GORAN TOMSON: This presentation will deal with health policy definition, policy models and analysis, evidence-informed policy, and the implementation the so-called know-do-gap. There is so much that we know that we don't apply and do.

But first, the universal health coverage. About 10 years ago, all WHO member states committed to universal health coverage, ensuring that all people obtain the health services they need, be it prevention, promotion, treatment, rehabilitation, and palliation. And very importantly, without the risk of financial ruin, being driven into poverty. This was being reiterated by director-general of WHO, Margaret Chan, a few years ago.

Now policy is a broad statement of goals, objectives, and means that can create the framework for action. And health policy can be understood as courses of action, and-- which is important, inaction that affect the sets of institutions, organizations, services, and funding arrangements of the health system.

Now on a national level, health policy is seldom rational. It's influenced by a number of actors with vested interests. So the so-called rationalist model is more a description of something that is not real world. It's like an ideal plan. And reality is more iterative, incrementalist model-- what some call muddling through, which is more of a diagnosis of what is really going on. Yet Walt's stages model is useful trying to understand health policy with the steps problem identification, policy formulation, policy implementation, and policy evaluation.

This is a simplified framework of something very complex, the so-called policy triangle, with the context, content, and process. And in the middle, and very important, the actors be them individuals, groups, or organizations. Let's go into some details regarding these concepts. Context, systemic factors-- the political situation of the country, the economic situation in the country, the role of civil society, which you will know, may vary very much between countries. But also culture. Such as gender. For example, women that are not allowed to seek care without the company of their husbands, but also international such as issues like antibiotic resistance, which needs multinational cooperation.

Content, that's quite straightforward. Exemplified by malaria policy, tobacco policy, maternal health policy, et cetera.

Process, that alludes a little bit to what I talked about with the stage model. This is the way in

which policies are initiated, developed, negotiated, communicated, implemented, and which is not so often the case, but still ideally, also evaluated.

Finally, actors. The HIV/AIDS epidemic very much influenced in different stages the global and national reactions to it by leading figures like Nelson Mandela and George W. Bush, in different ways notably, but still influential individuals. Organizations such as the World Bank, International Monetary Fund, and multinational companies-- be them drug companies, or tobacco companies, or other very influential actors. And obviously at the national level, also lead figures in the system.

Now I will take two examples. One of an evidence-informed policy. Let's move to a country in sub-Saharan Africa, and let's look at malaria policy. Research identified problems with access to first line antimalarials-- problems in the sense that a lot of the prescribing and moving of antimalarials took place in private sector, and quite irrationally. But the government and the interventions and control functions did not apply in the private sector. And finally, the drug market included a lot of non-essential, often substandard drugs.

So what happened with this evidence? In so-called policy dialogues, researchers and representatives of the policymakers and practitioners met and discussed. And new policy was being formulated, which addressed all the three issues that I just mentioned. The system adapted to this. For example, the governance of the system included also the private sector. The new policy was implemented, and there is a follow up with feedback and evaluations in a circular fashion.

Now we move to South Asia. We had major problems in maternal health. In maternal health, one of the challenges is the existence of the complication during pregnancy with preeclampsia or eclampsia, hypertension, seizures, and if untreated, sometimes leading to death. Now there is a low cost, actually in fact, cheap drug that treats this condition very well, very good effects-- magnesium sulfate.

So what is the reason why this condition is not being treated in the way it should be? Then we come back to this implementation challenges and the know-do-gap. Gender discrimination-- recall that I mentioned before that women, although they are in emergency situation, sometimes may not be allowed to visit health care, unless the husband is around and accompanies them. Sometimes distance is a problem. Sometimes there are human resource shortages at the point the care. And sometimes even the essential medicine, which is cheap

and should be available, is not stocked at the respective health facility. All these are contributing factors.

In the next presentation on health systems, I will come back to some of these issues. Thank you.