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

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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

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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:

"SMART"—specific, measurable, accurate, reliable, timely; 3) Measuring outcomes, sustainability, surprises; 4) Optional comments section for lessons learned and open issues; 5) Invite content input from all stakeholders, including hosts; 6) Modify the assessment tool based on regional or cultural features, new priorities, new complexities, and insights. By including input from all stakeholders and scoring the project or program based on all checklist submissions, a "quality rank" of each specific project/mission could be calculated. This assessment can be done at various times after project completion, for added insights.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): The design of an objective, quantifiable HA project evaluation tool is simple to use and encourages compliance and data gathering. All stakeholders, especially those in the host nation, participate in customizing measurement indicators and in the scoring and assessment. The product of this evaluation tool can be utilized for education of political leadership, for impact assessment, and for improved resource and budget decisions. This tool is ready for pilot study and implementation.

Summary/Conclusion: Using the lessons learned by international humanitarian organizations, the author found that the DoD should first determine the relative value of its vast array of projects/programs by engaging all stakeholders—host nation, US embassy, interagency US government, and military—and by better measurement of the long-term impact of the programs. The value of assessment can inform non-military humanitarian work also.

It's for the greater good: Midwives' perspectives on maltreatment during labor and delivery in rural Ghana

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Background: Encouraging women to deliver in facility settings is one strategy to improve maternal and neonatal outcomes in the developing world. However, in much of sub-Saharan Africa, less than half of pregnant women deliver their babies in health facilities. Fear of maltreatment during labor and delivery has been shown to be a major barrier to facility delivery, yet previous studies have focused solely on reports from women, rarely seeking insights from practicing midwives' about their thoughts and reported behaviors regarding maltreatment during labor and delivery.

Structure/Method/Design: All seven practicing midwives from a rural hospital in Ghana were recruited to participate in in-depth interviews regarding their perceptions of care during labor and delivery. Ten pregnant women with at least one previous delivery were also recruited from the same hospital. We utilized a semi-structured interview tool and a qualitative field interviewing approach. All interviews were audiotaped, transcribed, and entered into Nvivo 9.0 for analysis.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Several themes were identified during data analysis: Theme 1) The interaction between midwives and their patients is analogous to a mother/daughter relationship, including the need for disciplinary action when necessary; Theme 2) There is a knowledge imbalance between midwives and patients, whereby patients don't always know what is in their best interest; Theme 3) Midwives feel a strong sense of accountability and responsibility for the labor and delivery outcomes. As a result, they will do whatever it takes to deliver a live baby to a healthy mother. Hitting, yelling, and neglecting women during labor and delivery were reported as not uncommon occurrences in the labor and delivery ward. However, each was undertaken in an effort to encourage women to do what was needed to deliver safely.

Summary/Conclusion: The research findings suggest that the issue of patient maltreatment in low-resource labor and delivery settings is complex and may be undertaken in what is perceived to be the laboring woman's best interest. Midwives feel a strong sense of responsibility over birth outcomes, and even pregnant women interviewed agreed that midwives have to do "whatever it takes" to help them deliver a healthy baby. The exploration of alternative strategies to facilitate labor and delivery is warranted, as well as the provision of adequate support and resources for practicing midwives in rural settings.

Medicine in a hostile environment: Chinese medical providers' fear of retaliation from patients

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Background: Tension looms over the patient—physician relationship in China despite concerted reform efforts to improve access and the standard of care. Dissatisfied patients often resort to aggressive means to solve disputes over diagnosis, treatments, medical errors, and costs. In the past decade, the incidence of physical violence by patients against medical providers tripled to over 17,000 cases per year nationwide, including 34 murders that have gathered immense media attention. We wanted to assess the medical providers' perception of the practice environment in China, including their encounter with violence and the associated emotional impact.

Structure/Method/Design: An anonymous survey was distributed to medical students, trainees, and staff at three academic hospitals in Hunan Province. Respondents were asked to rate their fear of retaliation from patients, and disclose whether they have been involved in medical disputes or been a victim of physical violence by patients and/or family members. The answers were tested for statistical association with professional and personal backgrounds.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Among the 380 providers (62 attending physicians, 80 residents, 128 students, 110 nurses), 65.7% admitted to being somewhat or very afraid of retaliation from patients. Only 17.9% have been involved in medical disputes, and 1.84% have been a victim of patient-afflicted violence. However, 17.1% personally know someone who has been a victim, and another 48.2% are aware that this type of violence is happening near where they practice. Personal experiences with medical disputes or patient-afflicted violence did not significantly affect the extent of fear, nor did education, marital status, income, or religious beliefs. Nurses and physicians experienced similar degrees of fear but physicians were more likely to have been involved in a dispute (OR, 3.81; 95% CI, 1.94-7.49) and know someone who has been a victim of violent retaliation (OR, 4.45; 95% CI, 2.49-7.93). Providers under age 35 are more likely to harbor fear for patient retaliation (OR, 1.95; 95% CI, 1.06-3.60) but less likely to have been involved in a dispute (OR,0.11; 95% CI, 0.06-0.21). Intriguingly, the majority (74.5%) of the providers considered themselves in the bottom or lower-middle socioeconomic classes, and only 1.1% considered themselves in the upper-middle or elite classes.

Summary/Conclusion: Our results show that Chinese medical providers feel vulnerable in the current practice climate. Their fears may originate from the widespread incidence of retaliation from patients, media reports highlighting the violence, as well as financial insecurity. Whether this emotional backdrop negatively affect the providers' mental health and impede on their daily interactions with patients and decision making awaits further elucidation.