movement and ensure that global health principles are guiding university priorities.

Summary/Conclusion: Building a robust global health agenda for the training of talent, extension of relationships across multiple borders, and the mobilization of new ideas among higher education institutions and partners is what will unquestionably benefit our domestic community and foster global stability. Approaching internationalization of higher education where sector issues, like global health are core is a much richer, more relevant, and necessary approach to strategy development.

Health systems strengthening in the post-2015 global development agenda

K. Pettersen; University of California, San Francisco, School of Medicine, San Francisco, CA/US

Background: The United Nations (UN) Millennium Development Goals (MDGs) were created in 2000 to address the world's most pressing development challenges. Though successful in some regards, all three health MDGs are not on track to meet their objectives by 2015. One possible explanation is the lack of emphasis on health systems strengthening (HSS) in global health (GH) efforts. In 2007, the World Health Organization (WHO) described an HSS framework, including six building blocks: service delivery; workforce; information; medical products, vaccines, and technologies; financing; and leadership/governance. Many GH organizations have subsequently advocated for HSS (Hafner and Jeremey, 2012). The UN post-2015 agenda provides an opportunity to prioritize HSS; the extent to which this is occurring in the post-2015 dialogue is unclear.

Citations:

World Health Organization. Everybody's Business: Strengthening Health Systems to Improve Health Outcomes. 2007.

Hafner, Tamara and Shiffman, Jeremey. The Emergence of Global Attention to Health Systems Strengthening. Health Policy and Planning 2012;1–10.

Structure/Method/Design: Published post-2015 reports were reviewed from the following web pages (December, 2013):

UN: Beyond 2015 (http://www.un.org/millenniumgoals/beyond2015-overview.shtml)

UN: Sustainable development knowledge platform, health and population dynamics (http://sustainabledevelopment.un.org/index.php?page=view&type=9502&menu=1565&nr=6)

WHO: Health in the post-2015 UN development agenda (http://www.who.int/topics/millennium_development_goals/post2015/en/)

World We Want: Health Thematic Consultation (http://www.worldwewant2015.org/health)

Reports were examined if they discussed health goals for the post-2015 agenda.

These reports were searched for "health systems" and statements supporting the building blocks of HSS. Quotes were extracted and assessed for 1) the degree of support for HSS in the post-2015 agenda, 2) HSS metrics, and 3) the context arguing for HSS. Degree of support was categorized as absent (HSS not mentioned), weak (HSS mentioned but no building blocks included), or strong (HSS mentioned including at least one building block).

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): A total of 12 reports met the inclusion criteria. Four of the 12 reports were classified as "strong" in their support for HSS; 5 were weak and 3 made no mention of HSS. No reports suggested metrics for HSS. When HSS was mentioned, it was most often included in the context of calling for universal health coverage rather than other potential development goals, such as addressing noncommunicable diseases or accelerating the MDGs.

Summary/Conclusion: HSS appears to be mentioned in the majority of reports addressing health in the post-2015, although a robust roadmap for its incorporation is lacking. To insure that HSS is realized, subsequent steps in the post-2015 process should aim to 1) develop metrics to measure success and 2) broaden ways in which HSS can support all health-related development goals.

An NGO code of conduct for health systems strengthening: Maximizing the performance of nongovernmental organizations to support broad health system development

J. Robinson[1], S. Gloyd[2], A. Hagopian[2], J. Pfeiffer[1]; [1]University of Washington, Department of Global Health, Seattle, WA/US, [2]University of Washington, Seattle, WA/US

Background: Health systems in the developing world are often characterized by severe shortages of human resources, inadequate infrastructure, and limited capacity. Despite a growing donor focus on "health systems strengthening," programs like PEPFAR and the Global Fund continue to preferentially seek out nongovernmental organization (NGO) partners. In addition, the growing global focus on the end of AIDS in a post-Millennium Development Goals (MDG) world often results in vertically funded programs that can have detrimental effects on public-sector human resources. The rise of NGO-driven service delivery has led to a proliferation of different projects and approaches, often with poor follow-up, limited oversight, and varied levels of success.

Structure/Method/Design: In May 2008, a group of health-focused organizations launched the "NGO Code of Conduct for Health Systems Strengthening." This voluntary strategy aims to ensure that NGOs "do no harm" and contribute maximally to building public health systems. We will present the process of developing the code, key elements and rationale, and concerns that have arisen during the adoption and implementation of Code policies.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Our own experience in implementing the Code, as well as the results of a 2010 evaluation among a sample of the 57 signatories, has shown that the current donor environment—which funnels financing toward international NGOs rather than long-term investments into the public sector—makes it extremely difficult for signatory NGOs to implement more equitable hiring processes. Barriers to implementation include recruiting qualified staff to implement NGO programs without damaging the public-sector workforce and providing comparable salaries to MOH staff.

Summary/Conclusion: In the areas of hiring practices, compensation schemes, training and support, reduction of management burden, and assistance in integrating communities into the formal health system, international NGOs have an opportunity to support public-sector health system strengthening through sustainable practices promoted in the NGO Code of Conduct. To effectively implement these practices, however, donors must be called on to also sign and make the implementation of the NGO Code of Conduct a requirement for recipient organizations as a condition of funding.

Generating political priority for urban health and nutrition: Application of a policy framework

Y.R. Shawar[1], L. Crane[2]; [1]American University, Public Administration and Public Policy, National Harbor, MD/US, [2]Save the Children, Health & Nutrition, Washington, DC/US

Background: Over the past 2 decades there has been much discussion of the challenges posed by rapid urbanization in the developing world, yet the health of the urban poor continues to receive little political priority at the global level. Despite wide recognition that the world is rapidly urbanizing, little research has specifically examined why little action has been taken globally. Drawing on social science scholarship concerning how issues come to attract attention, this study examines factors that have shaped political priority for urban health. We draw on the Shiffman and Smith (2007) policy framework, which consists of four categories: 1) actor power, 2) issue framing, 3) the political contexts within which actors operate, and 4) characteristics of the issue itself.
Structure/Method/Design: The paper triangulates among several sources of data, including 18 semi-structured interviews with experts involved with agencies that shape opinions and manage resources in global health, published scholarly literature, and reports from organizations involved in urban health provision and advocacy.
Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Several key factors currently hinder urban health's advancement globally. First, with respect to actor power, there is no policy community cohesion or unifying political entrepreneur, and limited mobilization of civil society to champion the cause. While there has been demonstrated uptake in momentum for "urban" among development organizations, funders, state governments, and academics, this area has yet to be recognized as its own discipline and be attached to uniform, formal strategic policies. Second, with respect to framing, there is a lack of consensus in defining "urban," which has lead to longstanding conceptual and measurement difficulties. Third, concerning political contexts, the MDGs, rapid climate change, and the recent demographic shift to more than half of the world's population living in urban settings have been largely untapped as policy windows. Finally, with respect to issue characteristics, there is limited disaggregated data and a lack of accepted metrics available to capture the burden of disease and poverty within disadvantaged urban communities, which is needed to quantify the magnitude of the problem, develop effective interventions, and ultimately present it as a critical, unmet need.
Summary/Conclusion: The study concludes with insight around what can be done to secure attention and resources for this overlooked area of development. This includes focusing on health equity by framing urban health problems through an "urban—rural continuum" model, rather than reinforcing a strict urban—rural dichotomy; seeking more urban-specific data that enables disaggregation to highlight the most vulnerable urban communities; supporting systematic knowledge-sharing of effective urban interventions; and capitalizing on policy windows like the post-MDG discussions.

Emergency department overcrowding globally: The impact of non-urgent utilization

P. Troxell; University of Illinois at Chicago, Global Health, Chicago, IL/US

Background: Overcrowding in the emergency department (ED) is one of the most serious issues confronting EDs in the developed world. The US government has recognized non-urgent utilization as contributing to overcrowding. This study describes non-urgent ED utilization in 11 commonwealth countries and assesses prevalence, risk factors, and attempted strategies. This study pooled the knowledge of several countries in order to better describe the situation and present possible strategies for managing it. While studies have described factors associated with non-urgent ED visits and proposed possible solutions, few projects have attempted to address this issue on a multinational scale.
Structure/Method/Design: This descriptive, cross-sectional study examined published research obtained through keyword searches of the medical databases PubMedand EMBASE. The articles retrieved were selected for inclusion using abstracts and/or subheadings to determine relevance. Full text articles were obtained for all relevant literature and additional material was obtained through cross-checking the references from select sources.
Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): The international literature recognizes non-urgent visits as one factor that contributes to the problem of ED overcrowding. This problem results in adverse patient outcomes, reduced health care quality, diminished patient access, and financial losses from patient elopement and ambulance diversion. Over the last 10 years, literature estimates of non-urgent utilization across commonwealth countries ranged from 5% to 59.5%. The average of US prevalence estimates was 25.1% (10%-54.1%).

Factors: The literature describes these factors as potentially associated with non-urgent utilization: female gender, dissatisfaction with primary care, inability to get a same or next day doctor's appointment, inability to receive after hours care, inability to contact a regular doctor by phone, patient perception of severity, lack of a regular source of care (or ED as regular source of care), lack of financial access, lack of awareness of the medical/insurance system, self-referral, and physician referral

Strategies: The literature review identified these strategies: increasing the number of ED personnel, supporting resources, and beds; diverting non-urgent patients to other venues through referrals, creation of additional venues for non-urgent care, and counseling on proper ED usage; allowing long wait times to be self-regulating; and utilizing technology to map patient movement through the medical system.
Summary/Conclusion: All nations studied reported problematic ED overcrowding and ED utilization for non-urgent care. Results vary by country. The factors that appear most strongly correlated are high percent population using the ED, long wait times in the ED, concerns about ability to pay for care, and inability to contact a primary doctor by phone during working hours. Future research should focus on assessing this problem in low-/middle-income countries.

Evaluation of military humanitarian operations: Time for a new paradigm

S.G. Waller; Uniformed Services University of Health Sciences, Global Health, Bethesda, MD/US

Background: A comprehensive solution to the complex problems of global health would require a wide range of tactics and efforts. Among the array of potential solutions is military humanitarian operations. When security is poor or there is great need for large-scale, rapid response, or the boundaries between diplomacy, development, and defense are murky, the US Department of Defense (DoD) provides unique capabilities for humanitarian assistance (HA). A Kaiser Family Foundation study estimated that the DoD spent over $600 million on humanitarian work in a recent year. When employed, DoD assets should be used appropriately and effectively. The DoD has an opportunity to benefit from lessons from the international humanitarian community.
Structure/Method/Design: To assess individual DoD projects and programs, the author proposes the use of a checklist, much like those in USAID's Field Operations Guide. The checklist would employ a customized list of "yes/no/not applicable" questions and focus on: 1) 3 evaluation stages: planning, execution, assessment/impact; 2) Metrics: