Medicines List (EML), little has been done to determine the macroeconomic factors that influence ability to provide these essential medications. This study was done to explore potential macroeconomic factors related to essential cancer medication availability. The aim of this study is to explain variations in the number of essential cancer medications listed on national formularies.

Methods: Cancer medications on the WHO's EML were compiled and compared against official English-language national formularies made available on the WHO website. The relationships between national formulary listings and indicators of economic development were then tested. Participants were sixty low- and middle-income countries (LMICs). Exploratory analysis was conducted using regression. Both the total number of essential cancer medications and the number of newly-added essential cancer medications appearing on national formularies were tabulated and compared against a compendium of country-level national indicators of economic development from the World Bank.

Findings: Researchers determined the number of essential cancer medications available on national formularies for 60 LMICs. Regression analyses showed significant negative relationships between total numbers of essential cancer medications with health-related foreign aid and total health expenditures. However, a significant positive relationship existed between number of newly-added essential cancer medications and gross national income per capita.

Interpretation: Countries with greater income per capita provide more essential cancer medicines to its residents, but countries whose healthcare expenditures constitute a greater proportion of its total budget, or countries relying most on outside assistance, provide fewer essential cancer medicines to its residents. The main limitation of this research is that text mining was restricted to English-language documents. The main strength of this research is that it is the first study attempting to explain variations in essential cancer medication availability using measures of economic development.

Funding: This study was funded by the University of California, San Diego.

Abstract #: *1.003_FOS*

Corporate social responsibility - The power of philanthropy in the developing world for an academic medical center

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Program Project Purpose: The Academic Medical Center (AMC) and its affiliated College of Medicine (COM) partner are committed to new and innovative global health platforms building on the success and developed infrastructure and human capacity of their affiliated U.S. charitable organization (Charity).

Structure/Method/Design: Charity operates a Network of Children's Clinical Centres of Excellence (COE) 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 COE is managed and operated by a Charity-affiliated non-government organization (NGO). This organizational structure ensures that the COM and AMC institutional clinical, administrative, financial, monitoring & evaluation, and operational/clinical research best practices are embraced and adhered to. It also allows for the NGOs to access Corporate Social Responsibility (CSR) programs in countries where energy, pharmaceutical, banking, and manufacturing companies operate. The goal of CSR is to embrace responsibility for a company's actions by making a positive impact on the environment, consumers, employees, communities, and stakeholders.

Outcome & Evaluation: Many companies prefer that their CSR programs are locally driven through public-private partnerships (P3) with Government and local NGOs. The COM and AMC have successfully engaged major pharmaceutical and energy companies and others in CSR projects in women's and child health, HIV/AIDS, malaria, malnutrition and sickle cell disease due to their experience in P3 as well as operating the affiliated NGOs. Between 2011-15, the Charity and AMC secured over $15M for CSR projects in Africa, Colombia and Romania.

Going Forward: Companies that have CSR programs are encouraged to partner with United States institutions that have direct NGO affiliates on the ground in countries where they have operations. This provides opportunities for sustainable programs and services that impact local communities, build local human capacity, enhance infrastructure and build P3 alliances.

Funding: The COM and AMC provide in-kind support for all direct costs related to securing CSR project design, management and funding.

Abstract #: *1.004_FOS*

Political economy of health research for universal health coverage: An outline of a theoretical and methodological agenda

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Background: Within the field of global health, there is growing interest in conducting health systems research (HSR), particularly in the service of achieving universal health coverage (UHC) within low- and middle-income countries (LMICs). Political economy analysis has been put forward as a potentially productive way for researchers to examine health systems and paths toward establishing UHC policies in LMICs. However, complicating such a research agenda are the manifold approaches to conducting political economy analysis and the general confusion regarding the term in global health. To clarify future research in this area, I have outlined a novel theoretical and methodological approach to conducting political economy analysis of health systems that is based in the traditions of the political economy of health and social medicine.

Methods: A narrative literature review of books and articles pertaining to the political economy of health tradition and social medicine was conducted. Authors writing in the tradition of political economy of health and/or social medicine were further examined, with particular attention paid to their research on health systems.

Findings: Clear theoretical and methodological trends emerged from this narrative literature review that can inform a health systems research agenda that employs political economy analysis and draws on the traditions of political economy of health and social medicine.

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These include 1. the 'human right to health' theoretical position; 2. approaches to analysis that are "geographically broad and historically deep", that is, that are attentive to the effects of social, political, and economic forces operating both nationally and internationally throughout history (i.e. slavery, colonialism, military intervention, extractive economic arrangements, etc.) on present political and economic configurations. Such analysis might draw on world systems analysis and consider long-term historical trends consonant with the *longue durée* approach of the French Annales School; 3. the role of present social, political, and economic configurations as upstream "fundamental causes" of disease patterning across national and global populations; and 4. the relative balance of class interests as a latent variable in influencing national social policy pertaining to health and general welfare.

Interpretation: Political economy analysis is a potentially productive approach to conducting a form of health systems research that privileges the role of social, political, and economic arrangements in the distribution of national and global disease burdens and one that interrogates the relations of power that sustain the status quo. Here I present an outline of a political economy analysis that is based in the traditions of political economy of health and social medicine. More work is needed to clarify this approach, as well as other approaches based in alternative traditions of political economy (i.e. neoclassical, neoliberal, institutional, etc.).

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Old partners – who were they? Examining the factors that sustain global health partnerships

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Background: As academic institutions seek to integrate global health (GH) training into the education continuum, there is a growing recognition of the challenges to developing and sustaining a GH program. GH partnerships vary in focus, trainees, number, and type of partners. Little is known about the factors that sustain academic GH partnerships.

Methods: From March to November 2013, we conducted a series of structured interviews to explore the relationship between a reciprocal and a successful GH program. The study was approved as IRB exempt by the Indiana University Institutional Review Board. After a review of published program descriptions to identify reciprocal elements based on the WEIGHT guidelines, seven GH programs were selected to participate. All programs were part of a University-affiliated Center or Institute for Global Health. Six programs were U.S.-based, with one U.K.-based program. GH Program length was 5-25 (14.8) years with 5-9 (7.3) partners in Africa, Asia, Central and South America. Qualitative data from the interview transcripts were independently reviewed by two study investigators (JJ, RU) experienced in thematic analysis using the constant comparative method. Saturation was achieved after no new themes emerged from the data. NVIVO 10 (QSR International) software was used to organize data and assess coder agreement.

Findings: The themes that emerged around successful GH programs were: Attention to partnership development, often with a specific individual playing a key role as the "guardian of the mission"; "Identifying challenges", collaboratively with partner input; "Role of learners", in both developing and sustaining the program; a routine of "Constant communication"; "Role of funding" and "Evaluation of program impact". Other themes were: the "Randomness of program development", as programs responded to new needs and challenges; a "Constantly changing landscape", with changes in institutional leadership and local needs; and the challenges of leadership: "So much administration".

Interpretation: Global health programs encounter many challenges that threaten their longevity. Attention to early partnership development with mutual goals, work with local ethics committees in conducting research, keeping open channels of communication between partners, utilizing multiple sources of funding, and active evaluation of program impact contribute to long-term sustainability.

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Estimating country-level nutrition investments: Global implications of a two country study

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Background: Malnutrition is one of the greatest challenges to health and development in many low- and middle-income countries (LMIC). Like any national challenge, sufficient, sustained funding is needed to address this issue. Yet there is little information available in most LMIC on funding for nutrition. To meet the need for better data on nutrition financing, USAID's SPRING Project has collaborated with the governments of Uganda and Nepal to analyze funding for nutrition and to develop a series of tools that can be shared globally.

Methods: SPRING adapted the Scaling Up Nutrition (SUN) Movement's 3-Step approach to conduct a mixed method, country-specific analysis of multi-sector government budgets and donor reporting. SPRING defined the range of searchable nutrition activities across six sectors by using the country's national nutrition action plan (NNAP). Budgets and work plans were collected during key informant interviews with government, NGO and donor stakeholders, and analyzed against the NNAP activity matrices. Budget validation meetings were then held to ensure completeness, accuracy, and breakdown of integrated activities.

Findings: SPRING's validated estimates of two fiscal years (2013/14 and 2014/15) have been shared with country stakeholders and with SUN as part of their regional and global financial tracking exercises. By relying on nationally-recognized and locally-created documents, SPRING provided a familiar basis for discussions to increase credibility and local ownership of findings. Funding allocations for both countries can be provided by funding source, sector, and NNAP strategic area. Results of the analysis include that budgeted funds exceeded NNAP estimates of cost, but budgets were not