

test score of 11.6. Data is still being collected for 6, 9, and 12 months post-course completion.

Interpretation: As part of an ongoing initiative, a novel lay-provider trauma course was developed and implemented in rural Peru to address disparities of pre-hospital care in LMIC. Initial data indicates course efficacy with adequate knowledge and skill retention. Future project goals include completing longitudinal course evaluation, expanding training capacity, transitioning to in-country leadership, and collecting end-point data regarding patient outcomes in the Cusco region of Peru.

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Does the Measure Matter? Observed Quality of Care Score and Child Mortality in a Multi-Country Analysis

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Background: As interest grows on what occurs within the “black box” of health care service delivery in lower and middle income countries, rigorous metrics are necessary to measure the quality of care that a health facility provides. Face validity of a quality metric for health administrators and policy makers requires that higher quality scores be associated with better health outcomes in the population the facility serves. This analysis aims to validate a metric of sick child care quality adapted from the Integrated Management of Childhood Illnesses (IMCI) guidelines by assessing its association with under-5 mortality rates.

Methods: We use nationally representative health facility and population data in Kenya, Malawi, Namibia and Senegal. The quality of sick child care is defined as the proportion of 24 clinical care items from the IMCI guidelines that a provider completes during a sick child visit, averaged across the facility. Under-5 mortality is calculated in each sampled facility’s catchment area. We use negative binomial models to examine the unadjusted association between facility quality and mortality. We stratify the association at median utilization of care for children under 5 to examine areas where quality is most likely to contribute to mortality, and we examine how the association differs based on underlying regional mortality risk.

Findings: Among the 1,454 facilities in the sample, IMCI quality score averaged 0.37 (SD 0.15) and median mortality in the catchment area was 0 deaths per 1000 (IQR 0–58). Quality and mortality were negatively but not significantly associated overall and in strata of utilization; the association was stronger within high utilization areas (IRR -0.50; 95% CI -1.44, 0.63 vs. IRR -0.24; 95% CI -1.56, 1.08), as hypothesized. Quality was most strongly associated with mortality in regions with moderate mortality (IRR -0.89; 95% CI -1.71, -0.07) in comparison with regions with low or high mortality risk.

Interpretation: This analysis suggests that a score of adherence to IMCI guidelines in a facility may be associated with catchment area under-5 mortality rates, particularly in areas where people frequently utilize care and have average baseline mortality risk. Further research

is needed to validate this quality of care metric as a predictor of child mortality.

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Collaborative Methods to Prioritize Oral Health and Healthcare in Kenya

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Program/Project Purpose: With only one dentist for every 42,000 people, Kenya falls below the World Health Organization’s (WHO) recommendation of one dentist for every 7,000 individuals. Despite a well-trained dental and public health workforce, oral health is not included in the country’s health policy framework and donors do not target oral health. A cross-national partnership (Columbia University, the University of Nairobi, the Kenya Ministry of Health, Kenya Dental Association), is using collaborative methods to bring visibility to oral health and develop a framework to prioritize and inform oral health policy and advocacy in Kenya. These methods may be modified for other sites/settings.

Structure/Method/Design: A six-month planning phase that included in-country and phone meetings culminated in a two-day Oral Health Summit (Summit) designed to discuss oral health needs, resources and gaps in oral health policy, care and funding. Participants included medical/dental professionals and educators, public health experts, policy makers, funders, pharmaceutical/dental products manufacturers, community health workers, and community-based organizations. Key stakeholder presentations, data from a recently concluded national oral health (WHO Pathfinder) survey, SWOT analysis and consensus building exercises were used to develop shared goals and vision. A modified Delphi Method conducted among an expanded group of collaborative members was used to prioritize needs and develop a framework to inform health policy.

Outcome & Evaluation: Over 80 participants attended the Summit. Data suggest high levels of disease, and rural/urban disparity in service delivery, but policy and public resources are inadequate to address needs. Stakeholders identified priorities within five topical areas: policy, training, data/surveillance, integration with non-dental healing and helping professions, and collaboration with the private sector. As a direct result of the Summit, The Ministry of Health provides weekly oral health social media outputs, and the Inter-religious Council of Kenya has mobilized resources for oral health outreach.

Going Forward: The partnership has put in motion plans for participatory demonstration projects that can inform policy. The potential of the partnership will be used to build capacity and seek funding for future initiatives, but integration with existing care