Imperial College London

School of Public Health

BSc GLOBAL HEALTH

YEAR 4

2012-13

TIMETABLE

MODULE 3:

GLOBAL HEALTH IN CONTEXT:

POVERTY, DEVELOPMENT AND GOVERNANCE

PLEASE NOTE: THIS IS A DOCUMENT IN PROGRESS AND THE MOST UP TO DATE VERSION CAN BE DOWNLOADED FROM THE INTRANET.

OVERVIEW

Module title

Global health in context: poverty, development and governance

Module leader

Dr. Mariam Sbaiti

Intended learning outcomes

Upon completion of the module, you should be able to:

- Comprehend and discuss a broad range of contemporary issues, problems, and controversies in global health
- outline the components and discuss the aims and functions of a health system, and the range of complexities in producing and using evidence for health and health system policy including in resource-poor settings (demographic, developmental, economic, cultural, political and organisational)
- Appreciate the role of health policy analysis and discuss the role of power and values in global health governance
- Evaluate the tools used to assess health needs
- Discuss the relevance for Global Health of an eco-social approach to determinants of health
- Interpret the evidence on access to healthcare and the implications for policy, with reference to different financing mechanisms
- Critically appraise the potentials and challenges represented by technology for advances in Global Health
- Illustrate the potential of inter-sectoral collaboration for Global health advances
- Discuss critically the contemporary system of Global Health governance and the role of different actors
- Describe and appraise the main arguments around aid effectiveness
- Discuss the main issues in providing healthcare to vulnerable populations
- Search and review the literature including print, library, and online resources across disciplines, to develop a critical discussion on topical dilemmas within the global health academic field
- Critically appraise a systematic review relevant to Global Health

Readings

Speakers have indicated the readings they advise students to have completed before their session. There is a wide variation in the complexity and volume of these. Students are advised to complete the essential readings and then further their readings guided by the interests they have developed over the course.

To guide this learning, the first reading of each session will be available on the intranet. However, this does not mean that further titles are not recommended reading. Most titles are available via the electronic journals page of the Imperial College London Library.

Essential reading lists the readings that all students are expected to have completed this in advance of a session.

(Suggested) Readings refers to important readings for the session. When there are a large number of these, they will be in order of importance with the first titles considered recommended.

References are texts that students are not necessarily expected to read. However they are there to guide learning and can be used to resolve questions. You may find these useful if you decide to work more in-depth on a particular topic within your essay or in Part C. Please feel free to approach lecturers or Mariam if you wish to have more details about specific readings or resources in an area of interest.

Teaching

Teaching methods include lectures, (student–led) seminars, case studies, conference lecture, intercollegiate symposium and revision sessions.

Seminars provide a space for you to advance your learning in the presence of someone who has experience in the subject. Global Health studies rely on critical thinking skills, and the seminars are therefore considered to be centred around your own learning. This means that we expect you to arrive prepared for seminars having completed the Essential readings and with an idea of what you would like to get out of the session. Some seminars will be student-led, requiring you, as a group, to develop a discussion or activity based on the readings or on the lecture. Occasionally you will also be given more specific instructions for seminar preparation.

The guide below includes an introduction to each week. These are not comprehensive but they attempt to tie together the various parts of the module. They should also help you develop your thoughts prior to lectures and seminars.

The Module includes sessions by lecturers from a variety of backgrounds and with a range of experience from academic, policy-making and civil society experience. You are not only allowed but are encouraged to be critical of what you are being taught. It is always a good idea to think of a couple of questions prior to a lecture which you may not be able to find out about in the literature. Do you agree with what is being presented? Do you have anything to add from your readings or personal experience? Whose points of view do you see represented here

Joint Teaching

The last session of joint teaching will take place at Brighton and Sussex Medical School. Funding will be provided for your train journey there and back. As for the Joint Teaching with MPH students in previous modules, intercollegiate sessions are intended to build on the multidisciplinarity of the Global Health BSc, which already mixes students from different academic backgrounds. This aims to provide an environment where you can practise your skills for working with colleagues of other disciplines and backgrounds, and levels of training. This is increasingly essential in Global Health practice and is an important intended learning objective for the course.

Assessments

There will be two in–course assessments for this module (30% total). The in–course assessments will include:

1. ICA 1: Critical Appraisal of a Systematic Review

   Date: Tuesday 22 January 2013

   Feedback Due: Tuesday 6 February 2013

   Students will be given an unseen written in-class test, in which they will be asked to undertake a critical appraisal of a Systematic Review (15%). You will cover the critical appraisal of SRs in Week 2, as part of the use of evidence for Health Systems and Policy.

2. ICA 2: A short essay (2500 words, 15%):

   Submission Deadline: 5pm, Saturday 2 February 2013

   Feedback Due: Monday 18 February 2013

   The topic will be announced on 2 January 2013. This essay can be written as an opinion piece and gives you the opportunity to research the evidence around a Global Health policy issue and develop your own arguments. A commentary format is usually suitable. However other formats may be suitable and you are advised to discuss ideas with Mariam if you are considering taking a different approach. It is advisable to draw on specific cases to illustrate your answer. Please follow the guidance on the intranet for submission of your work. Your essay will need to be submitted with the Essay Proforma via Blackboard before the above deadline. Penalties will apply for late submission and for word counts in excess of 1% over the maximum limit. Please note that abstracts are INCLUDED in the word count.

   Essay Title 1

   Discuss the evidence which may help guide policy on health financing, including public and private finance.

   Essay Title 2

   Aid effectiveness has become a recognised priority in the aid community over the last decade. Is the current Global Health System more effective compared to the governance system of the second half of the twentieth century? Discuss, supporting your arguments with current evidence.

Resources for essay writing skills can be found on the Imperial College London webpage: **http://www3.imperial.ac.uk/library/subjectsandsupport/writingskills**

GROUPS

Some seminar leaders may ask you to work in groups. In these cases you can either assign yourselves to a group or follow the groups below.

Group 1
Jenni Forshaw
Purvi Patel
Maryiam Yasin
Jake Arnold

Group 2
Max Keech
James Yeats
Gabrielle Prager
Samuel Lee

Group 3
Marissa Lewis
Ellie De Rosa
Paddy McGown
Rele Ologunde

Group 4
Alia Johari
Rubeena Ramjan
Sanaa Zahid
Nisha Karnani

Group 5
Emma Grahame
Emaan Boussabaine
Yin Yin Lee
Luvarnia Sadasivan

Group 6
Ellie Stewart
Alvin Parish
Sung-Hee Kim
Amelia Chong

Group 7
Diaga Emanuwa
Jen Low
Elke Wynberg

Module 3 Timetable 2012-2013

The session highlighted in yellow is delivered as joint teaching at Brighton and Sussex Medical School.

Date	Time	Speaker	Session	Location
Week 1: Defining and Assessing Health Needs and Determinants				
Weds 2 Jan	9.30-10.30	Mariam Sbaiti	Interactive Lecture: Introduction to Module 3	MSc room
	11.00-12.30	Mariam Sbaiti	Interactive seminar: Global Health in Context	MSc room
Thurs 3 Jan	10.00-11.00	Simon Gregson Laura Robertson	*Empirical Data for Assessing Public Health Needs* Lecture: Demographic Methods	Clinical LT
	11.15-12.15	Simon Gregson Laura Robertson	Lecture: Epidemiological Methods	Clinical LT
	12.30-13.00	Simon Gregson	The Research Process – A Fieldwork Perspective	Clinical LT
	14.00-14.30	Simon Gregson	Exercise Based on Fieldwork Experiences in Rural Zimbabwe	MSc room
	14.30-16.30	Simon Gregson	Practical Aspects of Field-Based Research - Case Studies	MSc room
CANCELLED Friday 4 Jan	9.30-1.00pm	Majid Ezzati	Lecture: Measuring the health of populations and Global Inequalities To be rescheduled Seminar: Measuring the health of populations – The New Burden of Disease Study To be rescheduled	Roger Bannister
Week 2: Health Systems I				
Mon 7 Jan	9.30-11.00	Julie Balen	Lecture: Introduction to Health Systems	MSc room

	2-4pm	Teresa Norat	Critical Appraisal of a Systematic Review	MSc room
Tuesday 8 Jan	9.30-11.00	Rifat Atun RESCHEDULED – Peter Smith on 17 Jan	Lecture: Trends in Health Systems financing and impact Rescheduled	Rescheduled
	11.30-12.30	Rifat Atun RESCHEDULED	Seminar: case studies on health systems	Rescheduled
	14.00-16.00	Laura Robertson	Lecture: Introduction to Social Epidemiology theoretical frameworks Seminar: Causal pathways to health in orphans	MSc room
Weds 9 Jan	9:00-10.00	David Nutt	Lecture: Assessing the harms of alcohol and other drugs and developing new ways to minimise them	Clinical LT
	10.15-11.00	David Nutt	Seminar: Assessing the harms of alcohol and other drugs and developing new ways to minimise them	Clinical LT
Thurs 10 Jan	Self-Directed Study			
Fri 11 Jan	9.30-10.45	Julie Balen	Lecture: Health systems: Governance and the use of evidence	Clinical LT
	11.15-12.30	Julie Balen	Seminar: governance for security and health	Clinical LT
	1.30-5.00pm	Majid Ezzati	Lecture: Measuring the health of populations and Global Inequalities Seminar: Measuring the health of populations – The New Burden of Disease Study	MSc room

Week 3: Technology and Access				
Mon 14 Jan	09.30-10.20	Stephen Matlin	Lecture: Technologies for Global Health – Introduction and concepts	Rothschild LT
	10.40-11.30	Stephen Matlin	Lecture: Further examples	Rothschild LT
	11.45-12.30	Stephen Matlin	Seminar: open discussion	Rothschild LT
	3-6pm	Inter-BSc afternoon at Brighton	Genomics, Equity and Global Health Prof Mel Newport and Prof Stefan Elbe	Brighton Uni, Room 3.07a, Brighton & Sussex Medical School, University of Sussex Falmer campus
Tues 15 Jan	9.30-11.00	Michael MacDonnell	Lecture: Innovation in Health Care	MSc room
	11.30-1pm	Mariam Sbaiti Paolo Vineis ?Helen Ward	Plenary Q&A Preparing for Part B examinations and Part C	MSc Room
	2-5pm	Aulo Gelli (Partnership for Child Development)	Lecture/Seminar: School Feeding/agriculture Programmes	Hynds Lab
Weds 16 Jan	9.00-13.00	Josip Car	Seminar: Cases of Technologies for GH developments at IC	SAFB – Seminar Room 119
Thurs 17 Jan	1.30-3.00pm	Peter Smith	Lecture and Discussion: Health System Financing (rescheduled from Week 2)	Clinical LT
Fri 18 Jan	9.30-11.00	Kris Harris (DoW)	Lecture: Migrant health in the UK – understanding barriers and access to healthcare	3rd floor seminar room (Daads)
	11.30-12.30	Kris Harris (DoW)	Seminar: Globalisation and Migrants' health	3rd floor seminar room (Daads)
Week 4: Global Health Policy/Governance				

Mon 21 Jan	10.00-12.00	Sid Wong (Conference call)	Lecture and Seminar: Global Health Governance	Rothschild LT
Tues 22 Jan	9.30-11.30	**ICA 1: Critical Appraisal of a Systematic Review In-class Test**		MSc room
	13.00-14.30	Judith Cherni	Lecture and Discussion: Globalization and problems of equitable development	MDL1 Bay D (SAFB, South Ken)
Weds 23 Jan	9.30-11.00	Bev Collins	Lecture: Global health and humanitarian policy RESCHEDULED	Peart room
	11.30-12.30	Bev Collins	Practical: Case Study: Myanmar- on-going access to TB/HIV care RESCHEDULED	Peart room
Thurs 24 Jan	Self directed study			
Fri 25 Jan	9.30-11.00	Nathan Ford	Lecture: Is access to medicines a human right?	3rd floor seminar room (Daads)
	11.30-13.00	Nathan Ford	Seminar: Is access to medicines a human right?	3rd floor seminar room (Daads)
Week 5: Health Systems II				
Mon 28 Jan	10.00-11:00	Bayard Roberts	Lecture: health in humanitarian conflicts	Roger Bannister
	11.30-13:00	Bayard Roberts	Lecture: Bomalia - group work based on a case study on priority setting	Roger Bannister
	2-3pm	Kelly Swain	Revision session for HGH: how to answer a humanities question under exam conditions	Clinical LT
Tues 29 Jan	10.00-12.00	Alejandro Reig	Providing a health service to vulnerable populations: the case of	Clinical LT

		(Amazonic Centre for Research and Control of Tropical Diseases)	indigenous populations in Southern Venezuela	
	1.30-2.30pm	Chris Millett	Lecture: Primary Care in the World	Cockburn LT
	2.30-3.30pm	Chris Millett and Felix Greaves	Seminar: Primary Healthcare – Primary Care and the reform of the NHS	Cockburn LT
	4.00-5.00pm	Mariam Sbaiti	Plenary: Module Evaluation	Cockburn LT
Weds 30 Jan	9.30-11.00	Bev Collin	Lecture: Global health and humanitarian policy (Rescheduled from 23 Jan)	Clinical LT
	11.30-12.30	Bev Collin	Practical: Case Study: Myanmar- on-going access to TB/HIV care (Rescheduled from 23 Jan)	Clinical LT
Thurs 31 Jan	Self-directed Study			
Fri 1 Feb	Self-directed Study			
	In-Course Assessment 2: Essay **To be submitted via Blackboard as per instructions, by 5pm on Saturday 2 February.**			

Core material

Not strictly core material but useful resource relating to core material.

Non-core material though contains important concepts and useful material which can be used as illustrations when answering questions in assessments.

Week 1

Week 1 will include an introduction to Module 3 and a further look at the measurement of health and disease.

We will first introduce the aims of the module. These are to develop further the complex questions of policy-making and the politics of health.

In Module 1, Dr Wendy Harrison introduced the concept of Disability-Adjusted Life Years, and the quasi-universal context where resources for health are limited and allocative decisions need to be made based on the available evidence. This is the basis of cost effectiveness exercise such as NICE in the UK and CHOICE (coordinated by the WHO). We will look at examples where low-income countries have achieved successes in population health with the careful choice of cost-effective approaches (see Good Health at Low Cost: 20 years later Report). Wendy covered the inherent challenges of DALYs as global estimates of disease burden, including the underestimation of the diseases associated with poverty and the implication of DALY measurements for equity.

Beyond these issues, is there ever a value-free evidence-based way in which resources will most "efficiently" produce an output? At various levels of Health Policy-making this is not always known, and there may not be one answer to such question.

Despite the significant increase in cross-university collaborations in Scientific Research globally, it is still a leading elite in academic research which produces most of the work. Also, in our own discipline, Global Health courses are mainly based in the Global North.

Week 1 will develop the concepts introduced in Part A and earlier in Part B, relating to "measurement" for Global Health. In an editorial in the Lancet in 2007, Richard Horton wrote: "Too many people, especially the poor, are never counted; they are born, live and die uncounted and ignored." (Who Counts?, Lancet 2007).

In practice, how is empirical data used to inform the development of a global health programme? Prof Gregson and Dr Robertson will introduce demographic methods for quantifying disease, and a practical example based on a real-life scenario of devising a PH programme in Zimbabwe. They will review the research cycle, from a fieldwork perspective, from formulating a research question to dissemination and implementation.

Prof Majid Ezzati, co-author of the very recently published Burden of Disease Study 1990-2010, will build on this by looking at the ways in which we can compile data at a global level to inform global health policy. How many people die and how many suffer of disability and illness? How can we quantify this. Building on Module 1 lecture on DALYs, Prof Ezzati will also introduce the new results of the GBD Study.

Last month, Prof Rifat Atun (IC) compared the GBD Study to the cooperative capacity and power of the Global Burden of Disease with the Cochrane Collaboration. Do you agree? You have a chance to discuss this with Prof Ezzati this week and Prof Atun next week.

Wednesday 2 January

Introduction to Module 3

Intended Learning Outcomes:

By the end of this session you should be able to:

- Understand the structure, learning methods and aims of the Module
- Appreciate the significance of governance of health systems and of the Global Health Systems

What is the Know-Do gap in health policy? Do we have all the right evidence to improve global health significantly? What factors play in the "translation" of this evidence into policy? And is it even correct to refer to this as a "translation", or should we be representing the process of policy-making differently?

Essential Reading:

Gilson L. Understanding the nature of social and political reality. In: Health policy and systems research: a methodology reader. Lucy Gilson (ed.) World Health Organisation 2012. (pp34-39) Available at:. http://www.who.int/alliance-hpsr/alliancehpsr_reader.pdf

Gilson L. Health Policy and Health Policy Analysis. In: Health policy and systems research: a methodology reader. Lucy Gilson (ed.) World Health Organisation 2012. (pp28-9) Available at:. http://www.who.int/alliance-hpsr/alliancehpsr_reader.pdf

Shiffman J SS. Generation of political priority for global health initiatives: a framework and case study of maternal mortality. Lancet 2007;370(9595):1370–1379

Recommended Readings

Alkire S, Chen Lincoln. Global Health and moral values. Lancet 2004; 364: 1069–74

Buse K, Mays N and Walt G. Making Health Policy. Maidenhead: Open University Press, 2012. (available via IC SFX: 2005 edition which will be updated **at the start of term**) – particularly Chapters 1, 4, 7, 8 and 9)

Thursday 3 January

Lecture: Defining and Assessing Health Needs

Simon Gregson and Laura Robertson

Empirical Data for Assessing Public Health Needs

10.00-11.00 *Demographic Methods* SG

Sources of Demographic Data

Demographic Indicators

Recent Demographic Patterns

11.15-12.15 *Epidemiological Methods* LR

Sources of Epidemiological Data

Epidemiological Indicators

Practical Aspects of Field-Based Research

12.30-13.00 *The Research Process – A Fieldwork Perspective* LR

Study Design, Funding, Operationalisation, Implementation, Dissemination

14.00-14.30 *Exercise Based on Fieldwork Experiences in Rural Zimbabwe*
LR/ SG

Snakes & Ladders Game

14.30-16.30 *Practical Aspects of Field-Based Research - Case Studies* LR/SG

Task:

1. Outline an appropriate study design to answer the research question
2. Identify three specific practical problems that could be faced in conducting the fieldwork and ways in which these might be minimised
3. Identify what implications these problems might have for the reliability of the study results

Research questions (all for Zimbabwe):

1. How high is HIV prevalence in adults in the general population?
2. What is the prevalence of (illegal) induced abortions?
3. What is the prevalence of sexually transmitted infections in pregnant women?
4. How many new TB cases are diagnosed each year?
5. How many adults are dying of lung cancer each year?

Defining and Assessing Health Needs

Empirical Data for Assessing Public Health Needs Simon Gregson & Laura Robertson

Summary

Empirical data are needed for assessing health needs and for identifying, prioritising and evaluating appropriate public health programmes. Data on health outcomes are available from a number of different sources and specific indicators have been developed for use in assessing health needs. However, there are many practical difficulties involved in collecting valid and reliable data on health outcomes and the most commonly used indicators are often subject to limitations and misinterpretation.

Aim

To provide students with a critical understanding of the empirical data and indicators available for use in assessing public health needs.

Learning objectives

After this session, students should have:

- Awareness of the main sources of demographic and epidemiological data
- Knowledge of the main indicators used in measuring health outcomes
- Understanding of the limitations of the data available on health outcomes
- Knowledge of current global demographic patterns

References

Gregson S, Adamson S, Papaya S, Mundondo J, Nyamukapa CA, Mason PR, et al. 2007. Impact and process evaluation of integrated community and clinic-based HIV-1 control in eastern Zimbabwe. Public Library of Science Medicine. 27: 4(3): e102.

McMichael, A.J. 2001. Human Frontiers, Environments and Disease: Past Patterns, Uncertain Futures. Cambridge: Cambridge University Press.

Newell, C. 1988. Methods and Models in Demography. London: Belhaven Press.

Rowland, DT. 2008. Demographic Methods and Concepts. Oxford: Oxford University Press.

Smith PG, Morrow RH, eds. 1991. Methods for field trials of interventions against tropical diseases. Oxford: Oxford University Press.

Useful web-sites

1. UN Population Division – http://www.un.org/esa/population/unpop.htm
2. World Bank – http://data.worldbank.org/
3. Office of Population Research at Princeton University Data Archive – http://opr.princeton.edu/archive
4. Demographic and Health Surveys – http://www.measuredhs.com
5. World Health Organisation – http://www.who.int/research/en/
6. UNAIDS – http://www.unaids.org/en/KnowledgeCentre/HIVData/default.asp

Friday 4 January

Lecture: Measuring the health of populations / Inequalities in Global Health

Majid Ezzati

The aim of this session to introduce the conceptual, analytical and data issues related to measuring the health of populations, partly using materials from the Global Burden of Disease Study

Intended Learning outcomes: by the end of this session you should be able to:

- explain the concept of a summary measure of population health (SMPH) and to learn some commonly use SMPH
- describe the analytical issues and data needs in calculating SMPH
- discuss some of the current state of population health in different world regions
- become familiar with inequalities in health

Essential reading

Mathers CD, Murray CJL, Ezzati M, Gakidou E, Salomon JA, Stein C. Population health metrics: crucial inputs to the development of evidence for health policy. Population Health Metrics 2003; 1:6

Lopez AD, Mathers CD, Ezzati M, Jamison D, Murray CJL. The global and regional burden of disease and risk factors, 2001: systematic analysis of population health data. Lancet 2006; 367(9524):1747-1757

On the new GBD Study you should briefly read over the main sections of the following papers:

Chan M. From new estimates to better data. The Lancet 2012; 380(9859): 2054-5

Vos T, Flaxman AD, Naghavi M, Lozano R et al. Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. The Lancet, Volume 380, Issue 9859, 15 December 2012–4 January 2013, Pages 2163-2196

Salomon JA, Vos T, Hogan DR et al. Common values in assessing health outcomes from disease and injury: disability weights measurement study for the Global Burden of Disease Study 2010. The Lancet 2013; 380 (9859):2129-2143

Recommended reading

Murray CJL, Salomon JA, Mathers C. A critical examination of summary measures of population health. Bulletin of the World Health Organization 2000; 78(8): 981-994

Mathers CD et al. Healthy life expectancy in 191 countries, 1999. Lancet 2001; 357(9269): 1685-1691.

Stevens G, Dias RH, Ezzati M. The effects of three environmental risks on mortality disparities across Mexican communities. Proceedings of the National Academy of Sciences USA 2008; 105(44):16860-16865

Ezzati M, Friedman AB, Kulkarni SC, Murray CJL. The reversal of fortunes: trends in county mortality and cross-county mortality disparities in the United States. PLoS Medicine 2008; 5(4):e66

Week 2

Week 2 introduces the concept of a health system.

The WHO has dedicated 2 World Health Reports to Health Systems: Health Systems (2005) and Health System Financing (2010).

The most evident aim of a health system is to maximise population health. As we saw last week, we possess tools that allow to produce reasonable estimates of the latter if we have the correct data. However health systems may have other aims, such as achieving improvements in equity. AS health systems are complex, evaluating their performance also is a complex and value-laden exercise, which includes a broader set of health system outcomes.

National health systems around the world vary greatly in organisation, level of spending on health (< 1% - > 15%), financing mechanisms and other central features.

In 1978, world leaders signed The Alma-Ata Declaration, a major milestone for public health in the twentieth century aiming to achieve *Health for All* by the year 2000. This will be covered in more detail in Week 5. One of the core principles of Alma Ata was its "primary healthcare" strategy, which included a focus on universally available, free and socially sound healthcare in all countries.

Today, in many countries, across a range of national income levels, services are paid for through out-of-pocket payments (OPP) at the point of service delivery. It is estimated that this applies to a majority of the world's 1.3 billion people living in poverty (WHR 2010). OPPs are known to push people into poverty and deter people from accessing healthcare when they need to. Yet many countries lack the necessary central funds to finance a healthcare service free at the point of use.

Health systems in most Low and Middle Income Countries are now understood as being inextricably linked with the actions of Global Health Initiatives such as the Global Fund, Gates Foundation and others (World Health Organization Maximizing Positive Synergies Collaborative Group 2009). This week therefore also introduces you to the different actors in Global Health, which we will study in more detail in Week 4.

This week, we will also build on the methods introduced in the Introductory module, on Systematic Reviews. Dr Norat will go through the methods for the critical appraisal of a Systematic Review, employing some of the common Tools relevant to Systematic Reviews for Global Health. Synthesising and appraising evidence is a crucial step in policy-making and is one without which the know-do gap in health policy cannot be bridged. Dr Balen will develop this further with the case of evidence for Health System Policy in Week 5.

The subjects of Male circumcision for HIV prevention offers an interesting case study in epidemiology. As you read the paper, try and contextualise it in the hierarchy of evidence available for this intervention (see Crash Course in Methods #4):

- Ecological (e.g. Moses et al., 1990)
- Cross-sectional (e.g. Auvert et al., 2001)

• Case-control (e.g. Quigley et al. 1997)

• Cohort (e.g. Gray et al. 2000)

• Systematic review of observational studies [before RCTs were done] (Seigfried et al. 2005)

• Randomized controlled trials (Auvert 2005; Gray 2007 & Bailey 2007)

• Systematic review and Meta-analysis of RCTs

Do you think this high level of available evidence showing positive results represents an obligation for policy-makers to promote this intervention? What other types of evidence will be useful?

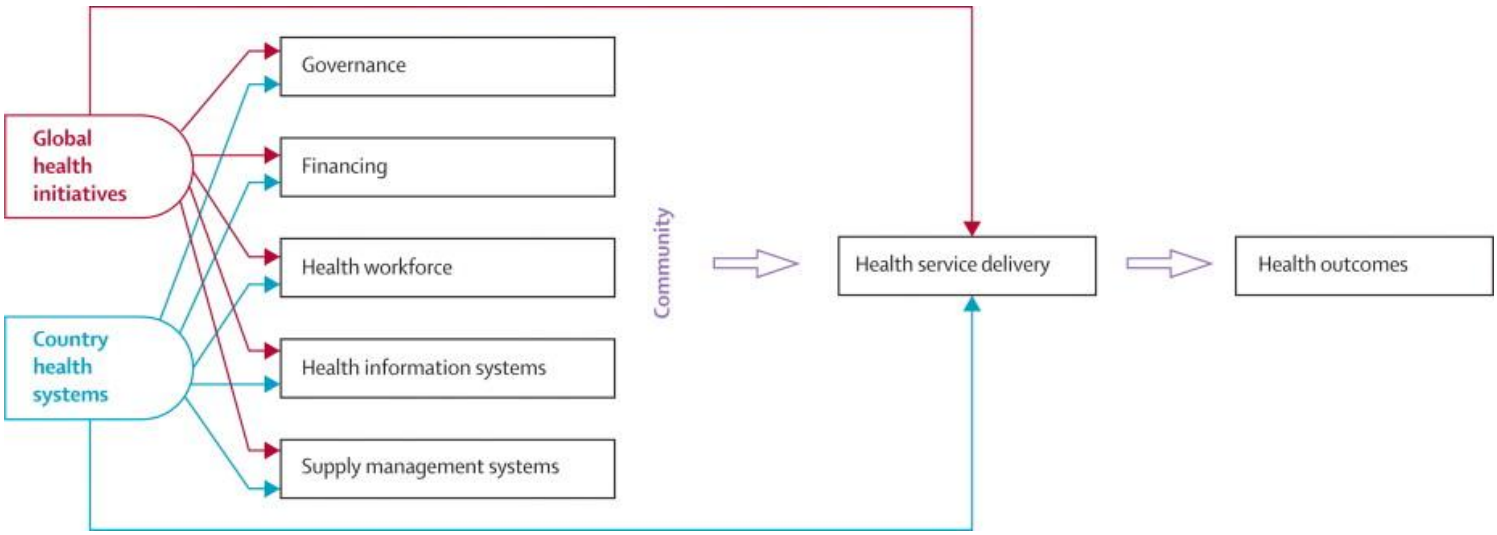

Figure. Conceptual framework of the interaction between global health initiatives and country health systems (Source: World Health Organization Maximizing Positive Synergies Collaborative Group 2009)

As we saw in the Methods Crash Course (Intro Module) and again last week, health systems rely on the interpretation of available evidence and this is a political and subjective process. Prof Nutt will illustrate this with the case of Drug Policy in the UK. Prof Nutt was appointed as the chairman of the Advisory Council on the Misuse of Drugs (ACMD) in 2008. During this time he published and spoke about the relationship between drug harm and classification. An editorial in the Journal of Psychopharmacology ('Equasy – An overlooked addiction with implications for the current debate on drug harms') compared the risks of horse riding (1 serious adverse event every ~350 exposures) with those of taking ecstasy (1 serious adverse event every ~10,000 exposures). Following the release of a pamphlet on the mismatch of policy and actual drug harm in 2009, Nutt was dismissed from his ACMD position by the then Home Secretary, Alan Johnson who wrote: "He was asked to go because he cannot be both a government adviser and a campaigner against government policy. [...] As for his

comments about horse riding being more dangerous than ecstasy, which you quote with such reverence, it is of course a political rather than a scientific point." (Guardian 2009).

The case of Prof Nutt's research is often quoted as an example of the political nature of evidence. Is the evidence he produced enough to refute current drug policy in the UK? What more would you like to know? Can you find any useful thoughts amongst the responses from different actors to the above events? Regarding policy actors, is a role in activism incompatible with an administrative or political role?

References:

Johnson, Alan (2 November 2009). "Why Professor David Nutt was shown the door". London: The Guardian.

General References

World Health Organization Maximizing Positive Synergies Collaborative Group. An assessment of interactions between global health initiatives and country health systems. Lancet 2009; 373: 2137–69.

Monday 7 January

What makes a health system healthy?

Julie Balen

Intended Learning outcomes

- Introduce the concept of a health system, and explain why it is important for good population health and equitable delivery of health services
- Describe the essential components of health systems, including 'hardware' and 'software' components
- outline the concepts of stewardship, governance and accountability
- Discuss the factors that influence supply/delivery of health services, including infrastructure, human resources, procurement and supply chain management
- Discuss the factors that influence demand for health services, including user incentives, information, education and communication materials
- appreciate the value of monitoring and evaluation and its role in performance improvement

Overview

Health systems can be defined either by what they seek to do and achieve, or by the elements of which they are comprised. The defining goal of health systems is health improvement, achieved through the provision of curative and preventative health services and through the protection and promotion of public health, emergency preparedness and inter-sectoral action (the extent of

legitimate Public Health action on a state's non-health sectors will vary depending on the country and on opinion (e.g. certain conservative public health practitioners consider that abortion is not a health issue but a political one). Moreover, health systems form part of the social fabric of the country, offering value beyond health (Gilson, 2003). Their wider goals therefore include equity, or fairness, in the distribution of health and the costs of financing the health system as well as protection for households from the catastrophic costs associated with ill health; responsiveness to the expectation of the population; and the promotion of respect for the dignity of persons (WHO 2007).

In terms of the elements they comprise, health systems can be understood in a number of ways, including as a number of functional building blocks (WHO, 2007) across macro, meso and micro levels (Van Damme et al., 2010). Health systems also encompass the interactions and relationships between those elements/blocks and between the individuals that make up the system. It is these relationships that build the blocks into a complex adaptive system (de Savigny & Adam 2009).

Essential reading

World Health Organization 2007. Everybody's business: Strengthening Health Systems to Improve Health Outcomes: WHO's framework for action. Geneva, WHO. http://www.who.int/entity/healthsystems/strategy/everybodys_business.pdf

Recommended reading

De Savigny D, Adam T etds (2009). Systems thinking for health systems strengthening. Geneva, World Health Organization. http://www.who.int/alliance-hpsr/resources/9789241563895/en/index.html

Frenk J 2010. The global health system: strengthening national health systems as the next step for global progress. PLoS Medicine, 7(1):1-3.

Gilson L 2003. Trust and the development of health care as a social institution. Social Science & Medicine, 56(7):1453-1468.

USAID. (2008) *Health Systems 20/20: Resources: Health Governance: Concepts, Experience, and Programming Options*. http://www.healthsystems2020.org/content/resource/detail/1914

USAID, 2010. (2010) *Health Systems 20/20 and Governance*. http://www.healthsystems2020.org/content/resource/detail/524/

Optional reading

For a good general survey of the main issues confronting health system policy makers, see the website and publications of the WHO European Health Observatory at: http://www.euro.who.int/observatory

Alva, Soumya, Kleinau, Eckhard & Pomeroy, Amanda and Rowan, Kathy. (2009) *Measuring the Impact of Health Systems Strengthening: A Review of the Literature.* http://www.usaid.gov/our_work/global_health/hs/publications/impact_hss.pdf

Van Damme W et al., 2010. How can disease control programmes contribute to health systems strengthening in sub-Saharan Africa? Studies in Health Services Organisation & Policy. Working Paper Series. Working Paper no. 1, Antwerp, Institute of Tropical Medicine. http://www.itg.be/itg/generalsite/default.aspx?WPID=756&L=e&miid

Lecture/seminar: Critical appraisal of systematic reviews

Teresa Norat, PhD

By the end of the session you will be able to:

-Use the Critical Appraisal Skills Programme (CASP) appraisal questions for systematic reviews

-Identify the main potential bias in systematic reviews and meta-analysis

-Present critical appraisal findings to lecturers and peers

Overview

Critical appraisal is the process of carefully and systematically examining research to judge its trustworthiness, and its value and relevance in a particular context. It is an essential skill for evidence-based medicine. It involves the use of the concepts and skills that you have acquired in precedent modules, such as the steps for conducting a systematic review and research methods.

Because of the explicit methods used for collecting, selecting and summarizing the findings of relevant studies on a specific topic, the risk of bias in systematic reviews should be minimized. However, there is a great deal of variation in the quality of published systematic reviews, and it is important that the reader can be in position to critically appraise them.

Guidelines and checklists have been developed for reporting systematic reviews (PRISMA) and a number of critical appraisal questions or checklists are also available. In the practical that follows this lecture, you will become familiar with the Critical Appraisal Skills Programme (CASP) worksheet.

Checklists and guidelines converge in three essential questions that need to be asked of any systematic review paper: is the review valid, what are the results and are the results relevant locally?

With respect to the validity of the review findings, one of the first issues is to establish whether the review authors have clearly stated the question(s) they are trying to answer. The review question should have been formulated following the PICO schema (P=population group; I and C= interventions being compared; O=outcomes considered). Once the question has been identified, you need to address if the right type of study designs has been included.

In a systematic review, it is important to ensure that all potentially relevant studies can be identified. The number of databases, use of grey literature and other sources of data, the search strategy, and the exclusion of research based on publication language and others have to be considered. The review author's should have assessed the quality of the studies included in the review. A number of tools and scales for study quality assessment have been developed. The Cochrane Handbook

recommends the use of a domain-based evaluation to assess the risk of bias in studies include in the review.

A detailed appraisal of each of the results presented in the review should be conducted. Look first if clear results are presented for each of the outcomes considered and if estimates of the precision (confidence intervals) are provided. Other issue is selective reporting bias. If the results are combined in a meta-analysis, look in the review authors should have explored heterogeneity and publication bias. If heterogeneity is marked, consider whether a meta-analysis should be carried or not.

The final question in a critical appraisal is about the applicability of the results and whether policy or practice should change as a result of the evidence contained in the review. This depends on the appraisal of the quality and strength of the evidence shown in the review and in the external validity of generalizability of the review findings.

You should read the paper before the tutorial so that you have sufficient time to work on it.

Paper for the practical Weiss HA, Hankins CA, Dickson K. Male circumcision and risk of HIV infection in women: a systematic review and meta-analysis. Lancet Infect Dis. 2009 Nov;9(11):669-77

Essential reading

Liberati A, Altman DG, Tetzlaff J, Mulrow C, Gøtzsche PC, Ioannidis JP et al. The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. Ann Intern Med. 2009 Aug18;151(4):W65-94.

Recommended reading

Critical Appraisal Tool for Systematic Reviews:
http://www.caspinternational.org/mod_product/uploads/CASP_Systematic_Review%20_Checklist_14.10.10.pdf

Further reading

Stroup DF, Berlin JA, Morton SC, Olkin I, Williamson GD, Rennie D, et al. Meta-analysis of observational studies in epidemiology: a proposal for reporting. Meta-analysis Of Observational Studies in Epidemiology (MOOSE) group. JAMA. 2000 Apr 19;283(15):2008-12.

Moher D, Cook DJ, Eastwood S, Olkin I, Rennie D, Stroup DF. Improving the quality of reports of meta-analyses of randomised controlled trials: the QUOROM statement. QUOROM Group. Br J Surg. 2000 Nov;87(11):1448-54.

Turner EH, Matthews AM, Linardatos E, Tell RA, Rosenthal R. Selective publication of antidepressant trials and its influence on apparent efficacy. N Engl J Med. 2008 Jan 17;358(3):252-60

Tuesday 8 January

Trends in Health Systems financing and impact

Rifat Atun

This session will help you to:

- Understand use of a framework for analysing health systems
- Understand of recent trends in international financing of global health and the impact of this financing.

By the end of this session you should be able to:

- Apply and use a framework for analysing health systems

Overview

This session will build on the body of research on aid effectiveness, to focus specifically on international financing of global health, emphasising in particular funding from innovative financing sources. Innovative financing gained prominence in the last decade as a promising new source of international health assistance, and especially with the global economic crisis. The session will present new research, undertaken with co-researchers at Harvard and Oxford Universities, that explores the nature and extent of international innovative financing, allocation of international innovative financing and research funding in relation to disease burden and need, and the health, economic and social benefits of these investments.

The session will introduce an analytical framework that can be used to holistically examine and compare innovative financing from international and domestic sources.[1]

The session will discuss findings from a series of studies that have focused on financing for health systems and for neglected conditions, for example, maternal and neonatal health[2,3], cancer[4], HIV/AIDS[5,6], malaria[7,8,9], tuberculosis[10,11,12,13] and health systems[14,15].

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1 **Atun R,** Knaul FM, Akachi Y, Frenk J. Innovative financing for health: what is truly innovative? **Lancet 2012**.
2 Fisk NM, **Atun R**. Market failure and the poverty of new drugs in maternal health. **PLoS Medicine 2008**; 5(1): e22. doi:10.1371/journal.pmed.0050022
3 Fisk, NM, **Atun, R**, Systematic analysis of research underfunding in maternal and perinatal health. **British Journal of Obstetrics & Gynaecology – Int J Obstetric Gynaecology 2009**; 116: 347-55.
4 Farmer P, Frenk J, Knaul F, Shulman L, Alleyne G, Armstrong L, **Atun R**, others. Expansion of cancer care and control in countries of low and middle income. **Lancet 2010**; 376: 1186-93.
5 Stover J, Korenromp EL, Blakley M, Komatsu R, Viisainen K, Bollinger L, **Atun R**. Long-Term Costs and Health Impact of Continued Global Fund Support for Antiretroviral Therapy. **PLoS ONE.** 1 Jan **2011** 6(6): e21048.
6 Resch S, Korenromp E, Stover J, Blakley M, Krubiner C, Thorien K, Hecht R, **Atun R**. Economic Returns to Investment in AIDS Treatment in Low and Middle Income Countries. **PLoS ONE 2011** 6(10): e25310.
7 Snow RW, Okiro EA, Gething PW, **Atun R**, Hay SI. Equity and adequacy of international donor assistance for global malaria control: an analysis of populations at risk and external funding commitments. **Lancet 2010**; 376:1409-16.
8 Pigott DM, **Atun R**, Moyes CL, Hay SI, Gething PW. Funding for malaria control 2006-2010: a comprehensive global assessment. **Malaria Journal 2012**; 11 (1): 246. doi:10.1186/1475-2875-11-246.
9 Akachi Y, **Atun R**. Effect of Investment in Malaria Control on Child Mortality in Sub-Saharan Africa in 2002–2008. **PLoS ONE.** 1 Jan **2011** 6(6): e21309.doi:10.1371/journal.pone.0021309
10 Marais BJ, Raviglione MC, Donald PR, Harries AD, Kritski AL, Graham SM, El-Sadr WM, Harrington M, Churchyard G, Mwaba P, Sanne I, Kaufmann SH, Whitty CJ, **Atun R**, Zumla A. Scale-up of services and research priorities for diagnosis, management, and control of tuberculosis: a call to action. **Lancet 2010**; 375: 2179-91.
11 Akachi Y, Zumla A, **Atun R**. Investing in Improved Performance of National Tuberculosis Programs Reduces the Tuberculosis Burden: Analysis of 22 High-Burden Countries, 2002-2009. **Journal of Infectious Diseases 2012**; 205 (suppl_2): S284-292S.
12 Glaziou P, Floyd K, Korenromp EL Sismanidis C, Bierrenbach AL, Williams BG, **Atun R,** Raviglione M. Lives saved by tuberculosis control and prospects for achieving the 2015 global target for reducing tuberculosis mortality. **Bulletin of the World Health Organization 2011**; 89(8): 573-82.
13 Korenromp EL, Glaziou P, Fitzpatrick C, Floyd K, Hosseini M, Raviglione M, **Atun R**, Williams B. Implementing the Global Plan to Stop TB, 2011-2015: optimizing allocations and the Global Fund's contribution. A scenario projections study. **PLoS One. 2012** 7(6): e38816. doi:10.1371/journal.pone.0038816.

Essential reading

Atun R, Knaul FM, Akachi Y, Frenk J. Innovative financing for health: what is truly innovative? **Lancet 2012**.

Recommended readings

1. Fisk NM, **Atun R**. Market failure and the poverty of new drugs in maternal health. **PLoS Medicine 2008**; 5(1): e22. doi:10.1371/journal.pmed.0050022
2. Farmer P, Frenk J, Knaul F, Shulman L, Alleyne G, Armstrong L, **Atun R**, others. Expansion of cancer care and control in countries of low and middle income. **Lancet 2010**; 376: 1186-93.
3. Resch S, Korenromp E, Stover J, Blakley M, Krubiner C, Thorien K, Hecht R, **Atun R**. Economic Returns to Investment in AIDS Treatment in Low and Middle Income Countries. **PLoS ONE 2011** 6(10): e25310.
4. Snow RW, Okiro EA, Gething PW, **Atun R**, Hay SI. Equity and adequacy of international donor assistance for global malaria control: an analysis of populations at risk and external funding commitments. **Lancet 2010**; 376:1409-16.
5. Pigott DM, **Atun R**, Moyes CL, Hay SI, Gething PW. Funding for malaria control 2006-2010: a comprehensive global assessment. **Malaria Journal 2012**; 11 (1): 246. doi:10.1186/1475-2875-11-246.
6. Akachi Y, **Atun R**. Effect of Investment in Malaria Control on Child Mortality in Sub-Saharan Africa in 2002–2008. **PLoS ONE.** 1 Jan **2011** 6(6): e21309.doi:10.1371/journal.pone.0021309
7. Shakarishvili G, Lansang MA, Mitta V, Bornemisza O, Blakley M, Kley N, Burgess C, **Atun R**. Health systems strengthening: a common classification and framework for investment analysis. **Health Policy and Planning 2011**; 26(4): 316-26.

Optional Readings

1. Glaziou P, Floyd K, Korenromp EL Sismanidis C, Bierrenbach AL, Williams BG, **Atun R,** Raviglione M. Lives saved by tuberculosis control and prospects for achieving the 2015 global target for reducing tuberculosis mortality. **Bulletin of the World Health Organization 2011**; 89(8): 573-82.
2. Korenromp EL, Glaziou P, Fitzpatrick C, Floyd K, Hosseini M, Raviglione M, **Atun R**, Williams B. Implementing the Global Plan to Stop TB, 2011-2015: optimizing allocations and the Global Fund's contribution. A scenario projections study. **PLoS One. 2012** 7(6): e38816. doi:10.1371/journal.pone.0038816.
3. Vujicic M, Weber SE, Nikolic IA, **Atun R,** Kumar R. An analysis of GAVI, the Global Fund and World Bank support for human resources for health in developing countries. **Health Policy and Planning 2012**. First published online February 13, 2012 doi:10.1093/heapol/czs012

Lecture: Introduction to Social Epidemiology theoretical frameworks

Laura Robertson

Synopsis

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14 Shakarishvili G, Lansang MA, Mitta V, Bornemisza O, Blakley M, Kley N, Burgess C, **Atun R**. Health systems strengthening: a common classification and framework for investment analysis. **Health Policy and Planning 2011**; 26(4): 316-26.

Social epidemiology is the study of the social distribution and social determinants of states of health. In more traditional risk factor epidemiology, social factors are often treated as "confounders" rather than explanatory variables in their own right. Social epidemiology explores the social conditions that give rise to patterns of health and disease in individuals and populations. Theoretical frameworks are often used to provide visual representations of the pathways through which social conditions influence health. In particular, the ecosocial approach integrates social and biological reasoning in multi-level frameworks of interlinked causal mechanisms (e.g. legal structures, social networks, psychosocial effects, biological dynamics of disease). In this lecture, we go over a specific example to illustrate the ecosocial approach: explaining the high risk of hypertension amongst African Americans. The observed increased risk is not fully explained by standard risk factors. The ecosocial approach provides a framework to explore the pathways that link racial discrimination with biological pathways, including economic and social deprivation, socially inflicted trauma, targeted marketing of commodities, toxic environments, inadequate health care and resistance to social oppression. These types of findings can be used to develop structural interventions to impact the societal conditions that lead to increased health risk amongst particular groups of people. Structural interventions address upstream determinants of health. A trial of a cash transfer intervention for adolescent school girls in a low income area of Malawi reported significant reductions in HIV and HSV-2 infections after 18 months.

Intended Learning Outcomes - by the end of this session, students should be able to:

- List the major social determinants of health
- Provide a working definition of social epidemiology
- Define an ecological approach to disease causation and outline its strengths and limitations
- Provide examples of disease pathways that illustrate an ecological approach to disease causation
- Illustrate how an eco-social approach links determinants of health across different levels to form explanatory models
- Demonstrate how eco-social frameworks support policies that target major determinants, including global inequalities
- Critically appraise the use of the above frameworks for global health research

Essential Reading

Krieger N. A glossary for social epidemiology. J Epidemiol Community Health 2001;55:693-700

Further readings

Berkman LE and Kawachi I. Social Epidemiology. Oxford: Oxford University Press, 2000

Kilmarx PH et al. Sociodemographic factors and the variation in syphilis rates among US counties, 1984 through 1993: an ecological analysis. Am J Public Health 1997;87:1937-43.

Thomas JC et al. The Social ecology of syphilis Sci Med 1999; 48: 1081-1094

Krieger N. Epidemiology and the web of causation: has anyone seen the spider? Social Science and Medicine 1994; 39(7): 887-903

Seminar: Causal pathways to health in orphans

Laura Robertson

The session is run as an exercise in small groups on Household headship and child nutrition. It will be based on a case study in western Kenya. A handout will be provided by the seminar leader and students will be asked to read the abstract of the Onyango et al (1994) paper and work through a set of structured questions.

Essential Reading

Onyango A, Tucker K & Eisemon T. Household headship and child nutrition: a case study in western Kenya. Social Science and Medicine 1994; 39(12):1633-9.

Further reading

Poundstone KE, Strathdee SA & Celentano DD. The social epidemiology of human immunodeficiency virus/acquired immunodeficiency syndrome. Epidemiologic Reviews 2004; 26 (1): 22-35.

Boerma JT & Weir SS. Integrating demographic and epidemiological approaches to research on HIV/AIDS: the proximate-determinants framework. The Journal of Infectious Diseases 2005; 191 (Suppl. 1): S61-7.

Mosley WH & Chen LC. An analytical framework for the study of child survival in developing countries. Population and Development Review 1984; 10 (Suppl):25–45.

Lewis JJ, Donnelly CA, Mare P, Mupambireyi Z, Garnett GP & Gregson S. Evaluating the proximate determinants framework for HIV infection in rural Zimbabwe. Sexually Transmitted Infections 2007; 83 (Suppl 1): 61-69.

Lopman B, Nyamukapa C, Mushati P, Mupambireyi Z, Mason P, Garnett GP et al. HIV incidence in 3 years of follow-up of a Zimbabwe cohort--1998-2000 to 2001-03: contributions of proximate and underlying determinants to transmission. International Journal of Epidemiology 2008; 37(1): 88-105.

Wednesday 9 January

Assessing drug harms

David Nutt

Intended learning outcomes: By the end of this session you should be able to:

- Understand the different sorts of harms drugs can cause
- That alcohol and tobacco are harmful drugs
- That the drug laws and international conventions bear little relationship with the real harms of the drugs they are supposed to control

Overview

I will cover the sorts of harms that drugs can cause and the relative frequency of use of them. Then I shall describe the ways in which they are controlled and the penalties for use, dealing etc commenting on interesting new development such as in Portugal and the USA. Finally I shall describe a new method for assessing the different harms of drugs – those to the individual user as well as those to other people and society in general. The method of multi criteria decision analysis will be introduced as a powerful way of comparing harms of different factors with very different metrics ranging from deaths to international criminality. Based on this the latest results on 20 drugs will be presented and discussed.

Essential reading

Nutt DJ King LA Phillips LD (2010) Drug harms in the UK: a multicriteria decision analysis Lancet 376: 1558-65 .

Further reading

Drugs without the hot air – David Nutt [book]

Friday 11 January

Health systems: policy, politics and practice

Julie Balen

Intended Learning outcomes

By the end of this session you should be able to:

- Explain the role of health policy in the design and reform of health systems
- Discuss examples of reforms that have succeeded in improving health system performance
- Discuss the barriers to implementing such reforms, and how they might be overcome.
- Discuss the role of power and politics in the global health agenda and the value of global health diplomacy in international relations
- Provide examples of the power shift in global health, using global and regional examples
- outline the concept of health security, and give examples of how various health issues have been framed as security issues on the global stage

Synopsis

Health policy can be understood as the formal, written documents, rules and guidelines that present policy makers' decisions about what actions are deemed legitimate and necessary to strengthen the health system and improve health. However, these formal documents are translated through the decision-making of policy actors, such as middle managers, health workers, patients and citizens, into their daily practices. These daily practices – for example management, service delivery, interactions with others – become health policy as it is experienced, which may differ from the intentions of the formal documents. Therefore, policy can be seen not only as the formal statements of intent but also as the informal, unwritten practise.

Health policy includes policy made in the public sector (by government) as well as policies in the private sector. As health is influenced by many determinants outside the health system, it may also include the actions (or inaction) and intended actions of organizations external to the health system, for example the food, tobacco and pharmaceutical industries. Moreover, at a global level, policy actors include the range of multilateral and bilateral organizations and the global public-private initiatives such as the Gates Foundation, as well as transnational civil society movements (eg People's Health Movement) – you will cover this in more detail during week 4 of the Module.

This lecture will be followed by a participatory seminar examining the above issues in more details through a fish-bowl group discussion. Please come prepared for this discussion by reading the essential seminar reading below. The discussion will cover this as well as the material included in the lecture. You will be asked to discuss the facts covered here and contribute any personal views and experiences.

Essential reading

Gilson L, Raphaely N 2008. The terrain of health policy analysis in low- and middle-income countries: a review of published literature 1994-2007. Health Policy and Planning. 23(5):294-307.

Essential Seminar Reading

Hunter DR, Killoran A. 2004 Tackling health inequalities: turning policy into practice? The Health Development Agency Working Paper (www.hda.nhs.uk)

Recommended reading

Shiffman H 2009. A social explanation for the rise and fall of global health issues. Bulletin of the World Health Organization. 87(8)608-13.

Buse K 2008 Addressing the theoretical, pratical and ethical challenges inherent in prospective policy analysis. Health Policy and Planning 23(5):351-360.

Sheikh K, Porter J 2010. Discursive gaps in the implementation of public health policy guidelines in India: The case of HIV testing. Social Science & Medicine. 71(11):2005-2013

Good Health At Low Cost: 20 years later. http://ghlc.lshtm.ac.uk/files/2011/10/Good-health-at-low-cost-25-years-on-Policy-Briefing-4P-HR2.pdf

http://www.sciencedirect.com/science/article/pii/S0140673612613403

Optional reading

Smith R., Hanson K 2011. What is a health system. In: Smith R. Hanson K eds. Health systems in low- and middle- income countries: an economic and policy perspective. Oxford, Oxford University Press: Chapter 1.

Frenk J 1994 Dimensions of health system reform. Health Policy. 27:19-34

Marchal B, Dedzo M, Kegels G 2010. A realist evaluation of the management of a well-performing regional hospital in Ghana. BMC Health Services Research, 10:24.

Week 3

This week introduces the questions relative to Technologies for Global Health. Technologies are a building block of health systems and a health system cannot function without their appropriate use and distribution. These are understood in the wider sense, beyond medical technologies, and include for instance, innovation in systems. Technologies are also central the the development of nations.

How are technologies use towards better health and what are the implications of equity?

Last week, we touched on some of the factors behind spiralling healthcare costs in High Income Countries, and barriers to access and quality of care in many Low and middle Income Countries. These are now said to highlight the need for new ways of thinking about what technology we use and how we use it.

In his book *Turning the World Upside Down* (under reference readings), Lord Nigel Crisp, Former Head of the UK National Health Service, draws on theories of development (such as leapfrogging and reverse technology transfer) demonstrating their relevance to global health. To become more democratic, Lord Crisp sustains, GH requires a remodelling of traditional concepts of international aid and development. These represent a high income country providing aid to a low income country. Newer notion of "co-development" emphasise development as interdependence and mutual learning. For instance, Reverse innovation "imports" knowledge and technologies from poorer countries to richer countries. This leads us onto the question of aid effectiveness which we will develop further next week. Amidst greater flows in Development Assistance for Health, there are increasing questions on the effectiveness of existing aid systems, in global health as well as in other areas of international development.

The term aid and its connotations are also being questioned with alternative terminology such as *'development cooperation'* being used in the diplomacy of Aid Effectiveness. Why do you think this is the case?

A crucial part of technologies are pharmaceuticals. The availability of these depends, inter alia, on research funding and trade regulations. Dr Nathan Ford will lead a session on the impact of Trade-Related Intellectual Property Rights (TRIPs) and their implications now and in the past, for the availability of important pharmaceuticals. International Trade in capital, goods and services each have a range of impacts for Health globally, and we have already touched on those relating to Infectious Diseases and Non-Communicable Diseases (Food and Tobacco Industry). An essential part of International Trade Agreements not covered in the course is that of Trade in Health Services.

Global health is also health also includes health at home. Kris Harris, Project Manager for Project:London, builds on Module 2 themes of migration and health from the perspective of healthcare and access, and its implications for equity in countries such as the United Kingdom.

Kris gives an academic account of the literature on the subject as well as her view from the Non-Governmental sector. In module 1, you also heard Dr Caroline Harper (CEO of Sightsavers) on strengthening health systems around eye health. Thinking of next week's theme, do you find any

differences between an academic's view and the view of a civil society organisation? What factors may determine these differences?

In Module 1, you also heard about Strategies for TB control at the nation's borders? What are the implications for this on access to appropriate healthcare for migrants?

Monday 14 January

Stephen Matlin

Technologies for Global Health

By the end of this session you should be able to:

* Explain the concepts of innovation and technologies for global health
* Give examples of a diverse range of technologies (products and processes) for global health and explain the significance of 'frugal' technologies
* Describe barriers to the development of appropriate technologies for different settings and discuss possible approaches to overcome them

The session will have three parts:

1. **Introduction and concepts**
   Global health; innovation; technologies FOR global health in the context of a broad range of determinants of health and the contribution of technical progress to increasing life expectancy globally; constraints on technologies for low- and middle-income countries (LMICs) and the role of 'frugal' technologies;
   Example 1: The pharmaceutical industry: pharmaceutical classes; innovation in the pharmaceutical industry, the drug pipeline, stages of drug development, the roles of regulation and intellectual property, costs of pharmaceuticals; impact of pharmaceutical markets and other constraints on innovation; neglected diseases and health issues, including drugs for diseases of the poor, fertility regulation and noncommunicable diseases; the problem of counterfeit drugs and technologies to combat counterfeiting.

2. **Further examples**
   A series of examples of technologies (including innovations in products and processes) for global health drawn from diverse sectors and fields, such as: road traffic injuries; transport; assistive technologies; medical & surgical technologies; medical imaging; water; sanitation; shelter. Health technology assessment; the role of the National Institute for Health and Clinical Excellence (NICE) in the UK and globally.

3. **Discussion session**
   * Opportunity to discuss further the material in the first two parts.
   * Class-led discussion of the proposal for an R&D Convention for global health.

Essential reading

Howitt P, et al. Technologies for Global Health. The Lancet, 2012, 380: 507-35.
www.thelancet.com/journals/lancet/article/PIIS0140-6736%2812%2961127-1/fulltext#article_upsell

Executive Summary of: Report of the Consultative Expert Working Group on Research and Development: Financing and Coordination. Research and Development to Meet Health Needs in Developing Countries: Strengthening Global Financing and Coordination. Geneva: WHO April 2012. www.who.int/phi/CEWG_Report_5_April_2012.pdf

BSMS Joint Global Health Teaching Seminar – 3-6pm

Genomics, Equity and Global Health

Prof Mel Newport, Prof Stefan Elbe and Dr Margaret Sleeboom-Faulkner

Room 3.07a, Brighton & Sussex Medical School, University of Sussex Falmer campus
http://www.bsms.ac.uk/about/visiting-us/

Overview of seminar

The joint teaching seminar will bring together three leading academics from medicine, international relations and anthropology to discuss the topic of 'Genomics, equity and global health'.

By the end of the session, students will be able to discuss the potential of the Human Genome Project to improve global health and to critique the equity of such advances in genetic technology & genomic research.

Session 1: Role of Genomics in Global Health
Professor Melanie Newport, Infectious diseases & Global Health, BSMS

The human genome project led to the publication of the first draft of the human DNA sequence about 10 years ago. The rate at which disease-associated genes are discovered is rising exponentially with associated benefits for wealthy societies (e.g. the development of 'personalised' medicine. However, these advances are bypassing those who stand to benefit the most from new developments and technologies – i.e. those who live in resource poor settings and bear the brunt of the global burden of disease – thereby widening the health inequity gap. This session will review the basic science and its implications to set the context.

Essential Readings:

Acharya T. Strengthening the Role of Genomics in Global Health. PLoS Med. 2004 December; 1(3): e40.

Daar AS. How can developing countries harness biotechnology to improve health? BMC Public Health. 2007; 7: 346.

Session 2: Viral Diplomacy - Why States are Now Fighting About Who Owns Deadly Flu Viruses

Professor Stefan Elbe, International Relations, University of Sussex

This session will look at how ownership of genetic information about deadly flu viruses has recently become the object of high-level and acrimonious international diplomacy. The session will explore the long-standing Global Influenza Surveillance System as a way of exchanging virus samples and information on the genetic evolution of flu viruses for international public health purposes. The session will then trace how - within the context of growing international concern about highly pathogenic bird flu (H5N1) - this system came under unprecedented diplomatic pressure. Indonesia - where the most virulent forms of the virus were circulating - began to refuse to share virus samples with the rest of the international community. The session will discuss why Indonesia took this drastic step and the consequences it has for global health. The session will also explore the wider global inequalities that lie at the root of this virus-sharing controversy.

Essential Readings:

Elbe S (in press). Competitive adaptation: biobanking and bioethical governance in China Medical City (CMC)1. (Forthcoming: East Asian Science, Technology and Society: an International Journal, January 2013).

Elbe S (2010). Haggling over viruses: the downside risks of securitizing infectious disease. Health Policy and Planning 2010;25:476–485.

Session 3: Epidemiology & Biobanking - Political decision-making, distributive justice and socio-political causes of modern welfare diseases in China

Dr Margaret Sleeboom-Faulkner, Anthropology, University of Sussex

Science and technology are seen as core drivers of modernization, enabling the rationalization of society, the control of nature, and medical progress. With the development of biobanks, genetic and environmental measurements routinely translated in terms of public health risk. They have become important political and economic assets in public health based on statistical correlations instead of socio-political insight and vision. In this biosocial framework (Rabinow 1999) all human behaviour is potentially determined by genetic and epigenetic processes and environmental factors. It not only continues and renews the medicalisation of society, it also provides authorities with tools for monitoring public health and controlling disease.

In European societies, this development has led healthcare providers, including medical councils, hospitals, educators and patient networks to spread awareness of risks factors, requiring and enabling individuals to monitor their health (Rose 2005). In China investment in epidemiology and biobanks has grown. But it is not developing in an environment of equal access to healthcare and health education. This raises questions of how in Chinese society tools for monitoring public health and controlling disease are employed, how epidemiological information is collected, and who benefits from its maintenance in biobanks.

On the basis of research on a longitudinal genetic cohort study near Shanghai, I argue that epidemiological tools in China leave little space for individual choice and social agency, where official bioethics and dominant discourse on life values and the creation of bioethics institutions are relatively new and intimately intertwined. Thus research into the genetic factors in the development of bowel- and stomach cancer in conglomerate areas directs attention away from the socio-political agency of individuals. Here, genetic/ environmental factors are treated as the determinants of social behaviour without paying attention to issues of political decision-making, distributive justice and the socio-political causes of modern welfare diseases.

Essential Reading

Sleeboom-Faulkner M. Title: How to Define a Population: Cultural Politics and Population Genetics in the People's Republic of China and the Republic of China. BioSocieties 2006. 1:399

Session 4: Group discussion

All speakers

The final session of the afternoon will be an opportunity for students to discuss and debate the issues raised by the three different speakers. Questions for consideration include:

- Why is there unequal access to genetic technology & genomic research?
- What can be done to address this growing divide?
- How can genomic research be used to improve global health equity?
- What is the scope of interdisciplinary collaboration?

After the seminar, students are invited to join us for drinks at the Institute of Development Studies bar.

Tuesday 15 January

Health service innovation

Michael MacDonnell

By the end of this session you should be able to:

- Understand key macro dynamics in healthcare and why innovation is necessary;
- Conceptualise types of innovation;
- Appreciate the big debates in innovation thinking and gain an introduction to some of the key literature.
- How best to provide high quality, accessible and affordable health services is one of the most pressing challenges shared today by nations across the world. Each country's circumstances are unique. But the basic issues are surprisingly similar.

Overview

In developed countries, spiralling costs and ever-increasing demand—driven in part by the non-communicable disease pandemic—combine to create powerful expenditure pressures on already stretched public and private resources. In other countries, the priority is to increase access to healthcare. Here too, the challenge is to satisfy unmet demand without generating unsustainable pressure on public resources. Healthcare systems look increasingly ill-suited to meet these challenges. Innovation – especially in how services are delivered – is badly needed. So too are ways of diffusing the best ideas, closing the gap between what we know and what we do.

This lecture will introduce students to key concepts in innovation thinking such as treatment v service innovation and disruptive v sustaining' innovation. It will also provide an overview of global trends in innovation including developments in emerging economies and their implications for advanced economies like the UK. It will address innovation from a policy or systemic level rather than from the point of view of a specific area or discipline.

The session will combine an introduction to some of the important literature with a practical perspective on why health systems are so hard to change, even as innovation proceeds apace at the micro or therapeutic level. Case studies will be discussed to elucidate barriers to innovation from a policymaker's perspective.

Essential reading

Donald A. Berwick, Disseminating Innovations in Health Care, JAMA, April 16, 2003 – Vol 289, No. 15

Clayton Christensen, The Innovator's Prescription (2009)

Recommended reading

Gabriel I. Barbash and Sherry A. Glied, New Technology and Health Care Costs – The Case of Robot-Assisted Surgery, NEJM 363; 8, August 19, 2010

Nigel Crisp, Turning the World Upside Down (2010)

Mary Dixon-Woods et al., Problems and promises of innovation: why healthcare needs to rethink its love/hate relationship with the new, BMJ Quality & Safety 2011; 20 (Suppl 1): i47-i51

Frugal healing: Inexpensive Asian innovation will transform the market for medical devices, The Economist, January 20 2011

J. R. Immelt, V. Govindarajan and C. Trimble, 'How GE is Disrupting Itself,' Harvard Business Review, Vol. 87, No. 10, 2009, pp. 56–65

Chakma et al. Indian vaccine innovation: the case of Shantha Biotechnics, Globalization and Health 2011, 7:9

Laura W. Geller and Greg Rotz, Getting Big by Going Small, Strategy + Business, Issue 61, Winter 2010

E. Richard Gold et al., Are Patents Impeding Medical Care and Innovation?, PLoS Medicine, January 2009 , Volume 7, Issue 1

Anna Pettersson and August Vlaak, The Missing Link in Innovative research, Strategy + Business, 30 May 2011 (about middle management in pharmacy innovation)

Mark V. Pauly, Innovation In Medical Care And Insurance Markets 'We Aren't Quite As Good, But We Sure Are Cheap': Prospects For Disruptive Innovation In Medical Care And Insurance Markets, Health Affairs, 27, no.5 (2008):1349- 1352

Andrew Witty, New Strategies For Innovation In Global Health: A Pharmaceutical Industry Perspective, Health Affairs, 30, no.1 (2011):118-126

Linking education, nutrition and agriculture: Managing trade-offs in the design of a school food programme

Aulo Gelli

Learning outcomes

- Improved understanding of the nutrition requirements of school food programmes in low- and middle-income settings
- Improved understanding of the key trade-offs involved in the design of school feeding programmes in terms of costs and child health outcomes

This session will include a presentation and then a seminar with a practical exercise aimed at designing school food programme using linear programming excel tool

In the seminar, the participants will be divided into two teams to develop the design of a school feeding intervention in Kenya and Pakistan respectively. Each team will be divided into 2 sub-groups to cover the following topics :

- Defining the problem and needs for the intervention
- Defining the target group and selecting the target population
- Developing programme objectives
- Developing the programme activities

- Developing the food ration (see details in section below).
- Developing performance indicators and setting performance targets
- Estimating the costs and total budget requirements

Essential reading

Galloway, R. 2010. Developing the rations for Home Grown School Feeding. Partnership for Child Development, London.

Recommended reading

Bundy DAP, Burbano C, Grosh M, Gelli A, Jukes, M and Drake, L. Rethinking School Feeding: Social Safety Nets, Child Development, And the Education Sector. World Bank, 2009

Bundy, DAP (ed.). Rethinking School Health. World Bank, 2011.

Friday 18 January

Migrant Health in the UK - understanding barriers and access to health care

Kristine Harris (Doctors of the world)

Key learning points:

Using migrant health in the UK as a lens you should be able to:

- demonstrate an understanding of the context of migration and place the right to health care in a human rights perspective
- understand the barriers to accessing health care in a national and European context
- have a clear understanding of UK rules and regulations governing access and entitlements to healthcare
- understand the impact of barriers to access to health care to individuals, to public health and to social structure.

Overview

Across the world people are increasingly on the move for political, humanitarian, economic and environmental reasons and this increased mobility has health and human rights implications on both global and local levels. Migrants often face serious obstacles in accessing health care due to discrimination, language and cultural barriers, legal status and other economic and social difficulties. Late access or denial of access to necessary health care constitutes a breach of human rights and can have serious consequences for the individual, for health systems and for society as a whole.

Every day in the UK migrants are denied access to the health care they need. There is a lack of knowledge in the NH of the rules and regulations that govern access and entitlement to health care

and this can impact negatively on the individual, with the upcoming reforms the fear is that this confusion will continue to cause problems in access to health care. This session will set out the basic rules and regulations governing access to health care at primary and secondary level and will draw on data collected between 2006-2012 at Project:London, a clinic and health advocacy project that helps vulnerable people access health care, to illustrate the most common barriers encountered by migrants in the UK. It will also place this data in a wider European and international context. Building an understanding of the implication of barriers to access, and placing access to health care within a human rights framework, demonstrates how important our continued commitment to free access to health care is to avoid detrimental impact and ensure that human rights are respected.

Essential reading

Qureshi, Hundt and Farah (2011) "Access to Primary Health Care for migrants is a right worth defending"

World Health Organisation (2003) "International Migration, Health & Human Rights", Health & Human Rights Publication Series, Issue No.4, December 2003 **(read page 7-10 & 19-29)**

Recommended readings

- "Access to Health Care for Undocumented Migrants" (2007) PICUM - Platform for International Cooperation on Undocumented Migrants **(read Introduction page 5-10)**
- Stagg HR, Jones J, Bickler G, et al. Poor uptake of primary healthcare registration among recent entrants to the UK: a retrospective cohort study. BMJ Open 2012;2:e001453 .doi:10.1136/bmjopen-2012-001453

Further Reference Documents

- *- European context: "Are Migrants entitled to Health Care. A comparison of 16 European Countries" - HUMA* http://www.epim.info/wp-content/uploads/2011/02/HUMA-Publication-Comparative-Overview-16-Countries-2010.pdf
- *- Details on UK law: Department of Health "Guidance on Implementing the Overseas Visitors Hospital Charging Regulations" (May 2012)*
- *- British Medical Association (April 2012) Access to health care for asylum seekers and refused asylum seekers – guidance for doctors*

Week 4

Week 4 develops some of the questions which have been raised in the Introductory Module and in the introduction of Module 3. For instance, is it possible to answer the question of who runs Global Health?

Development Assistance for Health has increased dramatically in the last decade (see IHME website) to a total of 27.73 billion (2009) US $ in 2011 (IHME 2011)

Below is the 2009 view of the Institute for Health Metrics and Evaluation's diagram of the Global Health areas of funding, which is an imprecise but useful approximation of the contemporary state of GH priorities. Disease-specific funding accounts for a large proportion of the total sum invested in GH.

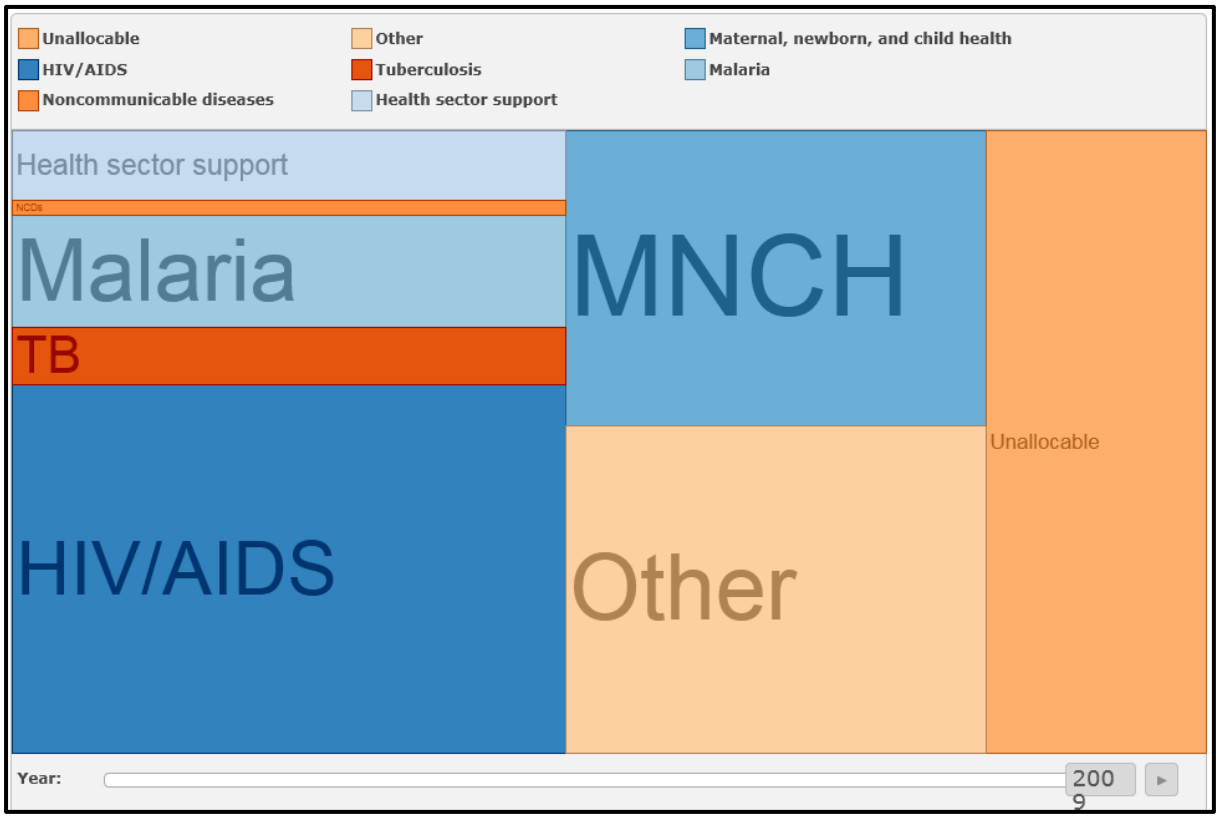

Figure: Development assistance for health by health focus area (Global), 1990-2009, interactive treemap. Source: Institute of Health Metric and Evaluation (http://www.healthmetricsandevaluation.org/tools/data-visualizations?page=1, accessed 14 December 2012)

Who sets the Global Health Agenda. This week will introduce the new actors who have gained a voice in Global Health over the last decades, developing further, the simple classification we looked at in the Introductory Module of The State, The Private Sector and Civil Society.

Global Health Initiatives, Global Public-Private Partnerships and Global Health Partnerships have not been well defined. Yet there are now about 100 of them and they have become the main source of funding in Global Health. Szlezák et al (2010) analyse the interaction of these actors in a loosely defined "Global Health System", with the case study of malaria involving over 500 different actors.

For each actor in this Global Health System, we can start analysing their roles with the following questions:

- Is the actor legitimate in their role?
- Who is the actor accountable to?
- Who does the actor represent?

Therefore understanding an actor's role within the GHS requires an understanding of the organisation's legal status and governance mechanism.

Whilst the expansion of actors in GH has led to an unprecedented availability of funding and real improvements in burden of disease, the accountability of actors has been questioned. For instance what is the comparative advantage of the World Health Assembly in setting priorities for Global Health compared to a GHI? What were the characteristics of the Global Health system of the past decades. What new characteristics can you describe today?

Sid Wong, currently a coordinator of Programme with Medecins Sans Frontieres in Zimbabwe, will give his lecture and seminar from Harare on Global Health Governance. He will build on the questions of aid effectiveness raised last week, we will develop these further in the context of Global Health by reviewing a few of the International Agreements on Aid effectiveness, including the original Paris Declaration).

He also reviews Olilla's (2010) arguments challenging the agenda-setting mechanisms of Global Health, asserting that GH priorities are set by the rich. What do you think? What evidence and cases may support this?

Policy-analysis can help understand the process of agenda-setting, within the policy-making process. We briefly touched on this in the ABC of Policy for GH and in the Introduction to Module 3, with the case of Maternal Mortality.

Dr Cherni, from the Centre for Environmental Policy, will discuss the wider implications of economic globalisation with specific reference to liberalisation and privatisation policies promoted by Bretton Woods institutions. She will also introduce an interesting autobiographical reading by the former chief economist of the World Bank laying out his view of the institution's role in development in Africa.

References

Leach-Kemon K, Chou DP, Schneider MT, Tardif A, Dieleman JL, Brooks BPC, Hanlon M, Murray CJL. The global financial crisis has led to a slowdown in growth of funding to improve health in many developing countries. Health Affairs. 2012; DOI: 10.1377/hlthaff.2011.1154.

Monday 21 January

Dr Sid Wong - Global Health Governance (this lecture will be delivered via Distance lecturing)

Aims of this session:

- Review the origins of international and global health governance
- Review the range of global health actors and initiatives
- Discuss the role of WHO as a leader in global health
- Discuss national states as global health actors: using the UK as a case example
- Introduce the concept of global health diplomacy and explore the interactions between health and foreign policy

Essential reading:

- Szlezák NA, Bloom BR (2010): The Global Health System: Actors, Norms, and Expectations in Transition. PLoS Med 7(1): e1000183. doi:10.1371/journal.pmed.1000183
- Ilona Kickbusch, Wolfgang Hein, Gaudenz Silberschmidt: Addressing global health governance challenges through a new mechanism: the proposal for a Committee C of the World Health Assembly. Journal of Law, Medicine and Ethics Fall 2010, JLME 38.3.

Recommended reading:

- Dodgson R., Lee K., Drager N. Global Health Governance: A Conceptual Review. Geneva: World Health Organization and London School of Hygiene and Tropical Medicine, 2002.
- HM Government (2011) Health is Global: An outcomes framework for global health 2011–2015
- United Kingdom. Health is global: UK Government Strategy 2008-13. Department of Health.
- Ilona Kickbusch: Global health diplomacy: how foreign policy can influence health: BMJ 2011; 342:d3154 doi: 10.1136/bmj.d3154

Tuesday 22 January

Globalization and problems of equitable development

Judith Cherni

Intended Learning Outcomes

By the end of this session you should be able to:

- Describe globalisation as a wider policy and economic context of contemporary society
- Recognise main processes of globalization that affect developing countries in the last decades

- Understand the role of crucial international organizations in the implementation of globalization policies
- Distinguish between the consequences of globalization for developed and developing economies
- Critically appraise some of the implications of globalization in terms of wellbeing, environment and development and link these with the social determinants of health

Overview

This lecture introduces few of the main features that characterize the process of globalization, and analyzes its impact on developing countries including adverse health consequences. Particular attention is given to the nature of economic and policy reforms during the last three decades and to the effects not only on the population but also on the environment and the health of the poor in particular. Reference is made to the Washington Consensus and the theory and application of its principles is discussed. The international financial organizations such as the World Bank and the International Monetary Fund are explained for their role in defining the rules of globalization. The lecture identifies four different types of globalization, i.e., political, environmental, cultural, and political and economic, but focuses on the latter. The global mechanisms of trade liberalization and international investment are discussed more in depth for their greater influence on health in developing countries. While remarkable economic growth was achieved in some regions, other parts of the world saw assets shrink and wellbeing compromised. Using social, environmental and health indicators, the lecture refers to main winners and losers in relation to development. Case studies from different, mostly but not only, developing, countries are used to exemplify the links between political and socio-economic contexts and the occurrence of adverse conditions that can have an impact on the health of whole populations.

Essential reading

Stiglitz, J. E. (2002) Globalization and its Discontents, **Chapter 3: Broken Promises,** Penguin, London

(Temporary Link: https://education.med.imperial.ac.uk/Years/4-1112/GH/m3/Stiglitz.pdf)

Friday 25 January

Is access to medicines a human right?

Nathan Ford

The session will look at the struggle to increase access to medicines for antiretroviral medicines in Africa over the last decade.

This session will comprise a mix of documentary, lecture and group exercises to provide an overview of key concepts relating to access to medicines as a human right. More broadly, the session will look at the struggle to increase access to medicines for antiretroviral medicines in Africa over the last decade.

Intended Learning Objectives

By the end of the session, students will:

- Understand the core human rights laws as they apply to access to medicines
- provide an overview of key concepts relating to access to medicines as a human right.
- Summarize the main lessons learnt over the last decade in advocacy for access to HIV/AIDS care in resource-limited settings
- Be able to debate the trade-offs between the need to stimulate research and development and ensure access to medicines
- be familiar with the main legal options available to countries to reduce the price of medicines
- have formed their own views on the balance between stimulating innovation (eg through patent rights) and ensuring access to medicines

Essential Readings

Hunt P, Khosla R. Are drug companies living up to their human rights responsibilities? The perspective of the former United Nations Special Rapporteur (2002-2008). PLoS Med. 2010 Sep 28;7(9):e1000330.

Chirac P, von Schoen-Angerer T, Kasper T, Ford N. AIDS: patent rights versus patient's rights. Lancet. 2000 Aug 5;356(9228):502. 18

Optional Readings

Hogerzeil HV, Samson M, Casanovas JV, Rahmani-Ocora L. Is access to essential medicines as part of the fulfilment of the right to health enforceable through the courts? Lancet. 2006 Jul 22;368(9532):305-11

Trouiller P, Olliaro P, Torreele E, Orbinski J, Laing R, Ford N. Drug development for neglected diseases: a deficient market and a public-health policy failure. Lancet 22 June 2002 359;9324: 2188-2194.

Week 5

Week 5 develops the theme of Health Systems further.

In guiding policy for health systems, what other disciplines are required to guide policy on complex question around health systems? Alejandro Reig, who spends much time researching the impact of being reached by government services (including health services) for vulnerable populations such as an indigenous tribe in Venezuela, will provide an example of how ethnographic research. What may be the social and cultural implications of access to technology and health services for such populations? This case study, with the illustration of the complex power implications of state intervention, develops the question from Week 2: is there a correct policy answer for each problem?

Dr Roberts will talk about another type of vulnerable population: those living through a humanitarian crisis. How is epidemiological data important here and how can it be intergrated with other data to guide bets practice.

Finally, Dr Millet and Dr Greaves will take a look at the very particular role of Primary Care in Global Health, revisiting the model of Health For All born out of the Declaration of Alma Ata in the 1970s, with a specific references to the recent changes in the UK NHS.

Monday 28 January

Armed Conflict and Health

Bayard Roberts (LSTHM)

Intended Learning Objectives: By the end of this session you should be able to:

- Describe general patterns related to armed conflict.
- Exhibit knowledge on the main impacts of armed conflict on health.
- Describe key health sector responses.
- Demonstrate an understanding of priority setting issues.

The aim of this teaching session is to introduce some of the key health-related challenges and appropriate responses for civilian populations affected by armed conflict.

The specific objectives will be to:

- Describe general trends and patterns related to armed conflicts globally.
- Describe general trends and patterns for civilian populations groups affected by armed conflict.
- Summarise the main impacts of armed conflict on health.
- Examine the key pathways by which armed conflict influences health.
- Describe key health sector responses and guidelines.
- Highlight the information needs in humanitarian settings.
- Discuss key priority setting issues.

The teaching session will focus on civilian population groups affected by armed conflict and humanitarian response (rather than military populations and responses).

The teaching session will involve a lecture for approximately 1 hour, with opportunities for questions and discussion. This will then be followed by a group work session for approximately 1.5 hours.

Essential reading

Spiegel PB, Checchi F, Colombo S, Paik E. Health-care needs of people affected by conflict: future trends and changing frameworks. Lancet. 2010 Jan 23;375(9711):341-5.

Recommended readings

Checchi F, Gayer M, Grais RF, Mills EJ. 2007. Public health in crisis-affected populations: a practical guide for decision-makers. HPN Network Paper 61. London: ODI. Chapters 3-5. http://www.odihpn.org/documents/networkpaper061.pdf

Roberts L and CA Hofmann. 2004. Assessing the impact of humanitarian assistance in the health sector. Emerging Themes in Epidemiology; 1:3. http://www.ete-online.com/content/pdf/1742-7622-1-3.pdf

Tuesday 29 January

Providing a health service to vulnerable populations: the case of indigenous populations in Southern Venezuela

Alejandro Reig

This lecture presents the complexities of providing health care to Yanomami indigenous population, in the upper Orinoco, Venezuelan Amazon, as a case study for situations which can be found in different indigenous settings.

Learning outcomes include understanding the need for specific approaches to Health Assistance towards traditional indigenous populations in different socio-ecological situations and living in the hinterlands of the National grid of communication and services.

Intended learning outcomes:

- Understand the problems implicit in conventional Health assistance mechanisms towards indigenous populations, given the scarce cultural sensibility of developmentalist Nation-State approaches .

- Understand that Health assistance in these contexts is an interaction between two societies (Global-National and indigenous) with different expectations, discourses and cultural presuppositions.

- Be able to open up different perspectives to examine critically the health assistance device.

Synopsis

The issue of medical attention to the Yanomami people of the upper Orinoco in the Venezuelan Amazon region allows for a case study of a more widespread problematic situation of populations located at the fringes of the Nation-State. This 'fringe' condition is here spelled both in geographic and in cultural terms, and can be read alongside other cases of ethnic groups located in the hinterlands of the State grid within ethnically diverse countries, which evidence dramatic differences in access to education, health and other services.

A brief historical overview of the development of health attention strategies for indigenous peoples will show some features that define the present context: a) the increasing presence of State welfare overtaking duties previously delegated to religious missions, within the framework of a 'developmentalist' vision that seeks to extend infrastructure and services as an integrating and homogenising device of nation-building; and b) a tension between the latter and a more participatory model of healthcare for indigenous peoples, promoted by indigenous organisations, activists, field doctors and scientists.

A specific program to train indigenous Health Agents to undertake the duties of primary sanitary attention at a local level is followed. Evidences are given of its beneficial impacts in a four-year timeframe, and of the consequences of its subsequent abandonment. Both the shortcomings of the model's implementation and the local appropriation of the initiative are to be examined as a socio-cultural misunderstanding in the interaction between two societies (Global-National and indigenous) with different expectations and cultural presuppositions.

This misunderstanding, it is argued, is to be expected and not to be feared. From an integral social health perspective, what has to be examined is its productivity in terms of two contrasting desired outcomes of healthcare strategies: either the goal is the homogenising expansion of the state grid; or it is the development of a healthcare model which takes on board socio-cultural differences. The direct dialogue and collaboration between field doctors and researchers and indigenous peoples on the ground is suggested as a way out of the problem, moving towards an intercultural model. The case study highlights that, as in other similar contexts in multicultural settings in the developing world, "Health is a power struggle between unequal contenders" (Freire and Zent, 2011).

Recommended reading:

Montenegro, Raul A, & Carolyn Stephens, 2006: "Indigenous health in Latin America and the Caribbean". *Lancet* 2006; 367: 1859–69.

Further references:

· Fassin, Didier, 1996: *L'Espace politique de la santé. Essai de généalogie.* Presses Universitaires de France, Paris.

· Ferguson, James. 1994. *The anti-politics machine : "development", depoliticization, and bureaucratic power in Lesotho*. Minneapolis ; London: University of Minnesota Press 1994.

· Harvey, David. 1985: ""The geopolitics of capitalism"" in *Social Relations and Spatial Structures*. Edited by D. Gregory & J. Urry. Basingstoke: Macmillan.

· Kelly Luciani, José Antonio, 2003: *Relations within the Health System among the Yanomami in the Upper Orinoco, Venezuela.* Dissertation Submitted for the Degree of Ph.D., Department of Social Anthropology and Darwin College, University of Cambridge.

· Kelly, José Antonio, 2011: *State Healthcare and Yanomami Transformations A Symmetrical Ethnography.* University of Arizona Press, 280 pp.

· Packard, Randall, 2011: "'Malaria Blocks Development' Revisited: The Role of Disease in the History of Agricultural Development in the Eastern and Northern Transvaal Lowveld, 1890-1960." *Journal of Southern African Studies* Vol. 27, No. 3, Special Issue for Shula Marks (Sep., 2001), pp. 591-612 .

· Scott, James C., 1998: *Seeing like a State: how Certain Schemes to Improve the Human Condition Have Failed.* Yale University Press, New Haven, CT.

· Zent, Stanford, and Germán Freire, 2011: "La economía política de la salud, la enfermedad y la cura entre los piaroa", in Freire, Germán (ed.), *Perspectivas en Salud Indígean. Cosmovisión, enfermedad y Políticas Públicas.* Ediciones Abya-Yala, Quito.

· Feather, C. (2009). The Restless Life of the Nahua: Shaping people and Places in the Peruvian Amazon. *Mobility and Migration in Indigenous Amazonia*. M. Alexiades.

Tuesday 29 January

Primary Care in the World

Chris Millett and Felix Greaves

An overview of the session:

This session explores the importance of primary care in health systems from a global perspective. It covers definitions of the common concepts, and the various dimensions, of primary care. It considers the history of the primary care movement, including its foundation at the conference of Alma-Ata,

through to the WHO's latest campaign of 'Universal Health Coverage' for all. The initial lecture will explore the evidence that primary care improves health outcomes, and evidence of its cost effectiveness. We will use a worked example of international health practice, the Brazilian Health system's Programa Saúde da Família, to consider some of these idea.

In the seminar, we will consider the Brazilian model in more detail, including a comparison with the UK primary healthcare model. We will also consider the current reforms going on in primary healthcare in England, and the potential impact of these changes.

Learning outcomes:

1. be familiar with definitions of primary care and it's key characteristics

2. appreciate the international policy context and calls for strengthening primary care

3. understand the evidence base of the benefits of primary care on population health

4. be familiar with key efforts to strengthen primary care in developing and developed country settings

Required readings:

Harris M. (2011). Integrating Primary Care and Public Health – learning from the Brazilian way. London Journal of Primary Care. October 2011.

For the seminar:

Greaves F, Harris M, Goodwin N, Dixon A. The commissioning reforms in the English National Health Service and their potential impact on primary care. J.Ambul Care Manage. 2012 Jul-Sep;35(3):192-9.

Optional Reading:

The World Health Report 2008 - Primary Health Care (Now More Than Ever). Geneva: World Health Organization. http://www.who.int/whr/2008/en/

Wednesday 30 January

Lecture: Global health and humanitarian policy
Bev Collin Health Policy Advisor

Learning objectives

This session is intended to:

1- Review the discourse on global health from a field perspective
2- Review importance of a more thorough understanding of the health and humanitarian policy context
3- Look at policy analysis linked to best policy implementation for improved health

ABSTRACT

What significance does the global health environment have for humanitarian assistance? What is driving current global health priorities and policy?
Such questions insist on a more robust analysis of the global and local health environments where for example, MSF works, beyond the health needs assessment to a more thorough understanding of the health and humanitarian policy context. That understanding will in turn lead to a better-informed advocacy and more skilled negotiation for improved health outcomes for populations we work with. It will nurture existing efforts of field staff to ensure health priorities of our patients are not undermined or dismissed by a politicized health agenda. Influence through 'talking' to other 'actors' and demonstrating how best to manage lethal morbidities (research agenda) is the core of MSFs medical work. It is however argued that a broader critique of emerging global health policy is essential to support the overall mission.

PRACTICAL:

SEMINAR CASE STUDY:
SOMALIA: the political dimensions of aid in Somalia
DRC: ongoing access to HIV care in Bukavu

By the end of the session you'll be able to:

- Distinguish how global health has originated, developed and grown significant to humanitarian action
- Identify what is meant by the policy framework and why useful to understanding policy debates, process and implementation
- Specify examples of the contextual aspect and the relevance power and political dimensions play with regard to the development of health and humanitarian policy
- Evaluate how analysis can support better understanding of the policy environment and lead to health advocacy and with effective outcomes for patients, populations concerned

ESSENTIAL READING:

Kaplan, J.P et al. 2009. Towards a common understanding of Global Health. *The Lancet,* Vol. 373.

Hemrich G. (2005) Matching food security analysis to context: the experience of the Somalia food security assessment unit. *Disasters*. 29 (Suppl 1): S67-91. Available free online: ftp://ftp.fao.org/docrep/fao/meeting/009/ae506e.pdf">ftp://ftp.fao.org/docrep/fao/meeting/009/ae506e.pdf

RECOMMENDED READING:

1. Lee, K. and Collin, J. (2005) Global Change and Health, *Understanding Public Health* Series, Maidenhead: Open University Press. Chapter 1.
2. Kawachi, I. and Wamala, S. (2007) *Globalization and health.* Oxford: Oxford University Press.
3. Kagan R. (2002) Power and Weakness, Policy Review. 113.
4. Ollila E. (2005) Global Health Priorities – priorities of the wealthy. Globalization and Health.
5. Tesner S, Kell WG. (2000) The United Nations and Business: a partnership recovered. New York: St. Martin's Press.
6. Calin P (2011). In Search of the Ωew Informal Legitimacy‟ of Medecins Sans Frontie`res. Public Health Ethics 1~1.
7. Mosse, D (2005) 'Cultivating Development: An ethnography of aid policy and practice‟. Pluto Books.

Biographies

Rifat Atun

Professor Rifat Atun is Professor of International Health Management at Imperial College Business School and Faculty of Medicine (School of Public health ad the Division of Medicine) Imperial College London where he heads the Health Management Group. Between 2008 and 2012 he was a member of the Executive Management Team at the Global Fund to Fight AIDS, Tuberculosis and Malaria in Geneva, Switzerland as the Director of Strategy, Performance and Evaluation Cluster.

Professor Atun has previously worked at the UK Department for International Development Resource Centre for Health Systems. He has undertaken assignments globally for the UK DFID, World Bank, World Health Organization and other agencies to design, implement and evaluate health systems reforms and targeted disease programmes. He was member of the Advisory Committee for WHO Research Centre for Health Development in Japan. He is a member of the Scientific Advisory Board for PEPFAR, the Global Health Group at the UK Medical Research Council, Global Advisory Group on Maternal Mortality, and the Global Task Force for Expanding Cancer Care and Control in Developing Countries. Prof Atun studied medicine at University of London as a Commonwealth Scholar and completed his postgraduate medical studies and masters in business administration at University of London and Imperial College London. He is a Fellow of the Faculty of Public Health of the Royal College of Physicians (UK), a Fellow of the Royal College of General Practitioners (UK), and a Fellow of the Royal College of Physicians (UK).

Julie Balen

Dr Julie Balen is a Junior Research Fellow at Imperial's Centre for Health Policy, with a BSc in Biology from Imperial (2004) and a PhD in public health from the University of Queensland, Australia (2009). Julie's PhD focused on the epidemiology and control of schistosomiasis and soil-transmitted helminths in Hunan province, China. Julie then took a post-doctoral position at the Centre for Non-Traditional Security Studies, Nanyang Technological University, Singapore, where she worked on health policy and health security across Southeast Asia. Her second post-doc was at the London School of Hygiene and Tropical Medicine, working within Thailand and Cambodia on health system integration. Having returned to Imperial, Julie is now collaborating with the MRC Gambia and other institutes in sub-Saharan Africa, with a trans-disciplinary interest in health system strengthening, capacity building and resource management.

Judith Cherni

Dr Judith A. Cherni is Senior Research Lecturer at the Centre for Environmental Policy (CEP) and member of the Centre for Energy Policy and Technology, and the Sustainable Futures Lab, both at Imperial College London. She teaches and supervises post-graduate and PhD students and convenes Departmental Research Methods module.

Bev Collins

Based with Médecins Sans Frontières (MSF) as a Health Policy and Practice Advisor. Beverley is a trained anthropologist with clinical experience as a paediatric nurse practitioner; she has worked within public health as a health advisor, medical coordinator and research study coordinator. She has done fieldwork in Africa, Central and South Asia, the Middle East, Asia and Latin America. Her formative work involves research and practice in qualitative methodologies in order to develop local health strategies that fit within the cultural context. More recently, she is studying public policy, which involves specific health policy research.

Dr Nathan Ford

Nathan Ford is currently has worked with Médecins Sans Frontières (MSF) since 1998, and is currently the medical co-ordinator for MSF‟s International work on access to medicines, diagnostics and vaccines. He holds a degree in Microbiology and Virology (Warwick) a Masters in Public Health and Epidemiology (Cape Town) and a PhD in Clinical Epidemiology (Vancouver). Areas of concern include evidence-based humanitarian action, and simplification and adaptation of medical care in resource-limited settings.

Aulo Gelli

Aulo works as a research fellow at the Partnership for Child development where he is the deputy director of the Home Grown School Feeding programme. His experience has focuses on the monitoring and evaluation of school feeding programmes in low-income countries, and particularly on understanding the costs and benefits of school feeding.

Felix Greaves

Felix Greaves is an Honorary Clinical Research Fellow in the Department of Primary Care and Public Health. He is also a public health registrar in South West London. Felix's research interests are in measuring quality and safety in healthcare systems. He is currently evaluating 'tripadvisor' models of health care performance in the UK. He previously worked as clinical adviser to the Chief Medical Officer at the Department of Health, where he worked on developing national quality and safety policy. He also worked for the World Health Organization’s Patient Safety Programme, where nhe managed their project on patient safety education for healthcare workers.

Professor Simon Gregson

Simon trained as demographer at the London School of Economics and Political Science in the late 1980s before completing a DPhil at the Centre for Epidemiology of Infectious Disease at the University of Oxford. Following a Wellcome Trust Research and Training Fellowship in Population and Reproductive Health, he was appointed to the academic staff in the Department of Infectious Disease Epidemiology at Imperial College London in 2001 and was awarded a Chair in Demography and Behavioural Science in 2008. Simon set up and directs the Manicaland Project, a longitudinal study using quantitative, qualitative and mathematical modelling methods to describe and interpret trends in the HIV epidemic in eastern Zimbabwe. His main research interests include the socio-demographic determinants and impact of HIV epidemics and scientific evaluation of the population impact of HIV control programmes.

Dr. Kristine Harris

Dr Kristine Harris trained as an anthropologist and holds a PhD in Public Health from the London School of Hygiene and Tropical Medicine where her research focused on the frontline implementation of leprosy services in urban India. She is currently working as Outreach and Advocacy Officer at Project:London, a clinic and health advocacy programme run by Doctors of the World UK that helps vulnerable people access healthcare. Project:London provides acute medical care as well as information, advice and practical support to vulnerable people in order to help them access the health services they need.

Stephen Matlin

Professor Stephen Matlin is an Adjunct Professor in the Institute of Global Health Innovation, Imperial College London. He is a former Executive Director of the Global Forum for Health Research (GFHR), promoting health research for the needs of low- and middle-income countries. He worked in academia for over 20 years, researching, teaching and consulting in medicinal, biological and analytical chemistry, collaborating with the Special Programmes in human reproduction and tropical diseases at WHO and the International Organization for Chemical Sciences in Development (IOCD). In 1995 he left academia to work full time in international development, holding senior positions in the Commonwealth Secretariat and UK Department for International Development, before joining GFHR. Professor Matlin has served as Kelvin Lecturer of the British Association for the Advancement of Science; President of the British Association for International and Comparative Education; Vice-President of the Royal Institution of Great Britain; Vice-President and Chair of the Commonwealth Association of Science, Technology and Mathematics Educators; and Senior Research Fellow at Oxford University. He has served on the governing bodies of the Alliance for Health Policy and Systems Research, the Child Health and Nutrition Research Initiative, the Initiative for Cardiovascular Health in Developing Countries; and currently serves on the board of IOCD and Steering Committee of the Netherlands Global Programme in Health Policy and Health Systems Research; and was a co-founder and co-chair of Global Health Europe. He has published more than 270 papers, articles, reviews and book chapters.

Michael MacDonnell

Michael is Senior Fellow at the Institute of Global Health Innovation. He was formerly an advisor at the Prime Minister's Delivery Unit under Tony Blair.

Chris Millett

Christopher Millett is a Senior Lecturer in public health at Imperial, and a Fellow of the UK Faculty of Public Health. He has published studies on a variety of public health areas, including tobacco control, active transport and obesity, infectious disease, cancer screening, health system performance and health inequalities. His current research interests are: assessing the impact of quality improvement strategies, including pay for performance, on inequalities in health care; impact of competition and patient choice on health system performance; financial protection in health systems; tobacco control, including the effectiveness of interventions to reduce youth smoking.

Teresa Norat

Teresa Norat is Principal Research Fellow in the Department of Epidemiology and Biostatistics, Faculty of Medicine, Imperial College London. Her main research interest is on the relationship of nutrition and metabolic factors with the risk of chronic diseases, in particular cancer. She coordinates at Imperial College the project Continuous Update of the Scientific Evidence on the Relationship of Diet, Physical Activity, Obesity and Cancer funded by the World Cancer Research Fund.

David Nutt

A psychiatrist and Neuropsychopharmacology prof who is interested in the benefits and harms of drugs – both legal and illegal. Was government adviser on drugs for 10 years till sacked by Alan Johnson the Home Secretary for challenging the evidence base on which the UK drug laws are made

Bayard Roberts (LSTHM)

Bayard Roberts is Senior Lecturer in Health Policy and Systems at the London School of Hygiene and Tropical Medicine. His research has included a number of studies with conflict-affected populations addressing issues of mental health, reproductive health, and mortality estimation methods.

Laura Robertson

I have just finished a PhD with the Manicaland Project at Imperial College London. My work has focused on orphans and other vulnerable children (OVC) in sub-Saharan Africa and particularly in Manicaland. I have investigated the rise in orphanhood in M anicaland, biases in the collection of parental survival data in demographic surveys and the effects of orphan status on nutritional health in children and sexual health in young adolescents. As part of my PhD I also developed a protocol for a community randomised trial investigating the effects of cash transfers on children in vulnerable

households in Manicaland. I continue to be involved in the running of this trial and I will also be pursuing my other research interests, which include the effects of HIV on children and finding the mot effective ways to target interventions for OVC in sub-Saharan Africa.

Alejandro Reig

Alejandro Reig is a Doctoral candidate in Social and Cultural Anthropology at the University of Oxford, with a dissertation on Yanomami landscape management and conceptualization, research carried out within an Amazonian health research and assistance institution in Venezuela. Works at an environmental institution in Venezuela, MPhil in Anthropology, Oxford, Philosophy Licentiate in Venezuela's Central University.