is thus necessary to establish favorable treatment regimens for MDRTB patients with hypertension to improve patient outcomes.

**Funding:** None.

**Abstract #:** *1.007_GOV*

### Perceptions of political actors on sex-selective abortion in Northwestern India

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**Background:** Sex-selective abortion (SSA) describes the abortion of an undesired female fetus (solely because she is a girl). Demographic studies on SSA demonstrate that a combination of three factors – high son preference, access to sex-selection technology, and low fertility rates – catalyze skewed sex ratios. Although SSA has been illegal in India since 1994 with the passing of the Pre-Natal Diagnostic Testing (PNDT) Act, as of 2011 there were only 875 girls to 1000 boys in Northwestern India. Even though the United Nations highlights the need to engage with public authorities to curb SSA, thus far studies have not analyzed the opinion of political actors on SSA. Thus, this study aims to understand perspectives of political actors in Northwestern India on SSA policies.

**Methods:** I conducted lengthy unstructured interviews. Political actors were from Northwestern India (Gujarat, Maharashtra, New Delhi, and Rajasthan). Sixteen political actors were recruited - eight were experts on SSA, while the other eight were not specialists in the field (non-specialists). Using Critical Discourse Analysis and a Readiness (demand) and Able (supply) framework, my study analyzes how political actors discuss policies aimed at curbing the demand or supply of SSA. Participants provided verbal consent and ethics approval was received from the University of Cambridge.

**Findings:** (1) While Census data demonstrates that sex ratios are most skewed in urban, wealthy, and educated populations, non-specialists incorrectly believed the practice occurred primarily in rural, poor, and uneducated populations. (2) Non-specialist political actors do not perceive the PNDT Act as valuable for lowering SSA; they believe SSA must be curbed through cultural change, not legal measures.

**Interpretation:** There is a lack of knowledge amongst non-specialists may lead to policy mismatches (e.g. conditional cash transfers). Additionally, there are debates on the role of the law, demonstrating the potential decreased political will towards legal solutions for SSA. Future studies will include 100 standardized surveys of non-specialist political actors to gain insight on their level of knowledge has well as opinions on SSA policies.

**Funding:** The Gates-Cambridge Trust funded my graduate studies.
**Abstract #:** *1.008_GOV*

### Morbidity pattern in individuals seeking treatment in primary medical care units in the division of the ampara regional director of health services, Sri Lanka and related costs

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**Background:** Sri Lankan government provides free health care. Ampara is one of the four health districts in the Eastern province of Sri Lanka. Morbidity pattern and associated cost of individuals attending Primary Medical Care Units (PMCUs) in Sri Lanka is scarce. Therefore, we conducted this study to describe the pattern of presenting symptoms and cost incurred by the government and the individual (out-of-pocket expenditure) attending PMCUs in the Ampara Regional Director of Health Services (RDHS) division.

**Methods:** The study was a descriptive cross sectional study. Of the fifteen PMCUs situated in the Ampara RDHS division, eight daily functioning PMCUs run by a qualified Medical Officer were randomly selected. All individuals attending them on a selected day in a week were included to the study. An interviewer administered structured questionnaire was used. Data was analysed using SPSS statistical software.

**Findings:** A total of 516 individuals were included in the study. The mean age was 34.8 years (SD=22.2 years). Respiratory symptoms were the commonest (28%), while 19% had musculoskeletal and 13% digestive symptoms. The pattern of presenting symptoms among children was different from adults. The mean cost incurred by the government was Rs.136.89 (1USD=40 SLR) per visit. Out of this cost 18% were for medicines and 82% for salaries of health care personnel. Antibiotics accounted for 45% of the total medicine cost incurred by the government and 44% were issued antibiotics. Issuing of antibiotics to children was statistically significantly higher than in adults ($p<0.05$). The mean cost incurred by the government for children (Age<=12years) was statistically significantly higher ($p<0.05$) than for adults. The mean out-of-pocket expenditure per visit was Rs.175.40. The main component of this consisted of loss of income (61%). The mean out-of-pocket expenditure (Rs.175.40) was statistically significantly higher than the mean cost incurred by the government (Rs.139.89) and the mean total cost for a PMCU visit was Rs.312.29.

**Interpretation:** As forty three million visits are recorded annually for PMCU care in Sri Lanka, Rs. $(312.29 \times 43) \times 10^6$ is spent for these visits. Visits to a PMCU affect the income of the individual and indirectly the family and the society.

**Funding:** Education Training and Research Unit, Ministry of Health, Sri Lanka.

**Abstract #:** *1.009_GOV*

### The West African Ebola outbreak: reforming international aid in emergency responses to promote universal coverage for comprehensive care of survivors

*M.D. Drasher[1,2], G.W. Schlough[1,2]; [1]Partners In Health, Boston, MA, USA, [2]University of Minnesota, Minneapolis, USA*

**Program/Project Purpose:** The medical identities of Sierra Leone's 4,000+ Ebola survivors came at the cost of losing socioeconomic support networks. Ebola Virus Disease sequelae leads to pain in the joints, chest, fevers, difficulty sleeping and blindness. In 2014 Partners In Health established an Ebola Survivors Program to provide comprehensive care to EVDS. Here we summarize a process for establishing a program for Ebola survivors as a model for building comprehensive care services for vulnerable individuals receiving care for chronic morbidities in global health.

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**Structure/Method/Design:** Ebola survivors represent a population in need of health care and socioeconomic support (access to education, livelihood, and employment). By pairing these two distinct activities the comprehensive care necessary for vulnerable populations to overcome the forces of structural violence is actualized. At our programs onset we established local associations of EVDS to listen and learn from their needs. We worked with these associations to employ those interested in educating others on breaking the chain of transmission in their communities. Case managers in our program—all EVDS themselves—worked with portfolios of other EVDS to perform weekly home-visits while accompanying those in need of health service to clinics, education and livelihood activities.

**Outcome & Evaluation:** At its peak our social mobilization efforts employed over 600 EVDS. The comprehensive care model led to more than 1,500 EVDS receiving free clinical care and home follow-up. Additionally, 850 EVDS are receiving educational support. Livelihoods activities opened 500+ bank accounts with financial skills workshops, distributed 517 National ID cards, and supported vocational activities of 250 EVDS. This information is linked to a National dataset creating a value added mechanism for strengthening the monitoring of vulnerable populations for the Ministries of Social Welfare and Health.

**Going Forward:** The effects of Ebola on social, biological, and economic livelihood necessitates the provision of comprehensive care with universal coverage in West Africa. A restructuring of international aid limitations must occur for an increase in comprehensive approaches to care for survivors.

**Funding:** Unrestricted funds from Partners In Health provided the initial investment and additional support has been provided by public sector grants.

**Abstract #:** *1.010_GOV*

### Establishing a collaborative governance structure at an academic medical center for global health programs in resource-limited settings

*C. Daskevich, M. Mizwa, D. Nguyen, A. Gibson, T. Napier-Earle, M. Kline*

**Program/Project Purpose:** The development and ongoing management of global health programs in resource-limited settings (RLS) is an all-too-often daunting task with issues arising both in the local management, operations and sustainability in the RLS as well as similar issues in the U.S.-based Academic Medical Center (AMC). The AMC leadership determined that key areas and departments were doing great work globally, but the work was primarily driven by the individual clinical areas, presenting an opportunity for integration and collaboration.

In order to maximize impact, effectively manage limited financial resource and maintain a standard of excellence in the implementation and sustainability of clinical programs in RSL, this AMC decided to create a governance structure that enhances coordination of, and provides strategic direction to, those groups engaged in global health initiatives.

**Structure/Method/Design:** The first and most important step in establishing an effective governance structure is the clear definition of the institutional imperative — in this case, *to create a healthier future for children and women throughout our global community by leading in patient care, education and research*. Armed with this mission, the executive leadership of the AMC formed a governance committee for its global health initiatives comprised of the top executives of the hospital, as well as the clinical service line leadership.

**Outcome & Evaluation:** This Global Health Executive Committee sets strategy, approves strategic investments and budgets and convened a Global Health Steering Committee comprised of members selected based on their knowledge, expertise and experience in global health program management and implementation. The steering committee was tasked with recommending operational infrastructure, developing a strategic plan, managing strategic investment projects, defining success metrics, providing operation advice/expertise and providing a forum for discussion, coordination and collaboration.

**Going Forward:** The AMC provided a team of qualified individuals across project management areas to support the committee and the individual programs in their efforts to achieve excellence in program development and management and ensure effective utilization of financial and human resources.

**Funding:** All funding for the governance committee meetings and initiatives is provided by the AMC.

**Abstract #:** *1.011_GOV*

### Creating indigenous non-government organizations for program management, support and operations

*C. Daskevich, M. Pifko, F. Louis, D. Nguyen, A. Gibson, T. Napier-Earle, M.B. Mizwa*

**Program/Project Purpose:** This pediatric HIV-focused charity (Pedi-HIV) based in the U.S. is a global leader in pediatric HIV/AIDS care and treatment. Through public-private partnerships with governments and donors, Pedi-HIV has created a Network of affiliated non-governmental organizations (NGOs) to operate its Children's Clinical Centres of Excellence (COE) throughout Sub-Saharan Africa, Colombia, Papua New Guinea and Romania.

**Structure/Method/Design:** Pedi-HIV operates COEs in Botswana, Lesotho, Swaziland, Malawi, Uganda, Tanzania and Romania, providing pediatric and family-centered HIV/AIDS prevention, care and treatment and support and health professional training. Each country program embraces a public-private partnership model with Government and donors, operating under memoranda of agreement with government and integrated into each Ministry of Health systems of care. This process is facilitated through the creation of affiliated NGOs which manage, staff and operate the COEs. These affiliated NGOs have indigenous boards of directors and report programmatically and financially to the parent College of Medicine (COM) and Academic Medical Center (AMC).

**Outcome & Evaluation:** Creating a legal framework through the establishment of affiliated NGOs has allowed the Pedi-HIV network to receive over $60 million in international aid through donors and government subventions. Critical to success is ensuring good governance systems and best practices, including board of director's composition, appropriate committee structures and programmatic and financial oversight. It has also allowed the