Annals of Global Health, VOL. 82, NO. 3, 2016
May–June 2016: 446–462

Conclusion: This review indicates that there are few publications that reflect specifically on the role of mHealth and teleoncology in cancer prevention, and even fewer that describe or evaluate interventions. Although articles suggest that mHealth and teleoncology can enhance the implementation and utilization of cancer prevention interventions, more evidence is needed.

Abstract #: *1.017_TEC*

Stanford-India Biodesign: Outcomes from an eight year collaboration with the government of India to promote medical technology innovation in India

Rajiv Doshi[1], Paul Yock[1], Uday Kumar[1], Anurag Mairal[1], Christine Kurihara[1], Sandeep Singh[2], Balram Bhargava[2]; [1]Program in Biodesign, School of Medicine, Stanford University, Palo Alto, CA, USA, [2]Cardiothoracic Sciences Centre, All India Institute of Medical Sciences, New Delhi, INDIA

Background: Begun in 2007, the Stanford-India Biodesign (SIB) program represents a first-of-its-kind collaboration between Stanford University, the All India Institute of Medical Sciences (AIIMS), and the Indian Institute of Technology (IIT) Delhi. Supported by the Department of Biotechnology (DBT), Government of India, the program is now in its eighth year. The goals of this ambitous program are threefold: train the next generation of medical technology innovators in India; commercialize novel medical technologies for India's medically underserved; and help catalyze the Indian medical technology industry. The primary offering of the program is a 1-year fellowship in which Indian nationals are trained in our Biodesign process of need-driven innovation at Stanford and then return to AIIMS in New Delhi to identify clincal needs and create India-specific solutions and business models.

Results: This international collaboration has resulted in the training of 32 fellows. Rights to eight separate technologies have been licensed to third parties including to seven startup companies that have been founded by SIB fellows. One product, a leg immobilization device for road traffic accidents is now commercially available in India. A second product has received FDA clearance and is being jointly commercialized in both India and the US. Inspired by the success of the SIB program, several other Biodesign programs located across India have been created and funded by DBT, with more planned. The program has coordinated eight nationwide medical technology summits in India, aimed at developing the medical technology ecosystem in India. Finally, methodologies created and disseminated by the Stanford-India Biodesign program are now being used by global health agencies and both Indian and multinational companies to create products and services for India's underserved population.

Conclusion: Now in its eighth year, Stanford-India Biodesign represents a novel international collaboration to advance medical technology innovation in India. The success of the program may serve as a model for the development of sustainable healthcare innovations in India and other developing nations.

Abstract #: *1.018_TEC*

Increasing access to quality health care using health technology to 'cut-out' urban communities in Nigeria

John Ede[1]; Presidents Malaria Initiative[2],The Nigerian Demographic and Health Survey (DHS) 2013 report[3],Food and Agricultural Organisation of the UN Nigeria profile[4],Nigeria Communications Commission November 2015[5],The Leadership Newspaper[6],[1]Ohaha Family Foundation, [2]http://www.pmi.gov/docs/default-source/default-document-library/malaria-operational-plans/fy-15/fy-2015-nigeria-malaria-operational-plan.pdf?sfvrsn=6, [3]https://dhsprogram.com/pubs/pdf/FR293/FR293.pdf, [4]http://www.fao.org/countryprofiles/ index.asp, [5]http://ncc.gov.ng/index.php?option=com_content&view=article&id=125&Itemid=73, [6]http://leadership.ng/features/488139/nigerians-benefit-ohaha-hospital-project-soon

Program/Project Purpose: Quality health is a fundamental right of all citizens. While primary health care (PHC) centres are relatively uniformly distributed throughout local government areas (LGAs) in Nigeria, the rural people tend to underuse the basic health services, while those in urban communities crowd the already stretched health facilities that are either understaffed, or underfunded. Unfortunately, there is a huge gap in the implementation of medical breakthroughs due primarily to distance to health centers and rugged topography to access quality healthcare centers. With a population of about 178 million and reporting more deaths due to malaria than any country in the world, Nigeria became the seventeenth PMI country in 2010. Malaria accounts for 60% of outpatient visits and 30% of hospitalizations among children under-five in Nigeria. The main goal of this article is to take a critical look at how to build local/traditional capacities to reach the 'cut-out' populations and communities, "marginalized" in the health coverage.

Structure/Method/Design: The Nigerian Demographic and Health Survey (DHS) 2013 reported an infant mortality of 69 per 1,000 live births and an under-five mortality of 128 per 1,000 live births in the preceding five-year period. Our primary focus is on Northern Nigeria with covering places like Madala - Niger State, Abuja-FCT, Kujipi - Nasarawa State, and Ancha - Kaduna State. Other communities focused on are communities in the troubled North East Nigeria, but with this region, data figure changes rapidly and thus we may not get accurate data. Interviews were conducted, test results were analysed to determine access and use health facilities and ease of use and the quality of services provided in the visited medical facilities.

Outcome & Evaluation: The goal of primary health care (PHC) was to provide accessible health for all by the year 2000 and beyond. Unfortunately, this is yet to be achieved where about two-thirds of Nigerians reside in rural according to the FAO report, therefore slowing the pace of health coverage to all. From the focus groups and communities under review, it was discovered that most people in 'cut-out' communities rarely have access to quality health services and the other population matrix who reside in urban settlements complain of high cost of accessing quality healthcare services at the underserved health facilities thus leaning towards traditional medicine, or unprofessional, unqualified medical services.