AEP Vol. 14, No. 8
September 2004 : 592–624

surveillance weeks. Among the 37 providers who participated during both seasons, reporting consistency improved a mean of 31% (95% CI = 20%, 43%), median 30%.
CONCLUSION: Active surveillance was a valuable addition to Pennsylvania's ISPN. Consideration of the improvement achieved versus cost incurred will be incorporated into decision making regarding future use of this active surveillance technique by PADOH.

doi:10.1016/j.annepidem.2004.07.049

P050S
ESTABLISHING SURGICAL POLICIES IN EAST AFRICA: RESULTS OF THE EASI-DELPHI PROJECT

Massey Beveridge, Kirsteen Burton, Office of International Surgery, University of Toronto, Ontario, Canada

PURPOSE: In East Africa, demand for surgical services is high: 400 surgeons provide care to a population of more than 200 million people. Given the paucity of official surgical policies in the region and the need for systematic regional planning to improve the delivery of surgical services in East Africa, as a start, basic surgical priorities needed to be identified.
METHODS: Thirty-one members of the Association of Surgeons of East Africa (ASEA) participated in a Delphi process. The first stage consisted of a survey of surgical issues in East Africa. The results of the survey were circulated to the participants who were then asked to generate statements in response to the question, "*What actions will most reduce the burden of surgical disease in East Africa by 2010?*" Seventy-nine statements were received; after combining similar statements, 60 were returned to the group, who then scored the desirability and feasibility of each statement. Lower-scoring items were discarded and the remaining 25 statements were returned to the participants for ranking. The 10 statements with the highest mean scores and least variance were identified.
RESULTS: Five of the top 10 priorities identified were to (i) improve opportunities for continuing medical education for practicing surgeons, (ii) introduce more surgical skills workshops for medical students and clinical officers, (iii) involve COSECSA in surgical training as well as curriculum development and certification of surgeons, (iv) provide a feedback system by which medical students and surgical trainees may evaluate their teachers, and (v) recruit and train more nurses and anesthetists.
CONCLUSION: If adopted and implemented, these priorities may help the ASEA, African Ministries of Health, surgical educators, hospital administrators and individual surgeons to reduce the burden of surgical disease in East Africa by the year 2010.

doi:10.1016/j.annepidem.2004.07.050

HEALTH SERVICES

P051S
WOMEN AND WILLINGNESS TO PARTICIPATE IN CLINICAL TRIALS: RESULTS FROM A HYPOTHETICAL RANDOMIZED CONTROL TRIAL

EL Ding, NR Powe, JB Braunstein, Johns Hopkins Medical Institutions, Baltimore, MD

PURPOSE: The U.S. Congress, the Institute of Medicine, and the National Institutes of Health have all expressed great concern about insufficient representation of women in medical research, particularly within large-scale cohort and clinical safety and efficacy trials. Despite federal mandates requiring adequate representation and enrollment of women in such healthcare research, gender-related participation disparities often persist. We asked whether underrepresentation of women in clinical trials could be due to a lesser willingness to participate (WTP) on the part of women relative to men.
METHODS: We randomly approached patients from 13 Maryland outpatient clinics to self-complete a survey of their WTP in a hypothetical cardiovascular chemoprevention randomized control trial (RCT). After participants rated their WTP on a five-point Likert scale (+WTP = very likely, likely), impact of gender on WTP was analyzed from logistic regressions, adjusted for potential sociodemographic and clinical confounders. Interactions between gender and covariates were also evaluated.
RESULTS: Of 1132 eligible individuals, 70% responded. By gender, 31% of women were WTP in the hypothetical RCT, compared with 38% of men. In crude analysis, women were marginally less willing to participate in the trial (odds ratio OR = 0.74, 95% confidence interval CI = 0.55–1.00, $P = 0.049$). In the adjusted model, women indicated a significantly lower WTP than men (OR = 0.61, 95% CI = 0.49–0.77, $P < 0.001$). Covariates interacting with gender associated with increased female WTP included lower education (<12 years education; $P = 0.001$), having a sick family member ($P = 0.03$), being current smoker ($P = 0.08$), Caucasian race ($P = 0.10$), having greater income (>$30,000/yr; $P = 0.09$), and rating religion as being less important in their lives ($P = 0.04$).
CONCLUSION: Women appear less willing to participate in randomized control trials than men. This gender disparity in trial participation may be an obstacle to federal mandates requiring adequate representation of women in cohorts and clinical trials.

doi:10.1016/j.annepidem.2004.07.051

P052
DIRECT MEDICAL COSTS OF PRETERM BIRTH FROM BIRTH TO AGE 7 YEARS: A POPULATION-BASED STUDY IN MANITOBA, CANADA

CV Newburn-Cook, M Heaman, D Schopflocher, E Forget, P Jacobs, O Casiro, J Blanchard, R Sauve, LL Roos, Universities of Alberta and Manitoba, Canada

PURPOSE: (i) To determine direct medical costs by gestational age and survival status from birth to age 7 years in two cohorts (16,079 newborns in 1987 and 15,853 newborns in 1993) in Manitoba, Canada, and (ii) to determine the incremental costs associated with preterm birth. The 1993 cohort was chosen to examine the impact of surfactant on survival and costs.
METHODS: A longitudinal population-based study using administrative data to calculate actual costs of hospital inpatient care (based on Refined Diagnostically Related Groups), physician and lab or diagnostic costs associated with hospital stays, and outpatient care, using 1995 constant dollars.
RESULTS: Costs were inversely associated with gestational age. Substantial costs were associated with the initial hospital stay and first year of life; costs declined dramatically over the next 6 years.