaining access to vaccines at an affordable price, threatens the global effort to track the virus and develop vaccines. But Indonesia has raised a valid point that needs to be addressed: if a pandemic should strike, poor countries would be left without protection.

The WHO relies on a global network of laboratories to provide virus samples so experts can determine which are most likely to spread. These strains are then used to develop the seed stocks that are given — at no cost — to manufacturers to use in making vaccines.

operating with the WHO and started negotiations to send future samples to another vaccine maker in return for technology that would allow Indonesia to make its own vaccine.

That may be good for Indonesia but could be harmful to global health — especially if other countries follow. Clearly Indonesia, which is in discussion with WHO officials, needs to rejoin the global network. Unfortunately, the organization has no good answer to the inequities Indonesia has spotlighted.

If a pandemic struck, the current vaccine makers could produce only 500 million doses of vaccine per year if they ran 24 hours a day. That is far short of what would be needed to vaccinate all 6.7 billion people in the world. Thus there seems no doubt that in a crisis, the countries that are
Global Outbreak Alert & Response Network

GOARN is a global technical partnership, coordinated by WHO:

– to provide rapid international multi-disciplinary technical support for outbreak response
– GOARN brings > 200 partners together worldwide
Sars travel alert extended

International travellers are being advised not to visit Toronto, Beijing and China's Shanxi province because of the danger of Sars.

The World Health Organization (WHO) has added the three destinations to Hong Kong and China's Guangdong province as it tries to halt the spread of the deadly virus.

The new warning came as it was announced that nine more people had died of Severe Acute Respiratory Syndrome on the Chinese mainland and six in Hong Kong.

WHO figures put the official death toll worldwide at 251.

Dr David Heymann, WHO's communicable diseases chief, said the three new areas on its advice list had "quite a high magnitude of disease and a great risk of transmission locally - outside of the usual health workers".

**KNOWN DEATH TOLL**
- China: 106
- Hong Kong: 105
- Singapore: 17
- Canada: 13
- Vietnam: 5
- Thailand: 2
- Malaysia: 2
- Philippines: 1

*Source: Latest WHO figures*
The Cholera Crisis in Africa


In July 1994, 500,000 to 800,000 Rwandans crossed the border into the North Kivu region of Zaire (now called the Democratic Republic of the Congo, DRC). During the first month after the influx, almost 50,000 refugees died; cholera was a major contributor (1).

From 1995 to 2005, the largest number of cholera cases and outbreaks in Africa continued to be reported from this area of the DRC (2). Renewed fighting has displaced at least 250,000 people, making an already difficult situation worse for more than a million people living without clean water, food, or access to healthcare. By December 2008, the most recent cholera outbreak had affected 10,332 people, with provision of safe water and adequate sanitation can be established as emergency measures but are not guaranteed to remain once the outbreak ends.

The international community has responded vigorously within recommended guidelines. Physicians for Human Rights recently called on the United Nations to take responsibility for the Zimbabwean health system (6). The World Health Organization’s (WHO’s) Global Task Force on Cholera Control urged prioritization of prevention, preparedness, and response activities and an efficient surveillance system (8). The WHO’s Disease Control in Humanitarian Emergencies program is helping with cholera in Zimbabwe, which has been raging since mid-2008. If the blockade against potential use of oral cholera vaccines could be lifted, then public-health workers, ministries of health, international organizations, and donor groups could discuss how, when, and where the vaccine could be deployed. The cost of the only internationally licensed oral cholera vaccine (Dukoral, Crucell-SBL) is U.S. $7 to $12 (£5.25 to €9) per dose; a lower price is offered for WHO-supported programs. A potentially cheaper vaccine was developed in Vietnam; its technology was transferred to Shanta Biotechnics (India) and is in clinical trials (16, 17). In the short term, the vacci-
Cholera deaths soar in Zimbabwe

The latest figures from the UN and Zimbabwe’s health ministry reveal that two-thirds of the victims of the cholera outbreak have died this month.

The death toll at the end of last week stood at 1,564, with 29,131 suspected cases since August, the UN said.

Figures from the health ministry on 1 December put cholera deaths at 484.

The UN has warned it could take six months to control the outbreak that has been fuelled by the collapse of the health, sanitation and water services.

As of June 6, 2009

4,300 deaths
100,000 cases
CFR : 4.3%
A political scandal in Washington = LEO & JACK & MATT & MARTY

A FISTFUL OF SUGAR
A PINCH OF SALT
A JUG OF WATER...

...is the simplest remedy for a miserable condition.

So why does the illness still kill 1.9 million children under 5 each year?

Time
October 16, 2006
Diarrhoea Treatment Guidelines

Including new recommendations for the use of ORS and zinc supplementation for Clinic-Based Healthcare Workers

2004 Revised Guidelines
Recent scientific advances have informed these revised recommendations. They are:

- Development of an improved formula for ORS solution with reduced levels of glucose and salt, which shortens the duration of diarrhoea and the need for unscheduled intravenous fluids\(^1\)

- Demonstration that zinc supplements given during an episode of acute diarrhoea reduce the duration and severity of the episode\(^2\), and

- Findings that zinc supplementation given for 10–14 days lowers the incidence of diarrhoea in the following 2–3 months\(^3\)
WHO Framework Convention on Tobacco Control

The WHO Framework Convention on Tobacco Control (WHO FCTC) is the first treaty negotiated under the auspices of the World Health Organization. It was adopted by the World Health Assembly on 21 May 2003 and entered into force on 27 February 2005. It has since become one of the most widely embraced treaties in UN history and, as of today, has already 165 Parties.

The WHO FCTC was developed in response to the globalization of the tobacco epidemic and is an evidence-based treaty that reaffirms the right of all people to the highest standard of health. The Convention represents a milestone for the promotion of public health and provides new legal dimensions for international health cooperation.

More information
:: About WHO FCTC

169 parties as of May, 2009
Recognizing that scientific evidence has unequivocally established that tobacco consumption and exposure to tobacco smoke cause death, disease and disability.
Climate 'biggest health threat'

Climate change is "the biggest global health threat of the 21st Century", according to a leading medical journal.

The Lancet, together with University College London researchers, has published a report outlining how public health services will need to adapt.

It also highlights the consequences of climate-related mass migrations.

The authors aim to add their voice to the call for carbon mitigation and will focus on making clear the ways in which climate change will affect health.

Climate change will have social, as well as environmental, consequences.
GLOBAL WARMING

Projections of Climate Change Go From Bad to Worse, Scientists Report

COPENHAGEN—Meeting 2 years after the most recent report of the authoritative Intergovernmental Panel on Climate Change (IPCC), some 2000 scientists delivered a consistent if not unequivocal message here last week on the energy. And inside, the organizers definitely felt the wind at their backs. Unlike IPCC, which is affiliated with the United Nations and its member governments, last week’s congress answered to no political bosses and,
### Figure 3: Effects of global average temperature change

<table>
<thead>
<tr>
<th>Category</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food</strong></td>
<td>Complex, localised negative effects on smallholders, subsistence farmers, and fishermen</td>
</tr>
<tr>
<td></td>
<td>Tendencies for cereal productivity to decrease in low latitudes</td>
</tr>
<tr>
<td></td>
<td>Productivity of all cereals decreases in low latitudes</td>
</tr>
<tr>
<td></td>
<td>Tendencies for some cereal productivity to increase at middle-to-high latitudes</td>
</tr>
<tr>
<td></td>
<td>Cereal productivity to decrease in some regions</td>
</tr>
<tr>
<td><strong>Coasts</strong></td>
<td>Increased damage from floods and storms</td>
</tr>
<tr>
<td></td>
<td>Millions more people could experience coastal flooding each year</td>
</tr>
<tr>
<td></td>
<td>About 30% of global coastal wetlands lost</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td>Increasing burden from malnutrition, diarrhoea, and cardiorespiratory and infectious diseases</td>
</tr>
<tr>
<td></td>
<td>Increased morbidity and mortality from heatwaves, floods, and droughts</td>
</tr>
<tr>
<td></td>
<td>Changed distribution of some disease vectors</td>
</tr>
<tr>
<td></td>
<td>Substantial burden on health services</td>
</tr>
</tbody>
</table>

Global average annual temperature change relative to 1980–99 (°C)

Lancet, May 16, 2009
Into the storm
What will happen to the emerging economies?

What next?
Who killed New Labour?
The war in Pakistan’s tribal areas
America’s unending culture wars
How to save fish
The last typewriter-repair man

World on the edge
Our guide to America’s election
Europe’s Schadenfreude
Music on your phone
Reassessing China
Somalia’s pirates
Italy and France 'failing Africa'

The campaigners fear the global financial crisis could affect aid donations.

Italy and France have been accused of reneging on promises to increase aid to African nations.

Anti-poverty group One, set up by rock star Bono, said Italy had actually cut aid to Africa despite making ambitious pledges at a 2005 economic summit.
Philanthropy

Give and count the cost
May 7th 2009 | WASHINGTON, DC
From The Economist print edition

Rich donors are hit by the credit crunch. Bad news for the poor

NO SOONER had philanthropy become fashionable than the credit crunch shrivelled fortunes and the donations they sustain. In the decade to 2007 America’s charitable foundations’ assets had doubled to $682 billion, according to a study by the Foundation Centre, a charity-research outfit in New York. But by the end of last year they had shrunk by just over a fifth, to $530 billion. Two-thirds of the foundations expect to cut giving this year, probably by around a tenth overall.

Poor countries were already coping with higher prices for food and fuel, putting 130m-155m people below the poverty line, the World Bank reckons. The financial crash has hit another 50m. So some people who used to have three meals a day, for example, are eating only two. The downturn has curbed tax-financed help too. Even after the grandiose promises made at aidfests such as the Gleneagles conference in 2005, rich-country aid to poor countries actually fell by 8.5% in real terms from 2006 to 2007. Now it will shrink further.
<table>
<thead>
<tr>
<th>Country</th>
<th>External resources for health as % of total expenditure on health (2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Niue</td>
<td>66.3</td>
</tr>
<tr>
<td>Marshall Islands</td>
<td>66.1</td>
</tr>
<tr>
<td>Mozambique</td>
<td>60.3</td>
</tr>
<tr>
<td>Malawi</td>
<td>59.6</td>
</tr>
<tr>
<td>Micronesia</td>
<td>57.1</td>
</tr>
<tr>
<td>Timor Leste</td>
<td>44.9</td>
</tr>
<tr>
<td>Tonga</td>
<td>34.4</td>
</tr>
</tbody>
</table>

Data from WHO, World Health Statistics 2009
Many health care delivery systems in the developing world are in a precarious state.
Distribution of health workers by level of health expenditure and burden of disease, by WHO region

Proportion of households with catastrophic expenditures vs. share of out-of-pocket payment in total health expenditure

Collection of health information a major challenge in developing countries
<table>
<thead>
<tr>
<th>Region</th>
<th>Births</th>
<th>Unregistered children</th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>133,028</td>
<td>48,276 (36%)</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>26,879</td>
<td>14,751 (55%)</td>
</tr>
<tr>
<td>Middle East and north Africa</td>
<td>9,790</td>
<td>1,543 (16%)</td>
</tr>
<tr>
<td>South Asia</td>
<td>37,099</td>
<td>23,395 (63%)</td>
</tr>
<tr>
<td>East Asia and Pacific</td>
<td>31,616</td>
<td>5,901 (19%)</td>
</tr>
<tr>
<td>Latin America and Caribbean</td>
<td>11,567</td>
<td>1,787 (15%)</td>
</tr>
<tr>
<td>CEE, CIS, and Baltic states</td>
<td>5,250</td>
<td>1,218 (23%)</td>
</tr>
<tr>
<td>Industrialised countries</td>
<td>10,827</td>
<td>218 (2%)</td>
</tr>
<tr>
<td>Developing countries</td>
<td>119,973</td>
<td>48,147 (40%)</td>
</tr>
<tr>
<td>Least developed countries</td>
<td>27,819</td>
<td>16,682 (71%)</td>
</tr>
</tbody>
</table>

Data are number (%). CEE = Central and eastern Europe. CIS = Commonwealth of Independent States. Data from UNICEF.  

**Table:** Unregistered births (1000s) in 2003 by region and level of development

Figure 4: Cambodia—alignment of donor assistance to country needs during 2003-05
(A) What Cambodia wanted. (B) What Cambodia was given. Reproduced from WHO and Ministry of Health of Cambodia with permission. *STDs=sexually transmitted diseases.
Many health care delivery systems in the developing world are in a precarious state.
Figure 3: Coverage estimates for interventions across the continuum of care in the 68 priority countries (2000-06)

Lancet 2008, 371, 1247-58
Figure 3: Use of basic maternal and child health services by lowest and highest economic quintiles
Data from more than 50 countries. ARI=acute respiratory infection. Reproduced with permission from The World Bank.²³

Figure: Target and actual rates of decline in maternal mortality, south Asia.

MDG5
Figure 3: DALY rate per 1,000 for the leading broad cause groups by sex, Indigenous and total Australian population, 2003

<table>
<thead>
<tr>
<th>Cause</th>
<th>Male RR</th>
<th>Female RR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intentional injuries</td>
<td>3.9</td>
<td>5.3</td>
</tr>
<tr>
<td>Unintentional injuries</td>
<td>2.4</td>
<td>2.9</td>
</tr>
<tr>
<td>Cancers</td>
<td>17.0</td>
<td>19.0</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4.4</td>
<td>6.0</td>
</tr>
<tr>
<td>Chronic respiratory disease</td>
<td>2.5</td>
<td>2.6</td>
</tr>
<tr>
<td>Mental disorders</td>
<td>17.0</td>
<td>15.0</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>4.5</td>
<td>5.1</td>
</tr>
</tbody>
</table>

*Total Australian rates age-standardised to the Indigenous population.
RR—Rate ratio of Indigenous Australian to total Australian DALYs.


Gracey & King, Lancet 2009, 374, 65-75
1. Unfinished agenda
2. Emerging problems
3. Globalization

- Inequities, MDGs not attainable, problems beyond the health sector (social determinants)
- Future?
- With its focus on intersectoral collaboration, participation and equity, primary health care (PHC) is the key to dealing with these
WHO Commission on Social Determinants of Health

August, 2008

Highlights great health inequities caused by the social determinants of health

Equity strongly influenced by the way health systems are organized and financed

Champions PHC as a model for a health system that acts on the underlying social, political & economic causes of ill health
"Health systems will not naturally gravitate towards equity and unprecedented leadership is needed.

Primary health care, which integrates health in all of government's policies, is the best framework for doing so."
Figure 1.10: How health systems are diverted from PHC core values

Current trends:
- Hospital-centrism
- Commercialization
- Fragmentation

Health systems

Health equity
Universal access to people-centred care
Healthy communities
PHC reforms needed to refocus health systems towards health for all.
• What are the major global health problems and how does WHO shape policy recommendations to help tackle them?

• How do developing countries deal with strengthening leadership and evidence-informed health policy development in the context of primary care reforms?
Whether or not knowledge is global, the use of knowledge is always local.
“If you are poor, actually you need more evidence before you invest, rather than if you are rich.”

Dr Hassan Mshinda
Ifakara Centre, Tanzania
What evidence is needed to achieve PHC reforms?

- Evidence-based goals needed to address both **systemic** and **clinical** aspects of primary care
- **Systemic**: equitable distribution of resources, progressive & universal financing, low/no co-payments, comprehensive coverage
- **Clinical**: access to and use of first-contact care, patient-focused care, care over time for defined populations, comprehensive & timely services, coordination & integration of care

Starfield, CMAJ 2009, 180, 1091-92
What evidence is needed to achieve PHC reforms?

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Starfield, CMAJ 2009, 180, 1091-92
• Examples
• Challenges
Tanzania
Essential Health Interventions Project (TEHIP)

Community-based, participatory research for more equitable distribution of resources

Reversing the Trend in Child Mortality
Impact of District Health System Interventions in Rufiji District, Tanzania

- Official MDG Target Trajectory for Tanzania
- DHS Estimates for Rural Coastal Zone, Tanzania
- DSS Data for Rufiji District, Tanzania

52% decline from 1990-2003

MDG Target for Tanzania 48.4

Year

Under Five Mortality Probability (600) per 1000

Thailand: 30 Baht Scheme

- Fragmented public health financing leading to inequity
- 2001: decision to provide universal coverage leading to "30 Baht Scheme"
- Covers both prevention and curative care, shifted resources to primary care, included private providers
- Covered 80% of population
- What factors pushed the universal access policy onto the political agenda and facilitated rapid implementation?
Thai researchers provided evidence to support the policy adoption

Idea communicated to political party by MOH researchers through brief, concise paper (24 pp)

Paper suggested universal coverage feasible using existing resources

Evidence from synthesis of international literature & domestic studies

After policy adoption, different research groups proposed 3 alternative estimates for costing

Thailand
30 Baht Universal Coverage Scheme
Seguro Popular in Mexico

- Programme to deliver health insurance, regular and preventive medical care, medicines and health facilities to 50 m uninsured Mexicans
- Started in 2004, full roll-out by 2010
- Huge effort to achieve consensus across political parties and different groups
- Informed by thorough analysis of evidence
- Systematic evaluation from the beginning-inclusion of a rigorous, independent, scientific assessment of the programme
Public policy for the poor? A randomised assessment of the Mexican universal health insurance programme

Gary King, Emmanuela Gakidou, Kosuke Imai, Jason Lakin, Ryan T Moore, Clayton Nall, Nirmala Ravishankar, Mariett Vargas, Martha María Téllez-Rojo, Juan Eugenio Hernández Ávila, Mauricio Hernández Ávila, Héctor Hernández Llamas

Summary

Background We assessed aspects of Seguro Popular, a programme aimed to deliver health insurance, regular and preventive medical care, medicines, and health facilities to 50 million uninsured Mexicans.

Methods We randomly assigned treatment within 74 matched pairs of health clusters—ie, health facility catchment areas—representing 118,569 households in seven Mexican states, and measured outcomes in a 2005 baseline survey (August, 2005, to September, 2005) and follow-up survey 10 months later (July, 2006, to August, 2006) in 50 pairs (n=32,515). The treatment consisted of encouragement to enrol in a health-insurance programme and upgraded medical facilities. Participant states also received funds to improve health facilities and to provide medications for services in treated clusters. We estimated intention to treat and complier average causal effects non-parametrically.

Findings Intention-to-treat estimates indicated a 23% reduction from baseline in catastrophic expenditures (1·9% points; 95% CI 0·14—3·66). The effect in poor households was 3·0% points (0·46—5·54) and in experimental compliers was 6·5% points (1·65—11·28), 30% and 59% reductions, respectively. The intention-to-treat effect on health spending in poor households was 426 pesos (39–812), and the complier average causal effect was 915 pesos (147–1684). Contrary to expectations and previous observational research, we found no effects on medication spending, health outcomes, or utilisation.
Summary of evidence of systematic reviews of governance, financial and delivery arrangements & implementation strategies that can improve PHC in LMIC's

Does not address specific clinical or public health interventions but rather health system arrangements and implementation strategies which support their delivery in PHC
Key messages

• Financial incentives can be used to influence provider and patient behaviours
• User fees reduce use of both essential and non-essential health services
• Task shifting can expand coverage and address workforce shortfalls
• Integration of PHC services not adequately assessed
• Quality improvement strategies can have important, although modest, effects on PHC quality
• Examples
• Challenges
Figure 4: Knowledge pyramid

- Basic, theoretical and methodological innovations
- Individual studies, articles and reports
- Systematic reviews of research
- Actionable messages

Three needs of policymakers

• Clear translation
• Accessible & easy-to-use information
• Relevance to policy context

Robert Wood Johnson Foundation Synthesis Project

Research glut & information famine-Making research evidence more useful for policymakers, Health Affairs 2008, 27, 1177-1182
• Systematic review of health policy makers perceptions of their use of evidence
• **Facilitators**: personal contact, timely relevance, inclusion of summaries with policy recommendations
• **Barriers**: absence of personal contact, lack of timeliness and relevance of research, mutual mistrust, power & budget struggles

J Health Ser Res Policy 2002, 7, 239-44
"Against the advice of experts, I made a decision to cull 1.5 million chickens in order to control the epidemic. This decision was based more on faith in my own personal experience than on solid scientific evidence."

WHO Director-General
Dr Margaret Chan
Jan 25, 2007

Describing her experience as HK Secretary of Health during the H5N1 flu epidemic in 1997
“There is nothing a politician likes so little as to be well informed, it makes decision making so much more complex and difficult.”

John Maynard Keynes
(1883-1946)
“Scientific findings do not fall on blank minds that get made up as a result. Science engages with busy minds that have strong views about how things are and ought to be”

Sir Michael Marmot
• Can it work?
• Will it work?
• Is it worth it?

Dr Abu Bakar Suleiman
Former DG of Health Malaysia
Problems facing evidence-based PHC in LMIC's

• Lack of systematic reviews relevant to PHC priorities of developing countries
• Many interventions reviewed cannot be implemented in resource-poor situations
• Limited amount of primary research conducted in developing countries

Number and proportions (%) of Cochrane reviews by location of contact author in developing/developed countries, 1997 to 2007

CDSR: Cochrane Database of Systematic Reviews
Systematic review production in 22 LMIC countries in Asia, Africa, Latin America between 2004-2007

Highest in Asia and Americas (336, 327, 28)

5/9 Africa, 3/9 Americas, 2/7 Asia produced no systematic reviews

Only 10 unique reviews addressed governance, financial and delivery issues within health systems
97% of grants were for developing **new technologies** – this can reduce child mortality by **22%**

If, instead, research were done on how to fully utilize **existing technologies**, this can reduce child mortality by **66%**

...two thirds of these could be prevented by interventions currently available and feasible for implementation in these countries. Other articles from the conference indicated that the systems for delivering these technologies great a reduction in mortality can be expected from new health technologies in the future, given present conditions of utilization and delivery.

We first examined the evidence for another “gap,” namely on the development of better health technology versus improvements in health care delivery and utilization, we examined the allocation of research by the National Institutes of Health (NIH) and the Bill and Melinda...
What is EVIPNet

- Promote systematic use of evidence in policy-making in low and middle-income countries.
- Promotes partnerships at country level between policy-makers, researchers and civil society to facilitate policy development.
EVIPNet BUILDING BLOCKS

Country teams and regional and global support structures

Research synthesis & Policy briefs

Capacity development & empowerment

Country dialogues (safe harbor)

Monitoring and evaluation; Development of new methodologies
Conclusions

• Evidence needed to inform PHC reforms in developing countries is limited, especially on systemic aspects
• Critical to systematically evaluate reforms and strategies to further build the evidence base
• Limited capacity in countries to do PHC research and to access, manage, analyse, synthesize and present evidence to policymakers
• Strengthening linkages between research and policy development a high priority-structures and mechanisms needed which are part of PHC delivery programmes
"There is a pathway from good science to publication to evidence, and to programs that work. In this way research becomes an inherent part of problem-solving and policy implementation"

Julio Frenk
Former Mexican Minister of Health
“The divorce of research and analysis from pragmatic efforts to remediate inequalities of access is a tactical and moral error - it may be an error that constitutes, in and of itself, a human rights abuse”

Paul Farmer
US physician/anthropologist
“Pathologies of Power”
University of California Press, 2003