Delivering Effective Health Care for All

New evidence from COMDIS, CREHS and TARGETS Research Programme Consortia

29th March 2010

Motivated health workers • Patient centred care • **Reducing user fees** • Private
iders • Evidence-based change • **New tools** • Protecting the poor • **Retaining sta**
proving access • **Equity orientated policies** • Monitoring and evaluation • **Effecti**
ommunicable disease control • Improved demand • **Scaling-up implementatio**

COMDIS CREHS TARGETS
Team for Applied Research Generating Effective Tools and Strategies for Communicable Disease Control

08.45-09.15	Registration			
09.15-09.30	Welcome address			
09.30-10.30	Keynote: **Making health systems work for the poor**			
10.30-11.00	Morning break			
11.00-12.30	Parallel sessions: **Reducing barriers to accessing health services**			
	Social barriers • Understanding stigma associated with TB in Bangladesh, Nepal and Pakistan • Fighting TB stigma in Zambia: a participatory toolkit • Socio-economic status and the media: reaching the poor with health communication messages in Tanzania	**Financial barriers** • Direct facility funding as a potential tool in user fee removal in Kenya • Achieving universal coverage in Thailand – progressive financing and access to services • Who benefits from public health care expenditure? Case studies from Nigeria and India	**Supply side barriers** • What do health professionals think about working in rural areas? Evidence from South Africa, Kenya and Thailand • What policies would attract more health professionals to rural areas? • Diagnostic policy change in Uganda • Demand and supply: community-based human resource mobilisation to improve TB control in Zambia	**Towards patient-centred care** • National programme, individual choice: patient-centred TB treatment in Tanzania • Trial of anti-retroviral treatment care in Swaziland: hospital vs. health centre • Community-based, patient-friendly TB care experience in South Asia, its relevance to ART and MDR-TB
12.30-13.30	Lunch break			
13.30-14.45	Keynote: **Engaging service providers – public, private and community-based health provision** • Diagnosing and treating delivery system disorders: cutting the complexity • Public-private mix for TB control in Nepal, Bangladesh and Pakistan			
14.45-16.00	Parallel sessions: **Scaling up services and policies**			
	Overcoming the challenges of health policy implementation • Implementing the Integrated Management of Childhood Illness strategy in Kenya and Tanzania • Implementing equity-oriented reforms in South Africa • Strategic management: a critical element in implementing private medicine retailer programmes in Kenya • Ensuring research influences scaling up	**Effective delivery of interventions** • What do health workers think about possible ways of treating malaria in pregnancy? A mixed-method approach in Ghana • Public Private Partnerships for TB-HIV: Lessons from Hyderabad city, India • Community-based care for malaria in Uganda • Improved targeting of interventions: the example of trachoma control in Southern Sudan	**New tools and strategies** • Operational materials for delivering MDR-TB care in Pakistan • Ensuring quality care at scale: management guidelines for clinicians • The IPTi webtool for policy makers: supporting localised malaria control • Tools and strategies for controlling drug resistant TB in Africa	
16.00-16.30	Afternoon break			
16.30-17.30	Round table: **Translating research findings into policy and practice: how can implementation research support the development of pro-poor health systems?**			
17.30-18.30	Reception			

Delivering Effective Health Care for All: New evidence from COMDIS, CREHS and TARGETS Research Programme Consortia

29th March 2010

Dear Friends and Colleagues,

Welcome to *Delivering Effective Health Care for All*, a conference which brings together new evidence from three Research Programme Consortia funded by the UK Department for International Development (DFID): the **Communicable Diseases: Vulnerability, Risk and Poverty RPC** (COMDIS), the **Consortium for Research on Equitable Health Systems** (CREHS) and the **Team for Applied Research Generating Effective Tools and Strategies** (TARGETS).

Each Consortium consists of a group of partners from academic and civil society organisations from around the world. The common goal is to generate new evidence and solutions that contribute towards strengthened health systems and the delivery of effective clinical interventions and services, so as to improve health outcomes, equity and contribute to poverty reduction. For the past 5 years, these Consortia have been operating to conduct multidisciplinary research on health services and health systems issues in a variety of country contexts.

The conference is organised into four sessions combining a range of findings and experiences from over 16 countries:

- Making health systems work for the poor
- Reducing barriers to access: addressing the social, financial and supply-side barriers to care
- Engaging service providers: public, private and community-based health provision
- Scaling up health services and policies: working with policymakers and programmes to implement change

We hope that this conference will provide a platform for discussing and debating some of the key challenges to meeting the health-related Millennium Development Goals.

Thank you once again for you interest in this conference. We very much hope you will engage actively in the discussions and help us to carry forward this new knowledge into further research and action.

Kara Hanson, Director, CREHS
James Newell and **John Walley**, Co-Directors, COMDIS
John Porter, Director, TARGETS

Making health systems work for the poor

The last decade has seen significant efforts aimed at reaching the health-related Millennium Development Goals (MDGs), with increased investments in health from domestic budgets, global initiatives and philanthropic organisations. Much of this investment has focused on interventions to combat HIV, TB and malaria – major causes of illness and death in sub Saharan Africa and Asia. However, through these efforts it has become clear that functioning health systems, which respond to the needs of all citizens, are essential for expanding and sustaining coverage of services and improving health outcomes. Health systems are also social institutions with potential to contribute to poverty reduction directly through protecting households against financial risk of illness, and indirectly as part of the broader set of institutions that generate social protection, social cohesion and resulting equity enhancement.

Despite their importance, health systems in many low-income countries face chronic under-investment, poor planning and weak accountability, manifesting in constraints at different levels. At the household level, financial barriers such as user fees or inadequate coverage of insurance schemes can prevent individuals from accessing essential services or expose them to the risk of expenditures which can have a catastrophic impact on household resources. At the service delivery level, acute shortages of health workers, especially in rural areas, have resulted in low levels of coverage and high workloads for existing staff, compromising service quality. At the state or national level, centrally controlled processes of health policy formulation that do not take into account the agendas of, or relations between, local actors create challenges to effective implementation of policies, especially those directed towards the poor.

New evidence about health system strengthening

CREHS research has focused on generating new knowledge about how to strengthen health system policies and interventions in ways that benefit poor and marginalised groups. Research has addressed issues of health financing, human resources, accountability, scaling up service delivery and policy implementation. Work on health care financing has included an evaluation of an innovative scheme that gives money directly to health facilities used by poor rural households in Kenya (see page 6). It has also investigated the role of universal health insurance coverage schemes in protecting the poor, an issue that is currently high on the policy agenda in South Africa, Nigeria, Kenya and Tanzania. Thailand's universal coverage scheme, which entitles all citizens to a comprehensive set of health services free at the point of use, provides one financing model of international interest. Since 2000, the incidence of catastrophic health expenditure in Thailand for the poorest quintile of the population has been halved.

New evidence on the recruitment and retention of nurses in rural Kenya, South Africa and Thailand highlights the importance of context and individual factors in determining preferences for job locations. Strategies to entice workers to rural areas also have different levels of effectiveness in the three countries pointing to the need to tailor human resource policies to national contexts (see page 7). Overcoming human resource and financial barriers are vital steps for strengthening health systems and scaling up coverage of priority health interventions. Reaching poor and vulnerable groups, however, often requires additional efforts and tailored solutions. Examples include the use of mobile health units to reach people living in remote and inaccessible areas in India, and working with private providers to provide more convenient access to essential commodities such as drugs and bednets in Tanzania.

Looking forward

Past research has generated ample evidence about health system failures. The challenge for health policy and system researchers is to generate a better understanding about how to overcome constraints. Stronger evidence is needed to make the most of the current momentum in favour of health systems strengthening and ensure that these systems are able to deliver the much needed progress towards the MDGs.

Reducing barriers to access

There are many barriers that prevent poor and vulnerable people from accessing health services and limit the coverage of effective interventions. Barriers to health care affect how people experience disease and its impact on their health, well-being and wealth. Social barriers, such as stigma surrounding TB and HIV/AIDS can deter individuals or households from seeking care and adhering to long-term treatment plans. Use of health services is also restricted by unaffordable health care costs, usually in the form of user fees that must be paid at the point of use.

Supply-side barriers refer to a lack of inputs such as drugs, equipment, staff or facilities to ensure coverage of health services. The shortage of health workers in many sub-Saharan African countries is a particularly acute problem. Supply-side barriers to care are often the result of poor infrastructure and supply systems and a lack of investment in the health system. Research has focused on finding new solutions to overcome these social, financial and supply-side barriers.

Social barriers

Fighting TB stigma in Zambia: a participatory toolkit

Social stigma is a barrier that exists in many different forms and societies across settings in the health facility, in the community, and in the home. TB stigma can prevent people from seeking diagnosis and treatment and can lead to the social exclusion of TB patients, especially in areas of high HIV prevalence. The HIV epidemic has deepened TB stigma since a TB diagnosis is assumed to signal underlying HIV infection.

Recognising the need for more tools to tackle TB stigma, TARGETS partner ZAMBART and the International AIDS Alliance have developed a TB stigma module, which has been used to train community facilitators in 19 communities in Zambia. The module is designed for use with mixed audiences, encouraging dialogue and establishing trust by asking groups to analyse serious real-life examples and situations in a light-hearted and engaging way. The TB stigma module has been tested and refined by users including TB patients and family members, community leaders, TB programme volunteers and health workers. Exercises in the module show how individuals, families and communities can challenge stigma in different contexts and provide support to TB patients and their families.

The publication of this module dovetails with the current shift in emphasis towards patient empowerment, with 300 community facilitators not only sharing information on TB stigma but also acting as agents of change. The toolkit also functions as a valuable teaching aid for new and existing health care staff in countries with high TB and HIV burdens.

"As I speak now I am very well and in good health. My appeal to all out there is that; please never stigmatize anyone with TB, it is a curable disease and if nursed and supported, TB patients can recover fully and contribute positively to the community. As a result of my experience I decided to join the local health centre as a volunteer treatment and adherence supporter so that I can be useful by encouraging and supporting others in a similar situation"

Financial barriers

Direct facility funding as a potential tool in user fee removal in Kenya

Reducing user fees is one of the top policy priorities in Africa today. It is widely recognised that fees present a critical barrier to poor people's access to services and many households are significantly impoverished by their efforts to meet health care costs. However, at facility level, user fees can also represent an important source of income and there is concern that reducing fees will impact on the range and quality of services that they can provide.

In Coast Province, Kenya, CREHS researchers evaluated an innovative pilot scheme to finance health facilities called Direct Facility Funding (DFF), introduced to compensate facilities for loss of revenue after user fees were substantially reduced. Through DFF, health facilities receive money directly into their bank account to pay for daily expenditures. Research found that DFF accounted for only 3% of their total running costs but over half of all cash income in the surveyed facilities. DFF was perceived to have improved health worker motivation, facility utilisation and quality of care through funding support staff, outreach activities and building renovations. However, over-charging of user fees remained common, with many facilities failing to exempt children under 5.

The study results suggest that even without performance targets, an increase in funding at the facility level can have a positive influence on health service utilisation and quality. The positive findings indicate that scaling up the DFF system to national level is warranted, although provinces may also require additional investments in drug delivery systems, infrastructure and management support. To ensure that the full equity benefits are reaped, it is essential that DFF is accompanied by stronger enforcement of user fee adherence.

Supply side barriers

What policies would attract more health professionals to rural areas?

In many low and middle income countries, the acute shortage of health workers in rural areas is a major barrier to implementing health interventions and policies. A range of strategies has been proposed to recruit and retain health workers in rural areas; however, there is little rigorous evidence on the impact and cost-effectiveness of such interventions.

CREHS researchers have modelled the relative effectiveness of different policies in attracting nurses to rural areas in South Africa, Kenya and Thailand using data on nurses' stated preferences. Policies included both financial incentives (rural allowances, car allowance) and non-financial incentives (improved housing, rapid promotion and educational opportunities). The study found that nurses' preferences for different interventions varied significantly between countries: in Kenya and South Africa, rural allowances and improved educational opportunities would be the most effective way to increase the uptake of rural posts, whereas in Thailand better health insurance coverage would have the most impact.

Policy recommendations:

- In the absence of rigorous evidence on the impact of different interventions, policymakers in low and middle income countries should make more use of modelling data to inform the design of human resource policies and tailor these to their national contexts.
- A combination of financial and non-financial incentives is required to attract nurses to rural areas. Some non-financial interventions can be as effective as salary increases and are more cost-effective.
- More careful selection of students into health worker training programmes appears to be an especially cost-effective strategy to increase the number of health professionals in rural areas.

Patient centred-care

Anti-retroviral treatment care in Swaziland: hospital vs. health centre

While antiretroviral treatment (ART) for HIV/AIDS patients in sub Saharan Africa has typically been delivered in hospitals and large specialist clinics, shifting treatment from hospitals to community health facilities could have significant benefits.

A COMDIS study set out to evaluate whether providing treatment at the community level in a rural African district could improve attendance rates and health, and contribute towards achieving the MDG of universal access to treatment for HIV/AIDS for all those who need it. This study was carried out in Lubombo, a rural region of Swaziland, the country with the highest prevalence of HIV in the world.

The study concluded that the roll-out of ART care to health centres from hospitals is both feasible and effective in a typical district setting in Africa, improving ART coverage, quality of life, productivity and reducing family poverty. ART can be delivered – and more effectively – through health centres at district level in sub Saharan Africa. Providing ART in the primary care setting reduces patient costs and achieves the same rates of attendance at scheduled appointments as at the hospital. It frees up ART clinic time to enrol more patients on ART, and so contributes to increased access.

Policy makers should consider the transfer of follow-up ART care services from overloaded hospitals to community settings for the benefit of both patients and staff. Health managers will need to address staffing and resources at the primary care level to support the process of adding ART care while maintaining existing services.

"I don't have names just the faces of the people seen at the ART clinics. But clients often arrived so sick it is hard to imagine they could walk. But they did walk in, and patiently they waited. They had their CD4 counts in their boots – were "candles in the wind" – so vulnerable to the next infection. Months later they are happy smiling fully well people, carrying their babies and young children to the health centre"

Engaging service providers: public, private and community-based health provision

Fragmented, parallel approaches to the delivery of diagnostic, treatment and preventive services lead to missed opportunities and sub-optimal service quality in public, private and community-based delivery systems. The coverage and use of interventions for the control or elimination of infectious diseases can be improved by integrating the delivery of diagnostic, treatment and preventive services; effective communication and targeting at-risk populations; and novel methods of delivering health services.

Public private partnerships (PPPs) are becoming increasingly common in many fields including health. Over the last decade considerable evidence has been generated and policies such as WHO's Stop TB Partnership strategy have given guidance on the ways of involving all care providers to strengthen disease control.

PPPs in TB control

In urban areas in Asia, recorded TB case-finding rates are low. One explanation is that a majority of TB patients in these areas first attend private medical practitioners (PMPs). This in itself might not be a problem, except that PMPs do not report the cases they diagnose, or their outcomes; and PMPs' TB care is in general very poor. Developing PPPs between national TB programmes (NTPs), NGOs and PMPs was thought to be more appropriate than attempting to regulate PMPs. COMDIS research partners led development in close collaboration with the National TB Control Programmes (NTPs) in three countries.

While the PPP models we have developed are all different to accommodate local context, they have similar structures. The NTP provides national minimum standards, free anti-TB drugs, and cohort analysis. PMPs give access to diagnostic services, either by direct diagnosis using accredited labs or by referring suspected cases to DOTS centres, but do not in general provide treatment. Treatment is provided either by government or NGO DOTS centres: in either case, PMPs receive notification of patients' registration and treatment progression, and patients are referred back to PMPs at the end of treatment. NGOs provide the essential roles of late patient tracing and patient health promotion.

The first PPP for TB control developed by COMDIS was tested in Lalitpur District, Nepal. It demonstrated that the approach was feasible, maintained treatment success rates above 90% while doubling case-finding rates, and was affordable. This PPP has been sustained for 10 years (coordinated by the District Health Office), and the model has been expanded to the capital, Kathmandu. The Nepal NTP is now rolling out the policy to other cities and towns in the country. Building on experiences in Nepal, COMDIS researchers developed a model to meet the needs and conditions of the Bangladesh NTP based on a review of theory and context analysis of Bangladesh, and demonstrated it was effective in the capital Dhaka. Scale up is now under way across urban Bangladesh. In Pakistan, the National and Provincial TB Programmes have adopted the PPP model and are currently implementing PPPs in cities and towns across the country with support from the Association for Social Development. Work by COMDIS has led directly to better informed public policy-making, improved public services, increased TB case-finding and high rates of treatment success.

Engaging public, private and community-based providers in malaria control

Although improvements in the coverage of malaria interventions are being made, achievement of internationally-set targets still remains unlikely in many countries. This is despite increased funding and efforts to improve the coverage of malaria interventions. There are multiple and complex reasons why malaria control is falling short of universal coverage targets for the treatment of infectious diseases, involving health system challenges and provider and user behaviours. Delivery strategies, whether pursued through a single channel or a mix of channels, must have the potential to reach the full target population, and these strategies must then be effectively implemented.

A key element that underpins these strategies to improve delivery of health services is an appropriate quality management system. TARGETS researchers have developed an approach to diagnosing and treating delivery system disorders with regards to the delivery of ACTs and insecticide-treated nets (ITNs). A variety of quantitative and qualitative methods have been used to evaluate ACT and ITN delivery through public, private and community-based channels in different settings, using modelling to predict the relative contribution of different delivery systems to coverage outcomes and health impact.

"According to the 2009 World Malaria Report, less than 15% of children under five with fever receive an effective anti-malarial (artemisinin-combination therapy, ACT) and only 24% of children under five slept under an insecticide-treated net"

For example, in Ashanti Region, Ghana, the Mobilise against Malaria (MAM) project contributed significantly to a 23% increase in the proportion of Licensed Chemical Sellers (LCS) who stocked ACTs, and a 20% increase in the proportion who knew the nationally recommended treatment for a febrile child. However, using our approach to delivery system analysis, we calculated that these achievements would increase the proportion of children receiving effective treatment for malaria through an LCS from 0% to just 2.9%. In another region of Ghana a voucher scheme for ITNs resulted in an increase in ownership and use of ITNs by pregnant women, whilst in a neighbouring region, it did not. Under the same scheme, it was found that 40% of women in Volta Region were offered a voucher on attendance at ANC, whereas vouchers were offered to just 20% of women attending ANC in Eastern Region. The main reasons for this were competing delivery systems and lack of synchronisation between the public and private sector arms of the voucher scheme.

Some recommendations derived from this approach to diagnosing delivery system disorders are:

- Improvements at *multiple* steps in the delivery process are required to impact upon coverage outcomes for the delivery of ACTs and ITNs. Interventions need to be multifaceted in order to have a significant impact.
- Where delivery systems are cross-sectoral, for example public-private systems, the readiness of the different sectors needs to be well synchronised, otherwise both are liable to dysfunction.
- A mix of delivery systems is necessary to reach the total target population for ITNs. However, not all delivery systems are complementary - some are competitive.

Scaling up services and policies

Scaling up is widely used to describe the process of expanding the uptake and delivery of health services and interventions. It can also refer to increasing the financial, human and capital resources required to expand coverage. The taskforce on Innovative International Financing for Health Systems estimates that an additional $10 billion per year is required to scale up essential health services in low income countries, mainly towards general health system support including health workers and facilities, and investments for logistics, information systems, governance and financing systems.

Successful scale up of services requires knowledge about which factors constrain effective implementation of health policies and delivery of interventions. Constraints range from a lack of demand for services, inadequate drugs or medical supplies at facilities, to weak systems for planning and management. Ensuring equitable access to quality services over a sustained period of time is a particularly important challenge to scaling up interventions, and can require new tools and strategies aimed specifically at reaching poor and vulnerable groups.

Overcoming the challenge of health policy implementation

Implementing equity-oriented reforms in South Africa

There is widespread evidence of significant gaps between health policies as laid down on paper by governments or ministries of health and their implementation in practice. As a result, newly proposed and effective interventions may fail to attain high coverage levels when implemented, and may not fulfil their potential to reduce mortality and morbidity. Such gaps often result from experiences in implementation.

In South Africa, CREHS research examined the implementation of two health policies: the Uniform Patient Fee Schedule which regulates payment for services and exemptions, and the Patients' Rights Charter which outlines patients' rights and responsibilities and aims to set out common standards of service across facilities. The research sought to understand how hospitals went about implementing the two policies and to explore how implementation was influenced by exercises of power and by institutional factors including organisation culture and staff members' trust in management.

Overall, from the perspective of policy and practice, the research points to the need for the active and strategic management of policy at the implementation frontline and the key role of managers and implementers in determining whether or not implementation is successful.

- Different types of policies place different demands on implementers and so can face varying levels of support or resistance in implementation.
- Active communication and management are key elements of the policy implementation process; implementers' understanding of policies shapes their actions and the eventual trajectory of the policy.
- Organisational environment, for example the trust between staff and management is also important and can have major consequences for how policy is implemented.

Effective delivery of interventions

Improved targeting of interventions: the example of trachoma control in Southern Sudan

Trachoma, a neglected tropical disease, is a major cause of blindness in Southern Sudan. While it is clear that trachoma is a serious problem affecting many people, the exact distribution of the disease throughout the country has only been partially established, which means that many communities in need of prevention and treatment support have not been identified or targeted.

Generating a better understanding of the geographical distribution of trachoma is therefore important so that the limited available resources can be better targeted to the areas and people that need the most help. This COMDIS study aimed to generate a national trachoma risk map as a tool to target further surveys to generate more information and to increase trachoma control activities in those areas.

The study concluded that trends in trachoma risk in Southern Sudan are associated with a lack of rainfall, but local clustering might partly be explained by ethnicity-related activities such as looking after livestock.

Policy implications

- The resulting risk maps show that trachoma is most prevalent in the centre, north and east of the country.
- The maps also show that large areas in the south-west have a low prevalence of trachoma.
- The maps developed can be used to prioritise surveys aimed at confirming suspected high-risk areas and to create data to monitor and evaluate further interventions in areas of the country that are not currently targeted.

New strategies and tools

The IPTi webtool for policy makers: supporting localised malaria control

Intermittent Preventive Treatment (IPT) is the administration of a therapeutic dose of an antimalarial drug at pre-defined time points regardless of infection status. IPT given to infants (IPTi) alongside routine vaccinations through the Expanded Programme on Immunization (EPI) is under review by WHO for recommendation "in areas of moderate to high malaria transmission". Once a policy recommendation has been issued by WHO, national policymakers will need assistance to ascertain where malaria transmission is "moderate to high", and whether there is sufficient sulphadoxine pyrimethamine (SP) susceptibility to justify implementation of this intervention.

TARGETS researchers have combined the results of research on the applicability of IPTi under six different scenarios of Plasmodium falciparum malaria transmission intensity and seasonality into an internet-based decision-support tool to aid policy-makers in deciding where to implement IPTi. The tool is user-friendly and flexible to changes in transmission or local knowledge. It enables the user to adjust the expected intervention coverage, and is being further developed to consider levels of susceptibility to SP, the intervention treatment, and local health system costings.

The IPTi webtool will provide indicative estimates of the numbers of cases of malaria that may be averted, taking into account local dosing regimens, EPI coverage and SP susceptibility, and will eventually provide estimates of local cost-effectiveness to support the development of localised policy-making.

www.iptiwebtool.org

Translating research findings into policy and practice: how can implementation research support the development of pro-poor health systems?

Much has been written on the various approaches to getting research into policy, and in particular on how to present the results of research in a form that will be used by policymakers. Such approaches are essential in influencing particular phases of policy development and, specifically, agenda setting. However, we believe these approaches are necessary but not sufficient. The aim should not only be to perfect techniques of feeding results to decision-makers, but also to design and carry out research from their perspective. This is particularly critical where the aim is to influence policy implementation and service delivery, and the decision makers are managers and frontline service providers.

The developing field of implementation research draws on a variety of disciplinary perspectives and encompasses a diverse set of issues. These range from evaluating the impact of specific interventions to developing a greater understanding of how and why specific interventions achieved (or failed to achieve) a particular level of impact, and developing new approaches to implementation and management that support greater impacts.

We propose that instead of expensive evaluations of donor funded programmes by external consultants, implementation research should be embedded, prospectively, into health services, programmes and policy implementation processes. Often, and certainly when evaluating impacts, such research should include identified comparison areas. But other study designs, including carefully conducted case studies, can also provide important insights into policy processes. By adopting implementation research perspectives, major investments by governments, bi and multi-lateral donors can be rapidly evaluated, and knowledge generated in a timeframe which allows the findings to inform policy and practice.

Key considerations include:

- Implementation research should focus on opportunities for going to scale and should consider what factors enable or constrain successful implementation of new services, programmes or policies
- Research questions often need to address people's and patients' barriers to large-scale access to services
- Implementation research should focus on policy conflicts and contestation, as well as resource constraints
- Research and service development should be linked
- Embedded research should aim to increase the effective use and availability of resources
- Multi-country research programmes are an effective way to develop the capacity of researchers to undertake implementation research and to influence health policies and programmes on national and international levels

Further Reading

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McCannon CJ, Berwick DM, Rashad Massoud M (2007) The Science of Large-Scale Change in Global Health. *Journal of the American Medical Association*; 298(16):1937-1939

Walley J, Khan MA, Karam Shah S, Witter S, Wei X (2007). How to get research into practice: first get practice into research. *Bulletin of the WHO*, 85, 424.

"The glaring gap between researchers and policy makers needs to be narrowed through a serious, ethical and honest rethink of the research prioritisation process at both national and international levels"

Communicable Diseases: Vulnerability, Risk and Poverty (COMDIS)

COMDIS

COMDIS is a Research Programme Consortium that works to drive research and development to combat communicable diseases in low-income countries. Through more than 50 ongoing and completed projects, COMDIS helps to ensure that prevention and treatment interventions for TB, malaria, HIV/AIDS and neglected tropical diseases are effectively delivered through strengthened healthcare systems to reach those most in need.

The big idea behind COMDIS is to anchor communicable disease research within operational programmes, so that knowledge generated is relevant and rapidly incorporated into policy and practice. COMDIS works closely with national health programmes to find solutions which will work in these low income countries.

COMDIS also focuses on communicating major findings from COMDIS research and on building an information bridge that links researchers with civil society, international institutions, policy makers, local health workers, local populations and donors across partner countries and beyond.

The COMDIS consortium comprises a team of public health researchers, tropical disease specialists, social scientists, statisticians, experts in research methods, gender specialists, communication specialists, and research support functions. COMDIS is committed to developing sustainable research capacity in partner countries.

COMDIS ensures that research makes a real difference to a huge number of people.

Partners

- **National Tuberculosis Control Programme (NTP), Directorate General of Health Services (DGHS);** Bangladesh
- **Bangladesh Rural Advancement Committee (BRAC);** Bangladesh
- **National Centre for Tuberculosis Control and Prevention, Chinese Centre for Disease Control and Prevention;** China
- **Shandong University and Shandong Chest Hospital;** China
- **Shanghai and Zhejiang CDCs;** China
- **Kwame Nkrumah University of Science & Technology;** Ghana
- **Health Research & Social Development Forum;** Nepal
- **Association for Social Development;** Pakistan
- **Good Shepherd Hospital;** Swaziland
- **Malaria Consortium Africa;** Uganda
- **Department of Clinical Medicine, Makerere University;** Uganda
- **Malaria Consortium International;** UK
- **Nuffield Centre for International Health & Development, University of Leeds;** UK

COMDIS partners work with National HIV/AIDS, TB and Malaria Control Programmes, including the National TB programme in Ethiopia, a new associate partner.

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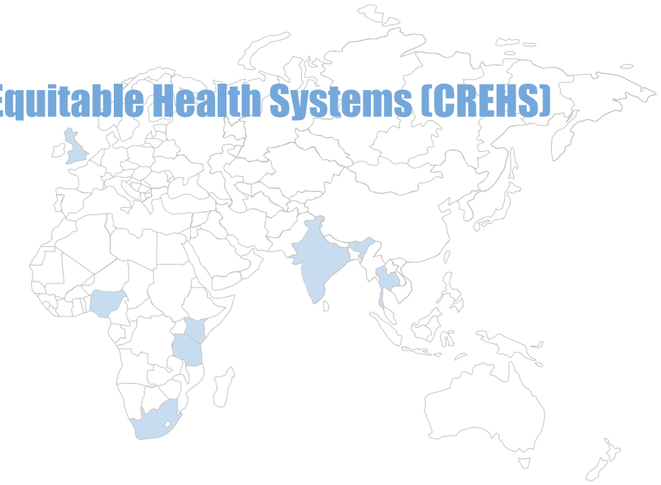
Consortium for Research on Equitable Health Systems (CREHS)



CREHS

The aim of CREHS is to generate knowledge about how to strengthen health system policies and interventions in ways that benefit poor and marginalised groups.

Research is organised in four key themes:

- **Health sector reform:** to identify the economic, political and institutional factors that enable or constrain the implementation of health policies that promote equity.
- **Financial risk protection:** to examine how health financing mechanisms can be combined and implemented to strengthen the allocation of resources to benefit the poorest.
- **Health workforce performance:** to identify strategies to improve health workforce recruitment, retention, productivity and responsiveness.
- **Scaling up:** to examine how strategies for scaling up coverage of priority health interventions can be designed and implemented in order to successfully reach the poorest.

CREHS is a partnership of eight organisations in Asia, Africa and Europe. Many of these organisations have developed close relationships with national policymakers and practitioners providing direct pathways of influence. By working in collaboration we are able to bring together the ideas, experiences and expertise of individuals from a range of backgrounds including economics, public health, anthropology and epidemiology.

Partners

- **Indian Institute of Technology, Madras;** India
- **Kemri-Wellcome Trust Research Programme, Kenya Medical Research Institute;** Kenya
- **Health Policy Research Group, College of Medicine, University of Nigeria, Enugu-campus;** Nigeria
- **Health Economics Unit, University of Cape Town;** South Africa
- **Centre for Health Policy, University of Witwatersrand;** South Africa
- **Ifakara Health Institute;** Tanzania
- **International Health Policy Program;** Thailand
- **Health Economics and Financing Programme, London School of Hygiene & Tropical Medicine;** UK

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Team for Applied Research Generating Effective Tools and Strategies for Communicable Disease Control (TARGETS)

TARGETS
Team for Applied Research Generating Effective Tools and Strategies for Communicable Disease Control

The TARGETS Consortium is a specialist team engaged in applied research to generate effective strategies for the control of communicable diseases. Our purpose is to develop new knowledge and tools that lead to better health for the poor and vulnerable.

Our research covers four broad themes:

- **Scaling Up:** To investigate how preventative, diagnostic and therapeutic tools for the control of communicable disease can be scaled-up most effectively in diverse settings.
- **Vulnerability:** To understand the interactions between communicable disease and factors such as gender, age, livelihood and environment, and the implications for disease control.
- **New Tools:** To assess the acceptability, effectiveness, adaptability and cost-effectiveness of new tools and intervention strategies for communicable disease control.
- **Monitoring and Evaluation:** To develop and apply new approaches and tools for monitoring and evaluating the impact, cost-effectiveness and sustainability of communicable disease programmes and delivery mechanisms.

TARGETS is led by the London School of Hygiene and Tropical Medicine and is formed of seven partner institutions in Sub-Saharan Africa, India and Europe, supporting projects in more than 17 countries. Currently in its fifth year of research, TARGETS continues to engage in cutting edge research producing high quality evidence to support public health policy and practice at district, national and international level.

Partners

- **INDEPTH Network;** Ghana
- **Maharashtra Association of Anthropological Sciences, Centre for Health Research and Development;** India
- **KNCV Tuberculosis Foundation;** The Netherlands
- **Ifakara Health Institute;** Tanzania
- **Makerere University School of Public Health;** Uganda
- **London School of Hygiene & Tropical Medicine;** UK
- **ZAMBART (Zambia AIDS-Related TB Project);** Zambia

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