

Oral Abstracts



23RD CANADIAN CONFERENCE ON GLOBAL HEALTH · 23^E CONFÉRENCE CANADIENNE SUR LA SANTÉ MONDIALE

OCTOBER 29-31 OCTOBRE, 2017



ADU, Prince, Global Health Research Program, School of Population and Public Health, University of British Columbia, Canada

The impact of globalization on tuberculosis incidence: evidence from the 22 high burden countries

Co-authors: Jerry Spiegel, Global Health Research Program, School of Public Population and Public Health, University of British Columbia; Annalee Yassi, School of Public Population and Public Health, University of British Columbia

Issue/Problem: With an ever increasing interconnected world, the need to be mindful of the consequent changes on the health of populations propelled by the wave of globalization cannot be emphasized enough. Tuberculosis (TB) continues to burden many populations, despite advancement in diagnostic procedures and treatment. This could be attributed to the fact that attention to risk factors and what can be done about them, has been skewed toward proximal factors observable in micro settings rather than broader systemic forces operating at the macro level. Empirical evidence is lacking on the degree to which these broader forces contributes to or undermines health.

Objective/Methods: The current study used a longitudinal multi-level regression analysis to determine the association between economic globalization and TB incidence, adjusting for human resources for health availability, density & urbanization, poverty, and health system performance. The outcome variable was the WHO reported TB incidence in the 22 high-burden countries between 1990 and 2015. The primary predictor variable was the economic dimension of the KOF Index of Globalization, which captures the extent of cross-border trade, investment and revenue flows in relation to GDP, as well as the impact of trade and capital transaction restrictions in each country. The data were extracted from different publicly available data sources and merged into a single panel dataset for analysis using STATA version 14.

Results: Economic globalization was significantly associated with TB incidence (RR=1.25, 95% CI: 1.16, 1.36), adjusting for relevant confounders. Health system performance (RR=0.947, 95% CI: 0.930, 0.964) and availability of human resources for health (RR=0.002, 95% CI: 0.000, 0.012) were also significantly associated with reduced TB incidence in the 22 high burden countries.

Lessons to Date: Global pressures place emphasis on economic growth through the promotion of private investment and fiscal policies leading to a growth in private health services at the expense of the public health sector. In TB management and control, while globalization has paved the way for innovation, and introduction of new technologies, market-oriented policies which drive this globalization process have also contributed to gross inequities in health across and within many of the TB high burden countries.

Main Messages: This study highlights the need to consider the health implications of macro level factors. As many low and middle income countries continue to integrate their economies into the global market, there is the need to consider innovative opportunities to address the inequities that come with it.

AJUZIEOGU, Obinna, University of Nigeria Teaching Hospital, Nigeria

Gains Of Ebola: Improvement In Hand-Washing Practice In a LMIC Hospital Following The Ebola Scare

Background: In the face of the Ebola Viral Disease (EVD) threat, the infection control unit intensified campaign on hand hygiene in the hospital.

Objectives: To compare compliance with hand hygiene (HH) rules amongst anesthesiologists in the theater before and after the EBVD awareness.

Methods: This was an observational study between March 2014 to February 2016 in the University of Nigeria Teaching Hospital using the "WHO SAVE LIVES" data form. Anesthesiologists were covertly observed at random from the pre-anesthetic preparation to patient handover for compliance to hand hygiene rules. Data collected was divided into a pre EVD and Post EVD periods. Compliance with the guidelines was calculated as: Compliance % = Actions/opportunities x 100%. Hand-Hygiene opportunities monitored were: (i) before patient contact, (ii) before clean procedure, (iii) after exposure to body fluid, (iv) after patient contact, (v) after contact with patients' surroundings. The results were subjected to statistical analysis.

Results: In the pre-EVD period, an average of 154 ± 8 HH opportunities were observed per hour of anesthesia and an average of 150 ± 10 HH opportunities were observed per hour of anesthesia in the latter period. The mean HH compliance rates were 2.5% in the initial phase and 45% in the later period.

Conclusion: Compliance with guidelines was significantly poor in the pre-EVD period and improved in the latter period. It is hoped that this positive attitude will be sustained. We recommend regular hand hygiene awareness campaign in hospitals

AKBARI, Fawad, Aga Khan Foundation Canada, Canada

Building implementation research capacity: experiences of Aga Khan Development Network in Central Asia

Co-Authors: Rozina Karmaliani, Aga Khan University (Karachi); Saleem Sayani, AKDN eHealth Resource Centre (Asia and Africa) (Karachi); Eelco Jacobs, Royal Tropical Institute - KIT (Netherlands); Rano Mansurova, ACTED Tajikistan

BACKGROUND: In line with the Conference sub-theme, Research, Innovation and Measurement for equitable action, there is need to strengthen research and knowledge translation capacity in LMICs to contribute to the local and global body of knowledge on effective interventions to inform program design and policy dialogue, improve the quality of health care systems and increase accessibility of health services for all populations.

Aga Khan Foundation Canada is implementing the five-year Central Asia Health Systems Strengthening Project (CAHSS) (2013 – 2018), with support from Global Affairs Canada, aimed at strengthening health systems and improving health outcomes, in particular for women of reproductive age and children less than 5 years, among select remote and rural populations in Afghanistan (Bamyan, Baghlan, Badakhshan), Tajikistan (Gorno-Badakhshan, Khatlon), Pakistan (Chitral, Gilgit-Baltistan) and the Kyrgyz Republic (Naryn, Osh, Chong-Alai).

This sub-region is characterized by rugged high-mountain terrain, vulnerability to natural disasters, isolation from centres of political and economic power, and insufficient provision of basic social services. Access to health services is limited, particularly in the rural areas where 45 – 70% of the population lives. Physical isolation and under-investment, particularly in the health sector, has led to inequities in areas such as maternal mortality, child health, nutrition, and access to diagnostic services. Further, gender inequalities limit access to health services for women, while socio-cultural practices, namely women's inability to travel without a chaperone, act as a barrier to accessing services, engaging in health-service delivery as health professional and participating in policy dialogue and decision making to improve health services.

Research capacity, knowledge translation and innovation are lacking in the Central Asia region, due to insufficient individual and institutional research capacity. This capacity gap contributes to a weak culture of evidence-informed programming, policy development and planning so that efforts to strengthen the quality and accessibility of health systems are often ineffective and inefficient.

Five implementation research studies were funded under CAHSS with key objectives, to:

- Build implementation research capacity of partners in LMICs
- Contribute to the body of knowledge regarding interventions that contribute to strengthened health systems and improved health status in Central Asia
- Contribute to accessible, policy-relevant knowledge translation
- To inform programming approaches
- To integrate and consider gender equality and diversity issues

All research studies were conducted in CAHSS geographies, either on CAHSS activities, or with CAHSS NGO/CSO partners on related activities.

Researchers were required to work in partnerships, including: a Low-Middle Income Country (LMIC) research partner (institution, university or other); a Canadian or other High Income Country (HIC) research partner; a registered local/ international NGO/ CSO actively implementing activities in project target regions; a gender specialist; and mix of relevant technical expertise.

1. The five CAHSS implementation research studies are:
2. Impact evaluation: Assessing the effectiveness of teleconsultation services in Gilgit Baltistan and Chitral district of Pakistan. Dalhousie University, Aga Khan University and Aga Khan Development Network (AKDN) eHRC and Aga Khan Health Services – P (AKHS-P).
3. What are the success and failure factors of different types of interventions (simple to complex) in relation to design and delivery of eLearning in Afghanistan? Dalhousie University, AKU, AKDN eHRC, Notre Dame Institute of Education, AKHS-Afghanistan, French Medical Institute for Children (FMIC).
4. Community-based financing in the context of 'free' health care in Afghanistan. Royal Tropical Institute (KIT) (Netherlands), Silk Route Training and Research Organization (SRTRO – Afghanistan), Care for Afghan Families (CAF – Afghanistan).
5. Assessing the role of marginalised community groups and its impact on strengthening health systems of Gilgit-Baltistan and Chitral, Pakistan. Fielding School of Public Health (UCLA), AKU, AKHS-P.
6. Obstacles and opportunities for effective community involvement in healthcare governance in Tajikistan and Kyrgyz Republic. Washington University Brown School of Social Work and Public Health in St Louis, Republican Research Centre of Pediatrics and Pediatric Surgery (Tajikistan), ACTED Tajikistan.

LEARNING OBJECTIVES: The focus of learning for this symposium will be the partnership to build research capacity between LMIC and HIC research partners. This symposium will explore the nature of these partnerships, capacity building strategies, learnings, challenges, best practices and impacts for research implementation and knowledge translation in Central Asia region.

TOPICS: The format for the symposium will be a panel discussion, with representatives from AKFC and each of the five research studies – two LMIC research partners and two HIC research partners. AKFC will introduce and moderate the session. Each panelist will give a brief presentation (five minutes/ three slides), including the focus of their research study, research methods and capacity building partnership. The moderator will ask prepared questions to panelists to facilitate discussion and information sharing on key symposium topics:

- Experience with the partnership (LMIC / HIC) to build implementation research capacity
 - Capacity building strategies
 - Learnings
 - Challenges and how these were addressed
- Impact of capacity building partnership on research design, implementation and analysis
- Impact of capacity building partnership on Knowledge translation strategies and outcomes to-date
- Recommendations for future research/ initiatives

Thirty minutes will be given at the end for a moderated discussion with the audience.

MAIN MESSAGES: The evidence generated by the research studies themselves have the potential to improve the understanding of health systems, burdens of disease and access to health services to inform program design, policy development and decision making. Determining effective strategies to build research capacity in LMICs will contribute to stronger and more sustainable research agendas and evidence-informed decision-making in countries faced with poverty, social exclusion, poor health outcomes for remote and isolated populations who are vulnerable to natural disasters and political instability. The AKDN has strategically sought to build the knowledge and skills of LMIC research partners in implementation research and knowledge translation, through strategic partnership with HIC research partners in remote and isolated areas of Central Asia. The lessons from this experience can help inform other actors seeking to engage in research in partnership with LMIC partners and build LMIC research capacity.

ALOMARI, Ayham, Canadian Red Cross, Canada

Working with the Ministry of Health to achieve the Sustainable Development Goals. Training community health care workers in Mali and South Sudan: Testing innovation in Mali and South Sudan

Co-Authors: Mary Thompson, Canadian Red Cross; Dr. Ayham Alomari, Canadian Red Cross; Lindsay Angelow, Canadian Red Cross; Dr. Thierry Nkurabagaya, Canadian Red Cross; Veronica Kenyi, South Sudan Red Cross; Dr. Lillian Nyamuda, Canadian Red Cross

Issue/problem: Community Health Workers (CHWs), as the first point of entry to the health systems for marginalized communities, have been recognized widely as a critical resource for achieving the Sustainable Development Goals (SDGs), particularly among people living in contexts in which they are marginalized. This oral presentation offers two examples of innovative strategies to strengthen CHWs' contribution to achieving the SDGs. In Mali, CHW training was made more effective by: negotiating with the MoH to restructure the training schedule, creating and delivering a three-day ToT curriculum which included peer education practices among trainers, and integrating recommendations from a gender expert review on how trainers and trainees can best utilize key curriculum elements to more successfully address gender barriers to health. In South Sudan, MoH personal are being used to train CHWs creating a sustainable pool of trainers who will remain in South Sudan post project financing. Substantive challenges due to a wide range of CHW capacities resulted in reducing the curriculum to four key topics with the greatest relevance for that context.

This oral presentation directly relates to sub-theme #1 as it tackles the universal health coverage starting at the community level, sub-theme #2 with the main focus on health of marginalized population after crises and sub-theme #4 by presenting examples of using innovation to increase equity.

Objectives and Methods: As a result of this oral presentation session participants will have compared training modalities for CHWs and evaluated their impact on improving CHW performance outcomes.

Results: In Mali, the innovations to the standard MoH CHW resulted in the transfer of these innovations to next program CHW training. In addition, knowledge levels among 92 CHWs tested times over went from 70% in the pretest to 85% in the final post-test, surpassing the MoH standard of 80%. In South Sudan, CHWs were trained and refresher-trained (12 months later) using a structured 6 day curricula. On average CHW knowledge scores from the initial post-test (72%) and a second post-test 12 months later (90%) demonstrated an 18% increase.

Lessons to date: MoHs are willing to adopt CHW curricula changes and the most effective tool of persuasion is evidence.

Main messages: The success of many CHWs training programs can improve with evidence-based negotiations and a willingness to deviate from standard training-protocols.

AMRI, Michelle, University of Toronto, Canada

Age and Alcohol Consumption During Pregnancy in Urban Versus Rural Colombia

Issue: Alcohol consumption during pregnancy has been studied broadly. However, the interactional association with residing in an urban versus rural area has not been well-documented, particularly in Colombia. This issue addresses the overall conference theme, as the world is urbanizing and individuals are increasingly residing in urban areas. As such, this research sheds light on the unique programming/policy needs of those in cities, given their vastly different outcomes, reflected in this study.

Objectives and Methods: The investigator aimed to better understand the interactional association of age and urban/rural residence on alcohol consumption during pregnancy in Colombia. Data from 1,722 Colombian women from the 2010 Demographic Health Survey was analyzed. Binary logistic regression was used to analyze the individual association of alcohol consumption during pregnancy with various variables: wealth, age, region, residing in an urban versus rural area, and whether or not the mother had terminated a pregnancy.

Results: The odds of drinking alcohol while pregnant was 6.5 times higher for those in urban areas than for those in rural areas, among 13-year-olds, on average. Overall, respondents aged 13-17 who lived in an urban area were more likely to consume alcohol during pregnancy than their rural counterparts, with partial effects varying by age. Interestingly, this trend reversed at age 18 when, as age increased, rural counterparts were more likely to consume alcohol during pregnancy than urban counterparts. NB: these results are preliminary and will be further refined before the conference to ensure accuracy.

Lessons: The associations between urban versus rural residence on health outcomes cannot be studied alone. This study demonstrated that age has a tremendous role interacting with urban versus rural residence which is associated with different rates of alcohol consumption during pregnancy. This has implications for allocating resources for health programming; namely, to target unique groups (younger urban women and older rural women) to ensure better population health outcomes.

Main messages: Overall, younger women who lived in an urban area were more likely to consume alcohol during pregnancy than their rural counterparts. Interestingly, after age 18 and as age increased, rural counterparts were more likely to consume alcohol during pregnancy than urban. Both Colombia (data available for six urban areas) and alcohol consumption during pregnancy served as a good starting point for this study. However, data for other outcomes, in different countries, need to be investigated to determine if the interaction effect is present globally and for other outcomes.

ASHOUR, Majdi, UNRWA/ University of Edinburgh, Israel

Determinants of and changes in catastrophic health expenditure in the occupied palestinian territory from 1996 to 2011: is resilience an emerging paradox in the Gaza strip?

Introduction: Measuring Catastrophic Health Expenditures (CHE) is commonly used to assess the financial protection from the risk of illnesses.

Aim: To examine the changes in the occurrence of CHE among different populations' groups in the occupied Palestinian territories (oPt) during a period of increasing political turmoil and the exacerbation of the population hardship.

Methods: The repeated cross-sectional series of Palestinian Expenditure and Consumption Survey which was conducted for ten times from 1996 to 2011 is analyzed to estimate CHE at a threshold of 10% as proportion of households' expenditure. The occurrence of CHE was traced from 1996 to 2011 and was compared across different populations' groups in oPt and within both of the West Bank and the Gaza Strip.

Results: The occurrence of CHE in the oPt has fluctuated from 6.4% in 1996 to 6.3% in 2011. This trend was encountered simultaneously in the West Bank and the Gaza Strip; however, the occurrence of CHE in the latter has been consistently lower in the latter than in former. The occurrence of CHE has been consistently higher among the worse-off expenditure quantiles in the West Bank than among affluent households. In contrast, the occurrence of CHE among financially vulnerable groups of the households is less than among the affluent households in the Gaza Strip since 1998 onward. While the occurrence of CHE in the rural areas of the West Bank was higher than in urban settings and in refugee camps, no difference was found in the Gaza Strip across urban-rural divide.

Conclusion: The higher occurrence of CHE in rural areas of the West Bank could be attributed to lower accessibility to health services. The lower occurrence of health-care related financial catastrophe in the Gaza Strip than in the West Bank and the trend toward leveling down inequalities among the more vulnerable households, especially after increasing the population exposure to socioeconomic adversity and political turmoil after 2007, may point to an emerging paradox of "resilience" in the Gaza Strip, which should be investigated carefully from the perspectives of both the health system and social lives.

ATAGUBA, John, University of Cape Town, South Africa

Reassessing global antenatal care coverage for improving maternal health

Issue/problem: There is a growing concern globally, especially within developing countries, to improve maternal and child health indicators. Access to quality antenatal care (ANC) services remains vital. Unfortunately, much of current assessment of ANC coverage focuses on pregnant women attaining at least one or at least four ANC visits. While having at least four ANC visits for pregnant women (in the case of uncomplicated pregnancies) increases the likelihood of receiving effective maternal health interventions, the adequacy of this measure is contested and debated.

Objectives and Methods: This paper proposes an index of ANC coverage that accounts for all the ANC visits attained by pregnant women. It also introduces a generalized index that accounts for the quality of ANC services. The proposed index can be decomposed by population groups and it is sensitive to any changes in ANC coverage within reasonable bounds. The index was applied to recent Demographic and Health Survey (DHS) data from 34 African countries. The countries were ranked based on the index and on the traditional coverage indicator of attaining at least four ANC visits.

Results: Disparities exist in country ranking between the two indicators. The added advantage of the proposed index is that it allows for the assessment of progressive realization that is rooted in the move towards universal health coverage. For instance, countries like Rwanda and Malawi are traditionally ranked poorly but better using the proposed index.

Lessons to date: There is an over-reliance on attaining at least four ANC visits but this indicator does not provide any information on service quality and it is not sensitive to policies that have increased the proportion of pregnant women attaining less than four ANC visits. And as a corollary, they are unable to adequately discriminate between countries with relatively similar proportions attaining at least four visits irrespective of the proportion attaining at least three ANC visits, for instance.

Main messages:

- The use of at least one or at least four ANC visits for ANC coverage is inadequate for tracking the progressive realization of access to maternal health services.
- An index is proposed to assess ANC coverage, which takes each ANC visit into account. It can also be used to assess coverage with quality ANC services.
- Beyond ANC coverage, the index may be generally applicable to assessing other social issues including coverage with quality education.

BERGEN, Nicole, University of Ottawa, Canada

Generating evidence to inform research interventions: a preliminary assessment of perceptions of health and disadvantage in Jimma Zone, Ethiopia

Co-authors: Abebe Mamo, Jimma University; Shifera Asfaw, Jimma University; Getachew Kiros, Jimma University; Lakew Abebe, Jimma University; Jaameeta Kurji, University of Ottawa; Ronald Labonté, University of Ottawa; Manisha Kulkarni, University of Ottawa; Muluemebet Abera, Jimma University; Gebeyehu Bulcha, Jimma Zonal Health Department; Sudhakar Morankar, Jimma University

Issue/problem: The Ethiopian Government has introduced policies to improve the reach of maternal and child health (MCH) services, which are underutilized in rural areas and by certain vulnerable populations. An intervention study using information, education and communication (IEC) workshops is underway to promote MCH service utilization in Jimma Zone, Ethiopia (Sept 2015-March 2020).

The main objectives of this research were to: explore participants' perspectives on the meaning of health and disadvantage in Jimma Zone, Ethiopia; and use these findings to inform the content and delivery of equity-oriented IEC workshops on MCH. In May 2016, we conducted 24 key informant interviews (with community health workers, religious leaders, and members of the development army) and 12 focus group discussions (with community members) across six rural sites.

Results: Participants differentiated between community and individual health. Important aspects of community health included a sense of belonging as well as safe and clean living conditions; community health was viewed as a precursor to protection, peace, development and education. Individual health was commonly linked to livelihood (e.g. doing daily activities and earning an income), disease states, happiness/well-being, and personal hygiene/sanitation. Participants identified several relevant determinants of health—namely, a lack of money or awareness, but also poor nutrition/food shortages, repeat pregnancies, substance abuse, poor hygiene/sanitation, and overcrowding. Certain disabilities and illnesses were perceived as unavoidable (“the will of God”). Participants valued being agents of their health, and described barriers and enablers specific to their environments that affected their ability to improve and/or maintain their health (access to services, quality of services, availability of information and resources, formal and informal support systems, etc.). All participant groups felt they had a role in promoting MCH.

Lessons to date: The IEC workshops follow participatory learning principles that build on participants' existing knowledge and experiences of MCH barriers and enablers. Workshops covered three key community groups (community health workers, religious leaders and development armies) which are integrated with vulnerable populations in their communities. Three workshop modules focused on different stages of MCH, and sought to reinforce health-promoting beliefs/behaviours at the individual and community levels, and challenge unhealthful beliefs/behaviours. A fourth ‘train-the-trainer’ module promoted further dissemination of the workshop material.

Main messages: Community-based needs assessment activities can provide relevant, current and context-specific evidence to inform research interventions. IEC workshops accommodated diverse perspectives and beliefs about health; a participatory approach promoted community-level action to improve MCH among vulnerable populations.

Bhuiyan, Shafi, Ryerson University, Canada

Harnessing untouched potential of internationally educated health professionals in Canada: Pilot results from the Internationally Trained Medical Doctors (ITMDs) Bridging Program at Ryerson University

Canada attracts many internationally educated health professionals each year. However, barriers to medical practice and broken immigration policies cause many highly skilled and educated professionals to be unemployed or work in jobs below their capacity, which results in a waste of human potential. The Internationally Trained Medical Doctors (ITMDs) Bridging Program was created in response to the need for better integration of ITMDs into the Canadian health workforce. The program trains students through coursework and practicum placements. This unique, innovative program is designed for an under-utilized group who possesses significant human potential. The pilot phase of the program graduated 67 students from four cohorts between 2015 and 2017.

The pilot evaluation aimed to determine the impact of the Program on individual capacity building its potential impact on institutional capacity building and also potential impact on the economy, as well as to examine students' acceptability of the program. To measure capacity building through skill development, students ranked their skill level for core skills in each course according to a five-point Likert scale upon entry and exit from the program. A weighted average approach compared skill levels before and after the program, and the change in skill level represented skill acquisition. Job status at program completion was also gathered. Exit surveys gathered information on students' perceptions of in-class sessions.

On average, students rated faculty support 98.5%, curriculum relevance 96.5%, scheduling 97.75%, and overall class management 97.25%. ITMDs demonstrated significant acquisition of skills in each course. Between cohorts one to four, ITMDs gained an average of 37 percentage points in Health Research Methods, 27 points in Health Data Management, 38 points in Project Management, and 30 points in Professional Communication & Leadership Skills. Over 70% of students who graduated from the program obtained employment or entered higher education.

The significant skill acquisition of students demonstrates the increased individual capacity, and this can strengthen the economy since highly skilled professionals will enter the labour market upon graduation. The program's structure was well-received by ITMDs, and thus the integrated model of the program may be important to adopt in other contexts.

Results from the pilot phase highlight the program's ability to develop individual capacity, which can strengthen economy through increased integration of skilled workers into the workforce. Given the influx of highly educated immigrants, there is a need for development or scale-up of programs to facilitate integration of ITMDs in the workforce to utilize their untouched potential.

Blouin, Brittany, McGill University, Canada

Assessing long-term effects of STH infection during a critical window of development: Ascaris infection and poor child development

Co-Authors: Martin Casapia, Asociación Civil Selva Amazónica, Iquitos, Peru; Theresa W. Gyorkos, Research Institute of the McGill University Health Centre

Issue/problem: It has been estimated that approximately 39% of children under five years of age living in developing countries have impaired child development. The three soil-transmitted helminth (STH) infections (Ascaris, Trichuris and hookworm) have been identified as a possible cause of impaired development; however, very little research has been conducted on this topic in young children who are in the critical window of development of the first thousand days of life.

Objectives and methods: The objective was to determine the long-term effect of STH infection between one and two years of age on child development scores at five years of age. A longitudinal cohort study was conducted in Iquitos, Peru between September 2011 and July 2016. A total of 880 children, recruited at one year of age, were followed-up yearly to five years of age. At each study visit, STH infection was measured from stool specimens. Child development was measured at five years of age using the Wechsler Preschool and Primary Scale of Intelligence-III (WPPSI-III).

Results: Complete data were obtained from 773 (87.8%) children of whom 57% were found STH-infected at least once by 24 months of age. At five years of age, WPPSI-III scores revealed that 87.8% and 20.6% of the children were considered to have below average, and extremely low, development, respectively. In multivariable linear regression analyses, children who were found infected with Ascaris between 12 and 24 months of age were found to have statistically significantly lower total IQ scores and verbal IQ scores at five years of age ($a\beta$ (95% confidence interval (CI)) = -1.45 (-2.88, -0.01) for total IQ scores; and, $a\beta$ (95% CI) = -1.97 (-3.56, -0.39) for verbal IQ scores). No effect was found for Trichuris or hookworm infection.

Lessons to date: STH infections begin to be acquired very early in life and can have devastating long term consequences. Our results document a statistically significant association between Ascaris infection during the first and second years of life and lower child development scores at five years of age (i.e. three years later).

Main messages: Appropriate control of STH infections (such as mass deworming campaigns) in STH-endemic areas around the world must target children as of one year of age. Deworming during this critical window of development would contribute to improved child development outcomes, including improved educational performance, and lead to overall gains in human potential.

Chupein, Thomas, Abdul Latif Jameel Poverty Action Lab (J-PAL), Massachusetts Institute of Technology (MIT), United States of America

Free is best: How to price preventive health products

Issue/Problem: For decades, policymakers argued about whether or not to charge fees to consumers in low-income countries for basic preventive health products, such as bed nets, deworming medication, or water purification treatment, but with little scientific evidence to settle the debate.

Objectives/Methods: To address this question, development economists have conducted more than a dozen randomized controlled trials in several countries over the past 15 years to rigorously evaluate the impact of pricing on take-up and usage of these types of preventive health products. These pricing studies have collectively generated a compelling body of evidence with a clear, applicable policy lesson that effectively ended this contentious debate: subsidize user fees for key preventive health products and eliminate cost-sharing when possible.

Results: Across time, space, and type of product, charging fees for preventive health products causes steep drop-offs in demand, which in turn can make cost-sharing less cost-effective, and excludes the neediest from access. There is also no evidence that paying for a product makes an individual more likely to use it; usage is uncorrelated with price paid. Likewise, there is no evidence that free distribution will generate a culture of dependency; free trials of health products with high private returns enable people to learn about their benefits, which can increase willingness to pay in the future.

Lessons: This presentation will share key findings from this body of evidence, and also demonstrate how the rigor of this research, the clear direction of findings across contexts and products, and the broad insights gained about human behavior strengthened the external validity of each individual study and successfully shifted the priors of those in favor of cost-sharing. The global debate subsided and policy began to change. The elimination of user fees is now strongly supported by a number of influential organizations including the U.K.'s Department for International Development, Save the Children UK, and the UN Millennium Project. In 2007, the World Health Organization called for free distribution of bednets.

Main messages:

- The methodological strength of well-designed and implemented randomized controlled trials have the ability to bring evidence to bear on contentious policy debates and thus shift global health policy;
- A synthesis of more than a dozen individual pricing studies demonstrate that cost-sharing sharply decreases demand for key preventive health products that have positive public health spillovers;
- Policymakers should subsidize user fees for key preventive health products and eliminate cost-sharing when possible.

CHUPEIN, Thomas, Abdul Latif Jameel Poverty Action Lab (J-PAL), Massachusetts Institute of Technology (MIT), United States of America

Generalizability of evidence: A practical framework for using global evidence to apply research from one context to another

An important pathway to advance evidence-informed policymaking is to enable decision-makers to effectively apply quality evidence to actual program and policy design decisions. But, how does a policymaker do this when it's highly unlikely that rigorous research on her exact question in her specific context exists? Policymakers will inevitably need to draw on evidence from other research questions and contexts, and so require a practical framework to help them use evidence well.

We underutilize their potential of research if we only learn about the impact of one specific program in one specific context. Apart from producing private benefits for the studies' implementing partners, theory-driven randomized controlled trials (RCTs) conducted by economists generate a public good by advancing global knowledge about human behavior. By explicitly applying theory to the design of an RCT, researchers and policymakers can better identify the exact mechanisms that drive the results, and where in the theory of change the program succeeds or fails.

For the policymaker, then, the question is not whether to use rigorous research from other contexts or less rigorous local evidence, but to view global and local knowledge as complementary inputs. Local data, qualitative and quantitative, are essential to understanding the primary constraints to a desired outcome in that setting, and are vital to hypothesizing mechanisms for change and for interpreting results. Global knowledge derived from other contexts provide generalizable insights about economic and human behaviors that transcend contexts. For example, humans procrastinate. Research that identifies concrete ways to overcome procrastination can potentially apply in many settings.

This framework for generalizability of evidence goes beyond the standard considerations for geography, income level, and indicators of human development in determining similarity of contexts to assess the extent to which the underlying theory of change that motivated the original research and generated positive impact applies in the new context. Using these data alongside the theory of change for comparative analysis of settings can help determine whether evidence from one context transfers to a new context.

Learning Objectives and Outcomes: The primary objective of this workshop is to provide exposure to and train participants on a practical framework with which policymakers can apply existing evidence from other contexts to inform their decisions. In the process, the workshop will transfer knowledge to participants about important global health policy lessons emerging from J-PAL-affiliated research.

Methods: J-PAL staff will begin with a short presentation that describes the use of RCTs in development economics to answer policy-relevant global health challenges, highlight key lessons emerging from this body of research, and provide a practical approach to generalizability of research.

During the interactive workshop, staff will facilitate small group sessions. Participants will be given a case study on J-PAL's generalizability framework, which will focus on how to understand the theory of change underpinning existing research and assess applicability of evidence to different contexts. The workshop will be centered on a case study that uses small incentives to increase child immunization in low-resource settings, and how a proof of concept study in India led to new research projects and policy scale-ups in other settings.

Format: The expected room layout would be four to five round tables that allow for a group-wide presentation and small group work for a total participant size of 20-25 persons. Basic A/V is all that would be required.

Main Messages: Participants will leave the workshop with:

- Increased knowledge of how RCTs have been applied to economic interventions designed to promote global health;
- Key policy insights derived from over 150 health evaluations conducted by J-PAL affiliated researchers;
- Practical skills on how to integrate local and global evidence to apply research from other settings to their specific context and policy question.

CHUPEIN, Thomas, Abdul Latif Jameel Poverty Action Lab (J-PAL), Massachusetts Institute of Technology (MIT), United States of America

Worth the wait: policy lessons from economic randomized evaluations to reduce early childbearing in Africa and South Asia

Co-authors: Becca Toole, Abdul Latif Jameel Poverty Action Lab (J-PAL), MIT

Issue/Problem: Adolescents who experience early childbearing are more likely to have lower educational attainment, be socially isolated, have high-risk pregnancies, be at risk of sexually transmitted infections, and experience intimate partner violence. Childbearing during adolescence is associated with high-risk complications and increased risk of mortality. Multiple factors can contribute to girls' early marriage and childbearing, including limited knowledge of sexual and reproductive health, limited bargaining power within the household or community, and/or limited educational or labor market prospects. However, other than legal bans, there remain limited policy approaches to reduce early marriage and childbearing.

Objectives/Methods: Over the past decade, development economists have conducted several randomized controlled trials in Africa, Asia, and Latin America to rigorously evaluate the impact of programs designed to directly or indirectly reduce early childbearing. The programs aim to change behavior through empowerment, information, incentives, skills development, or a combination of these approaches. J-PAL has synthesized the research findings to generate a few actionable policy lessons.

Results and Lessons to Date:

- Interventions that increase the opportunity costs of pregnancy or the benefits of remaining childless, contribute to adolescents practicing behavior to avoid childbearing and to parents changing their behaviors to deter childbearing;
- In contexts where adolescent females have less bargaining power relative to other family members, interventions targeting parents can be particularly effective;
- Encouraging participation in activities that develop human capital (e.g. job training or schooling) can help adolescents delay pregnancy;
- Interventions implemented outside of educational institutions may be more effective in reaching the most vulnerable adolescents.
- This presentation will provide evidence from a body of rigorous research and share actionable policy lessons for decision-makers searching for cost-effective ways to improve the health and well-being of girls and young women in low-resource settings by reducing early childbearing.

Main messages:

- The methodological strength of well-designed and implemented randomized controlled trials have the ability to bring evidence to bear on important health topics for which there is little evidence on what works;
- A synthesis of several randomized controlled trials in different contexts demonstrate that altering adolescent females' perceptions of the costs and benefits associated with childbearing can reduce pregnancy.

COLLINS, David, Management Sciences for Health, United States of America

Seasonal malaria chemoprevention – a cost-effective way of saving the lives of young children in the Sahel

Co-authors: Colin Gilmartin, Management Sciences for Health; Gladys Tetteh, Management Sciences for Health

Seasonal Malaria Chemoprevention (SMC), the intermittent administration of antimalarial medicine during the malaria season through a campaign approach, is among the World Health Organization's key interventions for preventing malaria in children. SMC can help to avert millions of cases of plasmodium falciparum malaria and thousands of deaths per year while significantly reducing the financial and economic burdens experienced by patients, families, and national health systems. In the Sahel sub-region of Africa, there are 25 million children ages 3-59 months who would benefit from SMC. To estimate the costs of delivering SMC and of replicating the interventions in other areas, cost studies were conducted in seven countries supported by the UNITAID-funded ACCESS-SMC project: Burkina Faso, Chad, Guinea, Mali, Niger, Nigeria and The Gambia. Data collection included the use of interviews with samples of providers and the analyses were conducted using a spreadsheet-based model. Direct costs incurred by the implementing partners and the government were included but the opportunity costs of volunteer time or costs incurred by beneficiary families were not.

In 2015, an equivalent of 3.12 million children (3-59 months) received SMC in the seven countries. The total start-up costs for the project interventions were USD 558,014 and the total recurrent costs were USD 12.7 million. The recurrent costs ranged from USD 0.4 million in The Gambia to USD 3.5 million in Nigeria. The unweighted average recurrent cost across the countries was USD 1.14 per cycle or USD 4.56 for four cycles. The weighted average recurrent cost was USD 1.07 per cycle or USD 4.26 for four cycles. The majority of financing of project activities was from UNITAID but country governments made considerable contributions through the payment of the MoH personnel involved in SMC distribution.

The specific lesson from the costing study is that SMC is a feasible and cheap intervention to prevent malaria for the children particularly in remote areas with limited access to health facilities. This lesson is applicable to other countries where this type of seasonal malaria is prevalent.

The key message is that the intermittent administration of antimalarial medicine during the malaria season through a campaign approach is both a feasible and low-cost way of reducing the incidence of malaria in young children in the Sahel.

COLLINS, David, Management Sciences for Health, United States of America

The cost and impact of community-based nutrition interventions in Afghanistan

Co-authors: Sayed Muhib Shah, Save the Children; William Newbrander, Management Sciences for Health; Laila Salim, Save the Children Canada

Malnutrition of children in Afghanistan is a serious problem with over 40% of under-five children suffering from stunting and over 9% suffering from wasting. Many of these children live in remote rural villages where insecurity has been the norm for several years. Access to health facilities is often difficult and there is a need in Afghanistan and many other countries to find the most effective way to reach malnourished children.

Save the Children Canada, developed a community-focused nutrition project that was implemented in six provinces in 2013. In the first two, 37,155 malnourished children were assisted through community-based nutrition activities, 71,992 children were treated for severe malnutrition and 1,605 children treated for severe malnutrition with complications. In addition 172,551 children were screened for malnutrition and 382,788 pregnant and lactating women were counseled in facilities and 326,805 at home.

A costing study was carried out in 2015/16 based on a survey of nutrition activities conducted with samples of providers in 3 of the 6 initial provinces: Jawzjan, Sari Pul and Kandahar.

The results showed that the recurrent financial cost in 2015/16 was USD 0.13 per child for community-level screening and USD 2.09 for treating a child for moderate malnutrition at the community level. The cost of treating a child with SAM without complications was USD 58.02, and the cost of treating a child with SAM with complications was USD 27.62 for inpatient care plus USD 58.02 for follow-on outpatient care, totaling USD 85.64.

The project is likely to have had a significant positive impact on children's nutrition. Compared with pre-2013/14 cure rates of 21% at OTPs and 32% at SCs, in 2015/16 the cure rates were 92% at OTPs and 89% at SCs. And a lives-saved analysis indicates that the SAM treatment interventions should have resulted in a decline in the under-five mortality rate. It is also important to recognize that a successful nutrition program results in savings to the health care system and to the family.

The lessons learned were that in hard-to-reach areas the most cost-effective to addressing child malnutrition is to base interventions at the community level. These lessons are applicable to other countries with similar access challenges.

The key message is that community-based interventions are likely to be the best way to address child malnutrition in areas where access to health facilities is a problem.

DAINTON, Christopher, McMaster University, Canada

Assessment of quality of primary care medical service trips (MSTs): an eDelphi based theoretical framework

Issue/problem: Short-term, primary care medical service trips (MSTs) are a controversial modality for addressing the health of marginalized populations and responding to the burden of communicable and noncommunicable diseases. As a healthcare delivery model, MSTs are challenged by concerns over sustainability, fragmentation of care in host communities, and degree of preparedness among volunteers. Despite the increasing prevalence of such trips, there are no frameworks in routine use for evaluating the quality or effectiveness of MSTs.

Objective: This study aimed to develop an objective, literature based tool for assessing the quality of volunteer MSTs operating in low resource settings in developing countries, and validate this tool by conducting an e-Delphi survey to build consensus among international experts.

Methods: Recent literature was reviewed to construct a preliminary list of commonly discussed best practices for short-term MSTs. We then recruited a multidisciplinary panel of public health/academics, medical professionals (clinicians, nurses, pharmacists), MST program coordinators, and non-medical MST volunteers for a 3-round e-Delphi consensus-building exercise to allow revisions to a list of potential best practice elements. A 7-point Likert scale was used, with mean scores of 4-7 resulting in rejection of the element, scores <2 resulting in acceptance, and scores in between being redistributed for Further discussion in Round 2 and 3.

Results: A preliminary literature based framework was constructed on best practices for MSTs, with 30 elements sorted into 6 domains (Preparedness, Impact and safety, Efficiency, Cost-effectiveness,

Sustainability, and Education). A total of 26 expert stakeholders were recruited for the eDelphi panel. The panelists rejected 4 elements, and reached consensus on 6 elements to remain in the framework. Eight

elements were redistributed during multiple rounds. A total of 18 desirable elements were included in the final framework for an effective MST.

Lessons to date: Evaluation of critical best practices may be broadly useful to medical professionals and trainees to help them select a high quality short-term volunteer opportunity with an effective, sustainable healthcare delivery model. Future research should use this framework to develop a tool that can be used to assess MSTs, and start a dialogue between host communities, local clinicians, and the MST-sending organizations.

Main messages: Expert panelists strongly agreed on 18 literature-based best practices for short-term MSTs in LMICs. These recommendations should be a foundation for the standards employed by such volunteer teams serving host communities abroad.

DANHOUNDO, Georges, York University, Canada

Using social accountability in malaria prevention and treatment programs in sub-Saharan Africa

Co-authors: Mary Wiktorowicz, York University

Background: Despite global attention since the Roll Back Malaria (RBM) Partnership (1998) and the US\$2.9 billion funding (2015), there were 212 million new cases and 429,000 deaths due to malaria in 2016. Millions lack access to preventive and treatment services in Africa, where 80% of malaria deaths occur. Progress is hampered by challenges in implementing accountability measures in sub-Saharan Africa. Drug shortages, disrespect of patients in public health facilities, health workers' concentration on donor-funded activities that offer access to per diems, and drug and bed net pilfering are among the factors affecting health service functioning. The research aimed to understand factors that affect implementation of accountability measures in malaria prevention and treatment programs in sub-Saharan Africa.

Methods: After reviewing policy reports and the literature published between Jan 1, 2000, and Aug 1, 2016, we undertook semi-structured interviews with key informants in the Global Fund to Fight AIDS, Tuberculosis and Malaria, WHO, and Gavi, The Vaccine Alliance in Geneva from November to December 2016. The results were triangulated with findings from interviews with local health professionals and pregnant women in 2015–16 in Benin. We analyzed recorded and transcribed interviews through framework analysis using NVivo software.

Results: Factors found to affect accountability mechanisms at the global level included lack of alignment with national priorities and fixation on short term results. At the national level, they included lack of timely and reliable data in health facilities, low involvement of targeted populations in accountability mechanisms, power imbalances, low involvement of frontline implementers and civil society organizations in decision-making processes and governments' limited capacity to enforce implementation.

Lessons: Within global accountability measures we found an absence of recognition of the challenges of local implementation. Accountability measures were found to be 'glocalised' by national actors as policy adoption was infused with local customs and practices. This suggests global leadership must better address local needs. National health leadership is a key driver in producing successful health outcomes.

Main messages: Changes in global accountability frameworks are necessary to foster sound national governance and leadership. Global accountability frameworks could support health sector reviews of progress (annual reviews). Civil society approaches that foster citizen voice and social accountability including policy dialogue, complaint mechanisms, whistle blowing schemes and community scorecards represent related approaches. Social accountability may further include campaigns to inform populations about their rights and services entitlements, information technologies for social monitoring, and third-party social audits and scorecards.

DANIEL, Kristie, HealthBridge, Canada

Public Spaces: A Key Tool for Implementing the SDGs

Issue: In September 2015, world leaders committed to achieving 17 Sustainable Development Goals (SDGs) and 169 targets as part of the Agenda 2030 for Sustainable Development. Agenda 2030 is an ambitious framework and in order to achieve success, governments and communities will need to choose strategies and interventions that have the greatest impacts across a number of goals and targets. This presentation will make the case that public spaces, including streets, local public markets, and open public spaces, are a key implementation tool for implementing the SDGs.

Results: Public spaces play in a key role achieving safe, inclusive, resilient, and sustainable cities and have been identified as a specific target under SDG 11 whereby safe, inclusive and accessible green and public spaces are to be made available in cities. However, public spaces have the potential to contribute to several development goals. Public spaces are where people interact with the city, with the environment, and with their neighbours. We have identified four specific SDGs as examples where creating quality, accessible, and safe public spaces will make an important contribution to achieving the goal:

- Good Health and Well-Being (SDG 3) – Ensure healthy lives and promote well-being for all at all ages.
- Gender Equality (SDG 5) – Achieve gender equality and empower all women and girls.
- Decent Work (SDG 8) – Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.
- Climate Action (SDG 13) – Take urgent action to combat climate change and its impacts.

The presentation will emphasize the environmental and equality impacts that public spaces interventions can achieve and outline examples of public space policies and implementation in low and middle-income countries that are resulting in improved equality and an improved environment. Examples from Vietnam, Nepal, Bangladesh, Niger, and Uganda will be highlighted.

Lessons/ Key Messages:

- With 169 targets included in the SDGs, governments need to be selective about the interventions they choose to implement.
- Public space interventions are an effective and cross-cutting intervention for achieving many SDG targets and goals.
- Public spaces include streets, local public markets, and open public spaces such as parks and playgrounds.
- Local organizations in LMIC are well positioned to advocate for the policies and implementation actions needed to improve the quantity and quality of public spaces.

DEACONOU, Ana, University of Montreal, Ecuador

Agroecological farmers mobilizing sustainable production for healthy food practice: a case from Imbabura province, Ecuador

Co-authors: Malek Batal, University of Montreal

Since the 2000s, indigenous farmers in northern Ecuador have organized around agroecology -- an organic production practice based on biodiversity and closed resource cycles -- to respond to environmental degradation, health impacts, and economic dependence caused by industrialized agriculture. Agroecological farmers have created specialized markets to commercialize their products. Doing so, they provide diverse, equitable, and pesticide-free products directly to consumers, and also create an opportunity for farmers to exchange products amongst themselves, experiment with new products and reclaim traditional ones, and exchange knowledge and ideas regarding food, gastronomy and nutrition. In a context where the double burden of micronutrient deficiencies coexisting with overweight/obesity disproportionately affects the indigenous poor, creative approaches are imperative to support the health of an already marginalized population.

This research aims to understand whether agroecological farmers obtain a healthier nutritional status as a result of their agrobiodiverse production practices and the ideas exchanged in their specialized markets. Ethnography as well as a cross-sectional survey based on nutrition research methods and associated dietary indexes are used in conjunction with assessments of production diversity, social participation, and health status to examine whether agroecological farmers' diet differs from that of conventional family farmers, and if so, what drives this difference. Doing so, this research provides a globally relevant understanding of the potential roles of sustainable production practices in promoting farmer health.

Preliminary results suggest that agroecology provides farmers with access to greater dietary diversity through consumption of a greater diversity of own-production. Meanwhile, agroecological markets and surrounding knowledge networks promote increased consumption of own-production, decreased consumption of ultra-processed foods, increased access to dietary diversity through barter, and increased dietary diversity through experimentation with new foods in the family diet-- including foods that are new to the culture (e.g. kale), as well as traditional products that are largely forgotten (e.g. amaranth). Such dietary practices are linked to better nutritional status, thereby suggesting that agroecology is promoting healthier nutritional status among Ecuadorian family farmers.

Results provide lessons on how social organization may mediate the connection between agricultural diversity and dietary diversity, and on the multiple roles played by alternative markets, not just as spaces of commerce, but as spaces of social exchange that may informally serve to provide health-positive education.

Main message: Family farmer initiatives based on sustainable agriculture, in conjunction with their alternative food networks, have potential to act as endogenous, self-organized means to promote better nutrition among vulnerable populations.

DILIBERTO, Deborah, McMaster University, Canada

Examining context: an innovative approach explored in the evaluation of complex health service intervention to improve care for malaria in Uganda

Co-authors: Clare Chandler, London School of Hygiene & Tropical Medicine; Sarah Staedke, London School of Hygiene & Tropical Medicine; Simon Cohn, London School of Hygiene & Tropical Medicine

Issue: The rhetoric underlying research on the SDGs is that ‘context matters’. Yet what is and how it can be accommodated in research remains contested. When following the gold-standard protocol, context is a factor to be ‘accounted for’ in statistical models assessing intervention effect. Alternative social scientific perspectives suggest that this approach strips context of the social relations necessary to produce interventions and evidence of their effects. These competing interpretations of context became evident when evaluating PRIME, an intervention to improve malaria care at health centres in Uganda from 2010-2013. Given the increasing emphasis on interdisciplinary research in the SDG agenda, understanding how alternative perspectives might inform new ways to conceive of context, and its role in the production of evidence, has become more urgent.

Methods: Objective – To critically examine effects of context when conceived of as part of the social processes necessary to produce the PRIME intervention.

Methods – Four health centres and health workers (HW) enrolled in the PRIME cluster randomised trial formed cases for exploration. Data included in-depth interviews with HWs, structured contextual record interviews with system stakeholders, observations at health centres. Data were analysed iteratively exploring descriptions of everyday realities and how the intervention was enacted and evolved over time.

Global health significance – Research to improve health service interventions in low resource settings

Results: Context emerged as an intersection of social processes, settings and structures represented in two socio-spatial locations – temporal and structural. HWs’ temporal locations, including past challenges, present opportunities and imagined future benefits, became enmeshed in how they attempted to improve provision of care. HWs’ structural locations described contrasting positions in national and community levels revealing how the PRIME intervention drug supply system was reconfigured into an inadvertent solution to these tensions.

Lessons: Examining context as part of its social entanglement with the PRIME intervention provided new avenues for producing the types of evidence needed to improve the equitable provision of quality health care. These findings are applicable to others undertaking evaluations of complex interventions in global health and seeking innovative approaches that may stimulate new ways of exploring social processes to tackle complex problems.

Main messages: Conceptualising context as a factor separate from its entanglement with the intervention limits what can be known about interventions and new ways to intervene to improve health.

Experimenting with concepts alternative to the dominant gold-standard protocol can produce innovative approaches to tackling complex problems.

EL MORR, Christo, York University, Canada

Global eHealth Solutions within a Context: The role of requirements analysis and Collaborative Design

Co-authors: Rachel Gorman, York University

Issue/problem: Internet technology and cell phone adoption in developing countries are on the rise, which has resulted in efforts by policy makers and researchers to find innovative affordable eHealth solutions to improve equity of access to care in the global south. eHealth, and particularly mHealth, shows promise in LMICs for increasing access to care in rural disadvantaged areas, as well as improving data management. However, despite the potential of eHealth and mHealth, the implementation of eHealth/mHealth solutions in developing countries, is often characterized by a lack of adequate collection of local requirements, and can result in solutions that are maladapted to the local context.

Objectives/methods: Our methods included a literature review on global eHealth experiences implementation in different contexts, a review of methods of requirements analysis and user-centered design, and exploratory conversations on eHealth implementation needs and experiences with an organization working to end child abuse in a LMIC.

Results: Designing for the global south needs a paradigm shift towards a south-centric analysis, design and development of eHealth strategies and tools. User-centered design is well-established ICT field; however, it has been considerably overlooked by developers of eHealth solution, despite its crucial role in change management and systems adoption strategies. eHealth solutions in LMICs are often technology-centered rather than user-centered, and are “parachuted” without consideration of the end users’ requirements.

Our case study of a child protection NGO revealed that the organization had to follow its funder’s suggestion to adopt an eHealth solution that has been developed in a completely different context. This decision resulted problems with data integration and administrative efficiency. Contextualizing eHealth solutions in the country context is crucial, and can be achieved by (1) a careful study of end-user requirements and (2) adopting a user-centered approach to eHealth design. The former can be achieved by applying requirements elicitation techniques and the latter by applying usability principles and standards. Certainly, this approach means additional development costs for eHealth solutions; however, it is more costly to implement a maladapted solution that misses the organization’s objectives.

Lessons/Key Messages: eHealth solutions need to be tailored to local contexts through requirements elicitation and user-centered design. Requirements can either be fed into the design and testing of a new local eHealth solution or lead to the customization of a solution that was developed elsewhere. The result would be an increased chance of the successful implementation of a context-aware global eHealth solution.

EL-KHATIB, Ziad, Partners In Health / Inshuti Mu Buzima - Rwanda, Rwanda

Risk factors for stunting among children under age 5 –Survey based study in Rwanda using the 2015 Demographic and Health Survey

Co-authors: Ziad El-Khatib, Partners In Health / Inshuti Mu Buzima - Rwanda; Christine Mutaganzwa, Partners In Health - Inshuti Mu Buzima - Rwanda; Catherine Kirk, Partners In Health - Inshuti Mu Buzima - Rwanda; Joel Mubiligi, Partners In Health - Inshuti Mu Buzima - Rwanda; Alice Nyirimana, Partners In Health - Inshuti Mu Buzima - Rwanda; Bethany Hedt-Gauthier, Partners In Health - Inshuti Mu Buzima - Rwanda

Issue/problem: Stunting contributes to poor development outcomes in over 200 million children globally. Identifying age-specific risk factors for stunting can guide future policies and targeted interventions.

Objectives and Methods: We assessed the risk factors for stunting in 2014-2015, using the Rwandan Demographic and Health Survey (DHS) data. Under-five children were stratified into three age categories: <6 months, 6-24 months and 25-59 months. We included 15 risk factors related to maternal and child clinical history, sanitation, socio-economic conditions and gender. Data on children, mothers and households were linked, and analyzed accounting for inverse probability sampling weights and complex survey sampling. Multiple logistic regression analysis assessed the associations between risk factors and stunting.

Results: For newborns (<6 months, N=35/331, 10.6% stunted), risk factors were low weight at birth (OR=14.93; 95%CI: 5.4, 41.5) and being born male (OR=4.0; 95%CI: 1.3, 12.1). For ages 6-24 months (N=451/1,232, 36.6% stunted), risk factors were being born male (OR=2.1; 95%CI: 1.5, 2.7), low weight at birth (OR=2.3; 95%CI: 1.3, 4.1), low mothers' height (OR=3.9; 95%CI: 1.6, 9.4), not taking anti-parasite drugs during pregnancy (OR=1.5; 95%CI: 1.1, 1.9), households located in highlands (OR=2.1 (95%CI: 1.4, 3.2), and households with low-socioeconomic status (OR=1.6; 95%CI: 1.2, 2.1). For ages 25-59 months (N=869/2,030, 42.8% stunted), risk factors included being born male (OR=1.3; 95%CI: 1.1, 1.6), low mothers' height (OR=15.0; 95%CI: 6.1, 37.3), low maternal education (OR=2.5; 95%CI: 1.6, 3.9), households with low-socioeconomic status (OR=2.4; 95%CI: 1.9, 3.1), households located in highlands (OR=2.2; 95%CI: 1.6, 3.1), and households with >5 occupants (OR=1.3; 95%CI: 1.0, 1.6).

Lessons to date: There was variation in risk factors for the three age groups, with prenatal factors playing an important role for children <2 years and conditions of the home environment predicting stunting at >2 years (when stunting is nearly irreversible). However, overall poverty and education were consistent risk factors for stunting, and may be targeted for interventions in a limited resource setting.

Main messages: To design and test an intervention to support mothers and children living in remote areas, to improve their access to health care systems. Interventions focused on maternal nutrition and prevention of low birth weight are warranted, in addition to longer-term efforts to promote economic development and women's education. With the high burden of stunting, immediate interventions promoting early stimulation are urgently needed to address the risk of poor developmental outcomes among stunted children.

FERRIS, Denise, BRAC, Uganda

Menstrual Perceptions and Practices among out of school “ELA” adolescents in central Uganda

Co-authors: Laura Hytti, WoMena

In Uganda adolescent girls and women face significant barriers to dignified menstrual health management (MHM), ranging from lack of access to convenient, accepted, and affordable MHM products; social stigma and embarrassment surrounding menstruation and lack of awareness, information, and knowledge about puberty and MHM. Much of our understanding in low-income setting on girls' perceptions and knowledge of MHM comes from school settings, with a concentration on formal puberty and menstrual education. However, learning through peers, family and community members is an important and influential route of knowledge acquisition and can influence menstrual health related practices and decisions. Findings from a baseline questionnaire conducted in the spring of 2016 with ELA Embers in 4 districts (Kayunga, Mokono, Lugazi, and Kampala) in central Uganda, with 1,615 of girls. The questionnaires collected extensive data on participant's menstrual experiences, knowledge, and practice as well as support networks and sources of MHM knowledge.

The preliminary results suggest that 41% of girls reported that they did not know about menstruation before starting to menstruate. A further 60.80% reported that they were not adequately prepared for their first menstrual period. Knowledge on menstruation was average with 74% of surveyed respondents believing that menstrual periods are a physiological process, with the rest reporting responses varying from menstruation being a curse, a sin, caused by God, or a disease. Most ELA members use only disposable sanitary pads (70.95%), with another 14.36% using disposable pads in addition to another method. Five-hundred girls (31.02%) reported that they do not discuss menstruation with family members. Out of those five-hundred girls, 41.2% do not discuss menstruation with friends either.

The results show that adolescent girls in Uganda feel they know little about menstruation, and experience fear and stigma. Furthermore, the information they receive about menstruation is often conflicting and confusing. Menstruation in Ugandan culture is often considered taboo, and thus, many girls do not discuss menstruation with family or friends yet their beliefs, perceptions and understanding derive from these sources. This suggest that menstrual education received from peers, family members and communities plays an important role in shaping perceptions and understanding of puberty and menstruation among out of school adolescent girls and can have impact on the choice of methods used to manage menstruation, the level of self-efficacy experienced by girls in managing their menstruation and going about their daily activities during their menstruation.

Gailits, Nicola, McMaster University, Canada

Balancing Rigour with Realities: Practical and Ethical Challenges of Ebola Research

Co-authors: Elysée Nouvet, McMaster University

Issue/problem: Conducting research during the 2014-15 West Africa Ebola outbreak presented a number of widely reported ethical and practical challenges. These included rolling out clinical trials in the context of social fear, with a deadly level 4 pathogen, in countries with seriously underfunded healthcare systems.

Objectives and Methods: To identify key ethical challenges mentioned and emphasized in the scholarly literature emerging from research conducted during the West Africa Ebola outbreak. Articles were retrieved via MeSH and keyword searches through 5 indexes (Embase, JSTOR, PubMed, Philosopher's Index, and CINAHL), screened, and if deemed eligible, uploaded to Nvivo for coding. An initial coding matrix using well-known points of debate in the conduct of research during Ebola (e.g. randomization) served as a departure point for the analysis, and evolved through parallel coding of 8 initial articles, team discussion, and dialogue.

Results: After screening and the removal of duplicates, 145 (of 2730) articles were included. Articles fell into two distinct categories: "bioethicist" or more theoretical articles, almost always by scholars and researchers based outside West Africa; and "lived" articles that described challenges within more extensive descriptions of research results or experiences of conducting research during the outbreak. Bioethicist commentary articles primarily focused on whether the use of experimental interventions as well as randomized controlled trials were ethical, locally appropriate, and scientifically valid. Several also discussed macro-ethical topics of political and economic inequities in EVD response and global health. Key challenges described in "lived" articles often stemmed in more practical issues (e.g. lack of resources, dwindling participant #s, community wariness), requiring new skills or approaches. Both sets of articles revealed the moral imperative to re-balance unequal transnational power relations when conducting research in the Global South, whether that research occurs in emergency or ordinary circumstances.

Lessons to date: On the ground research highlighted the importance of balancing rigour in research with realities on the ground and the flexibility in approach needed to do this, as well as the importance of South-South and North-South research partnerships, and collaboration in definitions of ethical research during the outbreak.

Main messages: (1) Challenges of conducting research during this outbreak were unique in some ways, but also represented research challenges in resource-limited, high mistrust settings in general; (2) What comes to define "the ethical" for many researchers emerges in the field, through unique practical challenges and the need to think through their origins and develop "best" practices to move forward.

GAUTAM, Nabaraj, Tribhuvan University, Nepal

Horrendous plight of people with cataract in rural communities of Nepal

Issue/problem: Of the total blindness, as cataract, an eye disorder, alone occupies about 51 percent worldwide and 62.2 percent in Nepal, lack of its management particularly by the government in managing disorders makes rural communities in Nepal particularly succumb to blindness, which brings in social, mental and financial insecurities. This study aimed to address burdens of such insecurities by instituting appropriate interventions after identifying socio-economic and socio-demographic characteristics, and knowledge, practices and barriers. Communities were deprived of even basic health facilities, let alone medical and surgical eye care. Eye care delivery has remained compromised since the peak of the 10-year-long Nepalese civil war which particularly affected rural regions of Nepal.

Objectives and Methods :

- To identify socio-demographic characteristics of households of people with cataract
- To determine effects of cataract on socio-economic development
- To identify knowledge, practices of and barriers in people with cataract

Observation, household surveys, focus group discussions, case studies, key-informant interviews were used after. Various statistical tools were used to compute data.

The need to address eye health needs of the people is crucial, which necessitated a thorough research. The algorithm used to assess and manage ocular needs can be extrapolated to similar other countries.

Results: A very pitiable condition - over 90% of those with cataract were blind- was noted. Occult healing was rampant. In particular, the civil war rendered communities deprived of basic health services. Food insufficiency, annual income and job type had interesting correlations with cataract. The onset of visually impairing and blinding cataract caused discrimination and isolation. Cataract adversely affected economic status by engendering loss of employment, reduced productivity, less rewarding jobs, unemployment, and lower salaries.

Lessons to date: In low-income countries, eye care neglect is common though eye care professionals are increasing. Since the study was done in rural settings, it predominantly depicts the real scenario of Nepal and similar other countries. A dreadful eye health status coupled with reluctance by the authorities concerned can be likened to grave injustice done to those afflicted. Non-availability, non-accessibility and non-affordability along with people's indifference to curable blindness are enemies of health care delivery.

Main messages: This research represents ocular health in rural communities of Nepal and similar low-income countries. This research vividly presents effects of long civil war on health services. There was a lack of equity in health care across the nation. The study pinpointed causes, correlations and addressed problems by offering appropriate solutions.

GORMAN, Rachel, York University, Canada

Potential for engaging ehealth tools to scale-up anti-violence programming in India and Lebanon—a preliminary exploration of contextualizing factors

Co-authors: Christo El Morr, York University; Tammy Bernasky, York University

There is a growing potential for Information and Communication Technologies (ICTs) to combat gender-based violence (GBV) and child abuse. This exploratory inquiry asks: Do local Non-Governmental Organizations (NGOs) and researchers working to end GBV and/or child abuse in Low and Middle Income Countries (LMICs) feel that a collaborative process of developing and/or customizing eHealth solutions could enable them to scale-up their activities?

Our methods included a literature review on ICTs and GBV, and exploratory conversations with two organizations and one university-affiliated researcher working to end GBV and child abuse in India and Lebanon—two LMICs with vastly different geographic scale, population, and state policies framing the role and operational scope of NGOs.

We found that the women's NGO in India was under significant pressure due to: a shift in International Development Agencies (IDAs) funding away from India after the World Bank's 2016 reclassification of India as 'lower-middle income'; the Indian government's prioritization of partnering with charitable foundations of major India-based private sector corporations; shifts in the federal regulation of NGOs accepting international donor funding; backlash against women's organizations working to end GBV; and widespread lack of internet and cell phone access through rural areas where the NGO operates, despite being based in a major city.

The child protection NGO in Lebanon lacked an efficient and streamlined reporting system between their remote offices and main office, which increased the repetition of paperwork by case workers and administrative staff, and reduced staff capacity for other programming and policy interventions by advocates of children's rights and wellbeing. Further, the absence of a nationally integrated information system was a barrier to developing more robust evaluation tools for their child abuse prevention programs. Finally, the NGO's experience with attempting to integrate data management platforms revealed that problems arise when IDAs offer NGOs software that has been developed in vastly different contexts and/or continents. Without a process of collaborative customization, attempts to scale-up programming and integrate data can create major obstacles to NGO efficiency and efficacy.

We concluded that attractiveness of collaboratively developed and/or customized eHealth solutions to local NGOs addressing violence against women and children may be correlated with: the level of NGO-ization of the sector; the state's capacity to manage the challenges of GBV; the state's political agenda around GBV; and basic access to internet infrastructure. NGOs often 'inherit' their ICTs; however, customized collaboratively developed solutions would likely enhance capacity and efficiency of anti-violence programming.

HACKETT, Kristy, Dalla Lana School of Public Health, University of Toronto, Canada

Factors affecting access to maternal and reproductive health services among ethnic minority women in Vietnam

Co-authors: Tung Duc Phung, Mekong Development Research Institute; Stephen Lye, Lunenfeld-Tanenbaum Research Institute, Mount Sinai Hospital; Nga Thu Nguyen, Mekong Development Research Institute; Thuy Hong Nguyen, Mekong Development Research Institute; Chi Quynh Nguyen, Mekong Development Research Institute; Kerrie Proulx, Alliance for Human Development (AHD), Lunenfeld-Tanenbaum Research Institute (LTRI)

Research Problem: The post-2015 development agenda calls for coordinated efforts to reduce health inequalities within and between countries, “leaving no one behind”. In Vietnam, maternal mortality is estimated to be four times higher in the ethnic minority population than in the Kinh (majority) ethnic group. While inequalities have been documented, key coverage indicators among specific ethnic groups are unknown. Additional research is needed to understand the barriers to maternal health service uptake among ethnic minority communities specifically.

Objectives and Methods: This study employed a concurrent mixed methods design to gain a deeper understanding of the disparities and barriers in accessing maternal and family planning services in remote regions of Vietnam. In 2016 we conducted household surveys with 4,609 women from 25 ethnic minority groups across six provinces of Vietnam to estimate coverage of antenatal care, skilled delivery, and family planning services. Qualitative data collected through focus groups and in-depth interviews with ethnic minority women, healthcare providers, and village leaders provided additional contextual information.

Results: Only 16% of ethnic minority women had at least four antenatal visits, less than half (49%) delivered their most recent child with a skilled birth attendant, and modern contraceptive use was 57%. Logistic regression showed that ethnicity, maternal education, maternal age at delivery, socioeconomic status, province, quality of the commune health centre, health insurance coverage, and distance to the hospital were significantly associated ($p < 0.05$) with composite coverage scores. Qualitative findings point to misalignment between dominant biomedical models of maternal health care and the beliefs, experiences, and socioeconomic contexts of ethnic minority women. Barriers to service utilization included: limited acceptability, reflecting women’s views that pregnancy is a healthy state rather than an illness requiring medical intervention; and low quality of services, characterized by language barriers and discrimination by ethnic majority health providers.

Lessons learnt to date: This study reveals where the largest maternal health coverage gaps exist for ethnic minority women in Vietnam. When healthcare is at odds with local beliefs and values, or poses personal or financial risks to end users, it is unlikely to be utilized, particularly when services are perceived to be of poor quality.

Main messages:

- Study findings indicate low coverage of key maternal health indicators among ethnic minority populations in Vietnam, particularly among the most socioeconomically disadvantaged.
- Existing service delivery models should be adapted to better suit the needs, preferences, and cultural expectations of ethnic minority women.

HAILU, Alemayehu, Addis Ababa University, Ethiopia

Economic burden of malaria and predictors of cost variability to rural households in south-central Ethiopia

Co-authors: Bernt Lindtjørn, University of Bergen; Wakgari Deressa, Addis Ababa University; Taye Gari, Hawassa University; Eskinder Loha, Hawassa University; Bjarne Robberstad, University of Bergen

Background: While recognizing the recent achievement in the global malaria reduction, the disease remains a challenge to the malaria endemic countries in Africa. Beyond the huge health consequence of malaria, policymakers need to be informed about the economic burden of the disease to the households. However, evidence on the economic burden of malaria in Ethiopia is scanty. The aims of this study were to estimate the economic burden of malaria episode and to identify predictors of cost variability to the rural households.

Methods: A prospective costing approach from a household perspective was employed. A total of 190 malaria patients were enrolled to the study from three health centers and nine health posts in Adami Tullu district in south-central Ethiopia, in 2015. Primary data were collected on expenditures due to malaria, forgone working days because of illness, socioeconomic and demographic situation, and households' assets. Quantile regression was applied to predict factors associated with the cost variation. Socioeconomic related inequality was measured using concentration index and concentration curve.

Results: The median cost of malaria per episode to the household was USD 5.06 (IQR: 2.98 – 8.10). The direct cost accounted for 39 %, while the indirect counterpart accounted for 61 %. The history of malaria in the last six months and the level of the facility visited in the health system predominantly influenced the direct cost. The indirect cost was mainly influenced by the availability of antimalarial drugs in the health facility. The concentration curve and the concentration index for direct cost indicate significant pro-rich inequality. *Plasmodium falciparum* is significantly more costly for households compared to *Plasmodium vivax*.

Main messages: The economic burden of malaria to the rural households in Ethiopia was substantial—mainly to the poor—indicating that reducing malaria burden could contribute to the poverty reduction as well.

HATEGEKA, Celestin, University of British Columbia, Canada

Evaluation of an emergency care training for in service healthcare providers in Rwanda: impact on providers' knowledge and patient outcomes

Co-authors: Larry Lynd, University of British Columbia; Lisine Tuyisenge, University Teaching Hospital of Kigali; Michael Law, University of British Columbia

Issue/Problem: Although efforts are underway to increase the number of specialist healthcare providers in Rwanda, many non-specialist healthcare providers in district hospitals often handle complicated pediatric and neonatal emergencies in the absence of specialists. Despite this they have expressed concerns about their lack of confidence with regards to dealing with newborn and child emergency conditions. At the same time, pediatric advanced life support management adapted for low-income countries (LICs) has increasingly been advocated as a method to reduce under-five mortality. In response, non-specialist healthcare providers from Rwandan district hospitals were trained in ETAT+ (Emergency Triage, Assessment and Treatment PLUS Admission Care) to prepare them to provide effective emergency pediatric and neonatal care and, ultimate, improve newborn and child health. The objective of this study was to evaluate the impact of the ETAT+ training on providers' knowledge and child health outcome in Rwanda.

Methods: We used a pre-post design to investigate the effect of ETAT+ on healthcare providers' knowledge. Moreover, using mixed methods design, we identified potential factors (barriers/facilitators) associated with healthcare providers' performance in ETAT+. Furthermore, using interrupted time series design and segmented regression methods, we evaluated the impact of ETAT+ on monthly pediatric hospital mortality rate (expressed as number of deaths per 1,000 admissions) among children younger than five years.

Results: Our analysis included 374 healthcare providers trained in ETAT+. Post ETAT+, providers' knowledge/skills improved significantly. Language proficiency, location of ETAT+ training, timing/delays in receiving training materials, and format of training materials were key factors associated with healthcare providers' performance in ETAT+. Furthermore, ETAT+ training for in service healthcare providers was associated with an immediate reduction in hospital pediatric mortality (level change =-12.07 deaths per 1,000 admissions; $p=0.04$) and 2.4 deaths per 1,000 admissions decrease in trend per month ($p=0.007$), leading to a reduction of 45.67 deaths per 1,000 admissions fourteen months following ETAT+.

Lessons: Improvements in post-ETAT+ performance were significant and key factors were identified as important influences on ETAT+ training outcomes. ETAT+ training for non-specialist healthcare providers from district hospitals lead to reduction of pediatric hospital mortality immediately and over time.

Main message: Implementing ETAT+ can contribute to improving child health and to achieving the Sustainable Development Goals. Given the importance of context and the reality that interventions are rarely implemented with perfect fidelity under real-world conditions, it is important to evaluate the real-world experiences with implementation of ETAT+ to identify barriers/facilitators to its successful implementation.

Hayes, Carly, International Development Research Centre, Canada

Re-purposing the nutrition policy wheel: Leveraging successful undernutrition policies to address the NCD burden in peri-urban communities in Peru

Issue/Problem: In 2015, more than 2.5 billion adults worldwide were overweight or obese, while 462 million were underweight. This double burden of malnutrition (DBM) has been particularly acute in Latin America and the Caribbean, where all countries have experienced overweight and obesity rates of 50% or higher. The WHO has recently highlighted the need for “double-duty” interventions that simultaneously reduce the burden of undernutrition and diet-related NCDs.

The majority of policy literature regarding dietary health in Peru has focused on the success that the government has had in combatting undernutrition, but prominent geographical inequalities still exist, particularly for Andean and Selva regions. With Peru experiencing steady rates of economic growth, many of these left-behind regions are undergoing a transition to high rates of overweight and obesity that co-exist with high rates of undernutrition.

Objectives/Methods: This research considers where successful policies in Peru may be leveraged to address the rise in NCDs and incorporate “double-duty” interventions, particularly in peri-urban areas where the problem is growing but data is lacking. To understand the potential for such interventions to take place, a policy network mapping exercise was conducted to determine whether existing policy infrastructure could integrate interventions for diet-related NCDs. Policymakers and nutrition experts at national and departmental ministries were interviewed. Focus groups were facilitated with community officials, health workers, and NGOs to understand patterns of dietary change and how implemented policies have impacted health in peri-urban communities.

Results and Lessons to date: Preliminary results show that the success of undernutrition policies was largely a result of sustained political will, driven by entrenched mechanisms for inter-sectoral collaboration on nutrition issues. Decentralization and innovative results-based budgeting were also significant for community ownership of the programs. However, certain programs designed to address undernutrition, such as the Juntos CCT program, may need to be re-structured to ensure problems of overnutrition and NCDs are not exacerbated. Moving forward, a more detailed narrative about the success and challenges of undernutrition policies and mechanisms for integrating NCDs into policy infrastructures will be developed.

Main messages: In order to achieve SDG 3.4 and ensure “no one is left behind,” double-duty actions must be undertaken to address both undernutrition and diet-related NCDs, which disproportionately impact the world’s most vulnerable people. This knowledge on scaling could provide an innovative base of understanding for other developing countries to leverage existing infrastructure to make the fight against NCDs more feasible, successful, and less resource-intensive.

HIADZI, Rosemond Akpene, University of Ghana, Ghana

Achieving the Sustainable Development Goal 3: Infertility Treatment Practices in Urban Ghana and its Implications for Reproductive Health

Co-authors: Daniel Kojo Arhinful, Noguchi Memorial Institute for Medical Research, University of Ghana

Issue/Problem: The sustainable development goal three on health has as a broad objective to ensure healthy lives and promote well-being for all at all ages. Following this goal, this study focused on the reproductive health of infertile women in Ghana, West Africa. Infertility rates in Ghana currently ranges between 11% and 15% for both men and women but the benefit package for the national health insurance does not cover infertility treatment. These estimates are significant especially in a cultural context where childbearing is espoused and involuntary childlessness is rare.

Objectives and Methods: The health seeking behaviour of the infertile, specifically, with respect to healthy practises and/or the absence of it in the search for biological parenthood forms the main focus of the study. The research targets women in their reproductive years who are experiencing involuntary childlessness and are thus unable to or are experiencing difficulty in having children of their own. Qualitative data was gathered through convenience sampling of thirty-five respondents seeking infertility treatment from one herbal clinic and two orthodox hospitals.

Results: Infertile women commonly visit different health care providers (both registered and unregistered) and employ varying remedies which they get to know of through the media or from friends and family. These women sometimes employ different methods simultaneously or otherwise in a desperate attempt to have children of their own. Their choices are also informed by the high cost in accessing fertility care which is largely a private enterprise. Lifestyle, habits and certain cultural notions that makes them susceptible to infections and the seeming lack of knowledge about reproductive cycle and care for their bodies have contributed to this.

Lessons to date: The evidence show that some of the current methods women are using are iatrogenic either singly or in combination with other types of treatment. Infertile women will go to any length to fulfil their desire to become biological parents.

Main messages:

- Infertile women resort to various remedies (both registered and unregistered) in an attempt to have a child of their own.
- The use of unregistered remedies particularly by poor women has implications for safe reproductive health.
- Sustained public education and sensitization buttressed by enforcement of regulation on airing of spurious fertility adverts is essential to protect vulnerable poor women from dangerous remedies in their attempts to have children

ISODJE, Anastasia, University of Port Harcourt Teaching Hospital, Nigeria

Access to tuberculosis treatment services: its implication on achieving global targets

Co-authors: Ayebatari Lawson, Treeshade Nigeria Ltd; Charles Tobin-West, University of Port Harcourt Teaching Hospital

Issue/problem: Tuberculosis (TB) is the second leading cause of infectious disease death globally. The current strategy for its management requires 2 months of daily clinic attendance for direct observation of therapy by healthcare provider. Although diagnosis and treatment are free, patients encounter other costs and barriers while seeking care daily. In order to achieve the World TB theme “Unite to end TB: Leave no one behind”, these barriers need to be identified.

Objectives and methods: The objectives of this study were to determine the experience of patients seeking TB treatment and to find out the barriers encountered in the process. This was a cross-sectional study, conducted in rural and urban Local Government Areas (LGAs) in Rivers State Nigeria. A total of 244 patients were selected from eight functional TB clinics, using the proportionate to size sampling technique. Ethical approval was obtained from the Ethics Committee of the University of Port Harcourt Teaching Hospital. Data were collected over a six week period, computed, and presented using tables and charts. Chi-squared statistic was also computed to test for homogeneity.

Results: The rural to urban distribution was 48.8% to 51.2% and 50% of the patients were <34years, Patients’ income was skewed with 76.6% of patients, earning <\$100 per month. Approximately 78.2% of the patients in the rural area incurred cost compared to 41.6% of patients in the urban area. The cost incurred was mostly for transportation: 86.8% - rural and 56.3% - urban region. Approximately 98.8% of the patients had sought for cure from the following: chemist, spiritualist, herbalist, church or taken self medication. Only 0.4% started correct medication at the onset of symptoms. Of the patients in the rural area, 84.9% said they waited for less than 30 minutes during their last visit compared to 51.2% in the urban. The response to availability of other services was higher among respondents in the urban region 82.4% compared to 52.1% in the rural. All the findings were statistically significant at $p < 0.05$.

Lessons to date: The group most affected by TB is the poor and the daily cost of accessing free diagnostic and treatment services may be detrimental to the success of this strategy. High-burden TB countries need to consider a community directed approach for its control.

Main messages: In order to “Leave no one behind”, barriers to access and utilisation of services need to be overcome using context specific interventions.

JACOBS, Eelco, Royal Tropical Institute, Netherlands

Catastrophic health expenditure and care-seeking practices in Afghanistan: a mixed-methods study.

Issue/problem: Access to health care remains impeded by inability to pay, and high Out of Pocket Expenditure (OOPE) on health in Afghanistan. Despite much progress in public health in general and Universal Health Coverage in particular since 2001, including the introduction of basic and essential packages of healthcare that are free of charge, unequal access to healthcare remains pronounced. A comprehensive consideration for the factors driving catastrophic payments obstructing UHC in Afghanistan is still lacking.

Objectives and Methods: The study analyses the factors affecting access to care and catastrophic health expenditure: care-seeking practices, the averages of OOPE on health per wealth group and in total, client perception of care and access barriers, the strategies that households employ to source the funds to pay for care, and the existence of local risk-pooling mechanisms. A mixed methods approach with qualitative, semi-quantitative and quantitative research methods was used. Data from Focus Group Discussions (FGDs) in three Afghan provinces, conducted in 2015, was triangulated with data from a nationally representative household survey. It is based on a multi-stage random sample of 23,137 households across all 34 provinces of Afghanistan.

Results: The results suggest that the conditions for catastrophic health expenditure in Afghanistan are present. Risk-pooling initiatives for health were not found in the three selected provinces, bar one small example. Instead, OOPE is widespread, particularly on pharmaceuticals. Private health providers, which is the choice for half the respondents seeking care, are an important driver of this. Debts and the sale of possessions feature prominently as strategies employed to source the funds for OOPE. 48.4% of hospitalized people reported a financially distressed situation as a result. 7.5% of those who were ill did not seek care because of cost considerations. Quality, affordability and reachability of care featured prominently among healthcare-related concerns, exacerbated by insecurity in the country, particularly for women.

Lessons and main messages: In a context of poverty and high insecurity affordability of care remains a major concern for Afghan citizens and policymakers. Contracting of private providers to deliver the basic and essential packages of healthcare coupled with more effective supervision and oversight on user fee charging and the pharmaceutical supply chain could make healthcare more accessible and reduce out of pocket, catastrophic health expenditure.

JIMOH, Kehinde, Abt Associates, Nigeria

Private sector engagement in TB control

Problem: Nigeria is ranked 4th among the 30 countries that has high TB burden. The country notified 15% (90,584) of the estimated TB cases (586,000) in the country in 2015. In Nigeria, health care provision by the private health sector to all segments of population is rapidly growing. And yet, there is little collaboration between the public and the private sectors in the delivery of care for control of Tuberculosis. Attempts to forge partnerships between public and private sectors in health care provision for TB & TB/HIV, if successful, could have valuable lessons for other disease control program

Results: The results for this study are preliminary. But based on some findings of this study, we have seen that this intervention will contribute to the NTBLCP in reducing morbidity, mortality and prevent the development of drug resistance through standardized diagnosis and treatment of TB and TB/HIV patient by all health care providers in the country.

Lesson Learned: This study explore the barriers and influencing factors to improve private sector engagement to control TB in Nigeria. It provided guidance to the NTP and states programs on how to overcome these barriers, including recommendations for advocacy efforts, stakeholder engagements and strategic partnerships to advance TB outcomes. There was active scale up Private sector engagement (which include Pharmacist, retail drug outlets/Patent Medicine Vendors and informal health sectors) in TB control in Nigeria. Different roles and responsibility was identified within the private based on the different schemes developed by the NTP. In line with the second pillar of the End TB strategy, this study explore how universal health coverage can be implemented for TB control in Nigeria. The resulting analysis was designed to ensure that its results are owned and endorsed by the NTP and state TB program, and that it can help lead to subsequent strategy and plan development.

Main Message: The intervention will help in the expansion of DOTS coverage and thereby increasing the national TB case finding, detection and treatment success rate. It will also help to reduce financial burden on patients, optimize the use of available resources as well as improve equity and access to effective and affordable services through the state health insurance scheme. It is also anticipated that this will help to improve patient centered TB care, support and treatment.

JIMOH, Kehinde, Abt, Nigeria

Demonstrating the benefits of innovative technology GxAlert for TB and HIV care and management in Nigeria

Background: The World Health Organization ranks Nigeria 11th among 22 high DR-TB burden countries in the world. Rapid diagnostic machines have been made available in Nigeria to test for infectious diseases such as tuberculosis (TB), drug resistant TB, and HIV. Yet test results were not reported in real-time due to communication delays, and oversight of diagnostic machines and their management was limited. Stock outs of test cartridges, quality assurance, or machine errors and misuse were not properly documented or resolved in a timely manner.

Intervention: In pursuit of improved healthcare responses to DR-TB by the Nigerian Tuberculosis and Leprosy Control Program (NTBLCP), Systemone developed an innovative mobile-based solution that sends GeneXpert diagnostic results to key health system actors instantly to enable quick enrollment of newly diagnosed patients in a DR-TB treatment program. GxAlert is configured on GeneXpert systems and requires internet access to send encrypted data to the secure web-based GxAlert database in real time. The system then sends the results in an SMS alert to program decision makers at the state and national TB program, shortening the new-case reporting period from months to seconds.

Results and Lesson Learnt: GxAlert eliminated the need for human error in data entry, reduced the lag time, and helped pinpoint patients that should be placed on care. More patients have been enrolled for DR-TB care. GxAlert strengthened surveillance of DR-TB, TB in children and TB in the HIV infected, speeding response and improving programmatic decision making for enrollment and placement of DR-TB patients on treatment. GxAlert also prevented cartridge stock-outs and tracked usage for accurate ordering. In 2014, on average, 74.6% of tests were reported only; this increased to 91.9% in 2015. Quality assurance checks also increased from 0.6% of tests to 1.7%. Twenty-two states performed any quality assurance checks in 2014, which increased to 32 states in 2015.

Conclusions and recommendations: The findings of this analysis show an added benefit of the GxAlert system as its reported tests and cases are at comparable levels with the NTP or higher. The GxAlert system shows that there is management and disease monitoring benefits to a real-time database system that not only provides information on complete tests and cases, but also on test errors and quality assurance efforts.

KAPIRIRI, LYDIA, MCMASTER UNIVERSITY, Canada

Research and measurement for equitable action in health systems priority setting

Priority setting (PS) if well done, can contribute to the realization of equity within the LIC health systems. However, PS in LICs is marked with extreme resource constraints, political instability, and limited institutional capacity play a critical role with regards to how priorities are set and if they are ever implemented. While there has been progress in developing frameworks to guide priority setting for health interventions in LICs, there has been limited discussion on how to evaluate priority setting within low income countries; with specific focus on equity. This CIHR funded project (2013- 2016) filled this gap.

The specific objectives of this presentation are to:

1. Describe and evaluate priority setting within the health system using a framework that was validated by decision makers at the national and sub-national levels within a low income country
2. To discuss the strengths, limitations and key lessons that can be shared within Uganda and other similar low income countries.

Methods: Multi- methods approach involving cross-sectional, follow-up and exit interviews, review of documents and newspapers.

Results: The framework was well accepted in the LIC context, almost all the quality indicators were deemed relevant to evaluating priority setting within these contexts. The data requirements were all accessible. In applying the framework to different cases of priority setting in Uganda, we found that while the Health sector strategic and investment planning is “participatory”, and relied on evidence, some of the respondents indicated that often the most vulnerable in the different settings do not participate as meaningfully as the rest; at the national level, the districts are less likely to participate; while at the district level, the poor, women are least likely to participate. While equity is often identified as a major value, it is not always clear how it is integrated in priority setting. There was a gap between the priorities and implementation; whereby a long list of priorities were labeled “unfunded” since they are often unfunded and not implemented. Various contextual factors affected the implementation of the priorities.

Conclusions: We identified key areas of strength, that can be shared; as well as challenges where intervention strategies are required. The framework enabled us to assess the degree to which priority setting was successful. The accessibility of the information required to evaluate priority setting using the framework makes it accessible to decision makers in LICs.

KARDAS-NELSON, Mara, Partners in Health, Sierra Leone

Connecting vulnerable populations to health care and socio-economic support: PIH Sierra Leone's community-based programs

Co-authors: Kumba Tekuyama, Partners in Health Sierra Leone

Partners in Health (PIH) Sierra Leone supports community-based programs across the country--in Freetown, Port Loko, and Kono--linking vulnerable patients to clinical care and further identifying and addressing socio-economic needs that are hindering access to long-term care and/or long-term improved health outcomes. In the absence of a strong health service, and in a country is one of the poorest in the world, these community-based programs are essential to finding patients, linking them to care, and holistically understanding their needs in order to support improved health outcomes. By employing a peer-to-peer approach, PIH has been able to improve case finding of Ebola survivors with ongoing health and socio-economic needs in both Port Loko and Kono district, and significantly improved case finding of both HIV and TB in Kono district, which has some of the highest rates of both diseases in the country. Once identified, patients are then linked to clinical care and further assessed for socio-economic needs, assigned a community health worker in order to provide ongoing support and continuous linkage to services. This holistic approach understands that patients' clinically-related needs do not stop at the clinic but that poverty remains a critical determinant of poor health outcomes. Perhaps most importantly, by working with a peer-to-peer approach, for both community-based survivor care and HIV/TB care, PIH has been able to be responsive to the needs of patients as they need, flexibly altering programmatic interventions as needs arise. This presentation will outline PIH Sierra Leone's community-based interventions, noting a strong focus and programmatic alignment between health needs and socio-economic needs; and PIH Sierra Leone's responsiveness to our clients' changing needs, outlining both how changes are understood and considered, and the impacts they have on the populations we serve. Our focus on a holistic approach, and flexible program design with both our clients' and the Ministry of Health and Sanitation's needs at the center, will be important lessons learned for other programs considering community-based models. The presentation will note significant differences between our survivor-specific community care and our HIV/TB community care, while highlighting the important theme of holistic accompaniment throughout a patient's socio-economic and health needs throughout and after their clinical experience.

KARMALIANI, Rozina, Aga Khan Univeraity School Of Nursing And Midwifery, Pakistan

Assessing the effectiveness of telepsychiatry services in the Gilgit-Baltistan and Chitral districts of Pakistan

Issue/problem: With an estimated 50 million people suffering from common mental disorders in Pakistan, about 15% of the country's population is in need of psychiatric help, but the 2009 WHO-AIMS report on mental health in Pakistan revealed that only 20% of the millions of individuals requiring psychiatric or psychological services actually receive some psychosocial intervention. Most people with access to mental health services reside in urban areas; remote rural regions like Gilgit-Baltistan and Chitral, face a relatively severe lack of trained professionals and mental healthcare facilities.

Objectives: To address this disparity in services, a telepsychiatry program was established with psychiatrists from the Aga Khan University Hospital in Karachi conducting tele-consultation sessions with patients at spoke sites in Gilgit and Chitral (January 2016 – January 2017). The study aimed to measure the impact of telepsychiatry services provided to individuals suffering from mental health conditions. The impact was measured in terms of increased accessibility to, and quality of healthcare, with a reduction in the economic costs of diseases.

Methods: The videoconferencing software Zoom was utilized for teleconsultation between the psychiatrist at the hub site and the patients at the spoke sites. Of 300 patients who had at least one session with the psychiatrist via tele-consultation, 214 participated in the study by completing questionnaires about their experiences based on 17 indicators of telepsychiatry effectiveness (divided broadly into access to, and quality and costs of health services).

Results: 34% of all participants reported consulting a psychiatrist for the first time through the telepsychiatry service. 41% acquired an appointment within a week. 18% reported taking over 2 hours to reach the medical centers, while 45% reached the medical centers within an hour. 16% reported zero transportation costs, and the majority (51%) spent PKR1000-2000 (US\$9-19) on transport to/from the medical centers. 76% stated their overall experience was excellent (apart from some issues in call connectivity), 98% were comfortable with interacting with the psychiatrist via tele-consultation, 99% reported they would use the teleconsultation service again and recommend it to others.

Lessons to date: Telepsychiatry services can be expanded to tele-counseling and tele-psychotherapy in order to make the program more sustainable for patients, in collaboration with local health authorities for training and awareness.

Main messages: Remote, rural, marginalized and underserved populations require professional mental health support, and telepsychiatry services are one method of providing this essential care to individuals in need without displacing patients or clinicians.

KHALID, Faraz, Prime Minister National Health Insurance Program Pakistan, Pakistan

Pakistan's progress towards Universal Health Coverage: an empirical assessment of summary and tracer indicators and associated inequities (2001-14)

Co-authors: Abdus Sattar, World Food Program; David Hotchkiss, Tulane University - School of Public Health and Tropical Medicine; Maria Brunal, The Global Fund to Fight AIDS, Tuberculosis and Malaria; Justine HSU, World Health Organization

Problem: Globally, it has been acknowledged that monitoring national level Universal Health Coverage (UHC) progress can hide the underlying variations within a country. After a recent constitutional amendment, health has become a provincial government mandate in Pakistan. All the provincial governments have recently committed to UHC targets in the National Health Vision 2016-25. No previous study has comprehensively captured both dimensions of UHC (health service and financial protection coverage) simultaneously to give a complete picture of UHC at the provincial level in the country.

Objective and Methods: This study's main objective was to examine the progress of provinces towards UHC using the tracer indicators (six health service and two financial protection coverage) from 2001 to 2014 and to assess inequities within provinces because of place of residence and economic status.

For elaborate tracking, inequities were assessed for each indicator with average annual rate of change and percentage change in the gap between sub-population groups. For policy makers, spider radar graphs were generated to demonstrate UHC status in 2014, and a composite UHC index was created to show the trend from 2001-14. Four Household Integrated Economic Survey data sets (2001-02, 2004-05, 2010-11, 2013-14), each with a sample size of about 15,000 households, were used for analysis.

Results: Overall, all four provinces made progress in their UHC index values over the study period. The general trend was towards improvement for health service coverage indicators; average annual rate of change in coverage for preventive indicators was higher than for treatment indicators; higher reduction in gap between rural and urban, poorest and richest was also observed for the preventive indicators. However, coverage for most of treatment indicators remained below 70% and inequities existed among sub-population groups. Coverage of financial protection indicators remained above 90% for all the provinces across the study duration and no substantial differences were found between and within provinces.

Lessons:

- Higher level of financial protection with limited health services coverage was most likely due to non-utilization of health services and/or unmet health needs.
- Simultaneous monitoring of both dimensions of UHC enabled authors to comment on the holistic picture of UHC status and to avoid inappropriate interpretations about a single dimension.

Main messages:

- This is the first comprehensive analysis on progress towards UHC at the sub-national level in Pakistan
- Though higher progress has been made by the traditionally disadvantaged groups than their counterparts, but wide inequities still exist.

KURJI, Jaameeta, University of Ottawa, Canada

Women's interest in mHealth interventions to improve utilization of maternal health care services in Jimma Zone, Ethiopia

Co-authors: Getachew Kiros, Jimma University; Yisalemush Asefa, Jimma University; Shifera Asfaw, Jimma University; Abebe Mamo, Jimma University; Kunuz Hajibedru, Jimma Zonal Health Department; Sudhakar Morankar, Jimma University; Muluemebet Abera, Jimma University; Ronald Labonte, University of Ottawa; Lakew Abebe, Jimma University; Manisha Kulkarni, University of Ottawa

Issue: Additional efforts are required to improve coverage of maternal health care services if Ethiopia is to meet the Sustainable Development Goal targets. With the high levels of mobile phone penetration in sub Saharan Africa, the use of mHealth interventions is growing rapidly. mHealth interventions are showing promising results including improvements in health service utilization and enhancement of women's status. mHealth is still in its infancy in Ethiopia and existing research is focused on interventions targeting health workers. With increased access to care included as a key objective in Ethiopia's mHealth strategy, information on acceptability from women's perspectives is also needed.

Objective and Methods : As part of a baseline survey, women were asked about the potential utility of mHealth interventions focusing on antenatal and postnatal care reminders and increased communication between women and health workers. Women were interviewed between September 2016 and January 2017 prior to roll-out of safe motherhood interventions being evaluated in a cluster-randomized control trial. 3784 women were recruited from catchment areas of 24 health centres in three districts in Jimma Zone. Exploratory descriptive analyses were carried out using STATA v.13.1.

Results: Approximately 6% (n=242) of women reported owning a mobile phone while 54% of their husbands owned one. Service coverage was reported as adequate in their area of residence by 72% of women. Only 18-20% of women had previously used their mobile phone to obtain health information from a health worker. Both users and non-users felt that it would be useful to receive reminders about antenatal care visits (92% vs. 76%), postnatal care (92% vs. 86%) visits and child immunizations (93% vs 90%). The majority of women expressed an interest in registering their mobile phones for future mHealth interventions. Women who had experienced health problems during their last pregnancy were more inclined to participate than those who had not.

Lessons: Given the large gender disparity in mobile phone ownership and the need for more male involvement in maternal and child health, gauging male interest in mHealth interventions would have been informative.

Main messages: Most women felt that mHealth interventions would be useful and expressed an interest in participating in such an initiative. There is potential to take advantage of this interest to improve utilization of maternal health care services in Ethiopia.

LAWSON, Ayebatari, Rivers State Ministry of Health, Nigeria

Where do our women deliver and why; barriers to uptake of free maternal and child health services

Co-authors: Anastasia Isodje, University of Port-Harcourt Teaching Hospital

BACKGROUND: Improving maternal health outcomes by ensuring access to skilled care during pregnancy and delivery, (particularly in developing countries), is key to achieving the Sustainable Development Goal of ensuring health for all. In a bid to scale up universal access to skilled care, the Government of Rivers State Nigeria between 2011 and 2013, built and equipped over 200 model primary healthcare centres across the 23 local government areas in the State. Services were provided free-of-charge and open to all pregnant women.

In spite of the huge human and capital investments, the review of routine data on utilization of antenatal and delivery services in the state between 2012 and 2014, revealed a high rate of client attrition from these facilities. In view of this, a community-based survey amongst nursing mothers was conducted over a six-month period the objectives of which were;

- To determine possible causes/reasons for the poor utilization of antenatal (ANC) and delivery services in these well-equipped model healthcare facilities.
- To ascertain alternative choices of care for ANC and delivery

METHODOLOGY: The study was carried out in three LGAs randomly selected from the 6 LGAs with >40% client attrition rates in the State. Two of these, Asari-Toru, Etche were rural and one, Obio-Akpor was urban. 2 model Health centers in the rural LGAs and 4 Model health centers in the urban LGA were enrolled. The calculated minimum sample size was 350.

A semi-structured questionnaire was administered to a total of 362 with infants less than or equal to 6 months of age at immunization clinics.

RESULTS: 57.5% of the women sampled registered for Ante-natal care in a model facility but only 39.4% of the women who registered delivered their babies there.

Factors related to health workers' attitude (32.6%) were the most common barriers to utilization of the model health facilities in both rural and urban women. Only 4.7% stated cost as a factor. The common alternative source of delivery services were private maternity homes for women in urban centres (36%) and traditional Birth Attendants (63.2%) in the rural areas. Majority of the women sought alternative care "to receive better attention" (40%)

CONCLUSION

Eliminating cost-related barriers alone may not be enough to improve access to care. Interventions that address quality of services should also be taken into consideration to ensure that 'no woman is left behind' in efforts to improve maternal health.

LUDWICK, Teralynn, International Development Research Centre, Canada

Food systems research for noncommunicable disease (NCD) prevention: Is gender being considered?

“NCDs affect women inequitably and more than most people think,” states the WHO . In order to achieve the SDG targets on NCDs and contribute to the broader agenda on gender equity and leaving no one behind, NCD interventions need to more clearly target and respond to women’s need and contexts. Food systems research – targeting food-related NCDs and risk factors such as obesity, diabetes, and hypertension – is generating a growing evidence base on effective population-level interventions. This field is demonstrating the effectiveness of fiscal measures (e.g. taxes on sugar-sweetened beverages), policies/regulations (e.g. restricting marketing to children), and enabling environments for promoting healthy foods (e.g. school food programs). However it is not clear to what extent gender factors are being consistently and meaningfully integrated into these solutions.

Methods: A survey of 32 established food systems researchers from Latin American was carried out as part of a pre-consultation to a workshop hosted by IDRC and the Instituto Brasileiro de Defesa do Consumidor. The surveyed aimed to better understand how gender dimensions are being examined in their research, barriers encountered, and surface opportunities for gender-transformative work. The results were presented at the workshop and discussions were deepened using a participatory methodology/framework developed by Gender at Work.

Results: Of the 26 responses, 69% of projects collected sex-disaggregated data and 58% conducted gender analysis. Only 2 projects provided specific examples of using gender analysis to inform recommendations/solutions. Barriers to examining gender considerations included limited data and evidence in the literature, assumptions, lack of knowledge/capacity, lower male participation in studies, and subject sensitivity. Proposals for generating gender-empowering and transformative research for prevention of food-related NCDs included addressing household structures (e.g. women’s autonomy/responsibility for food preparation), the food chain (e.g. representation of men/women in processing/transport/wholesale/retail of foods), marketing (gendered targeting), literacy/education, and public policies (gender inequalities in decision-making). Most suggestions focused on the household-level.

Discussion: Meaningful integration of gender into food-related NCD prevention research remains limited. More clearly integrating gendered findings into publications, recommendations, and solutions will be important for the field. Reasons for not investigating gender factors surfaced important challenges, including working with secondary data. Lack of pre-existing evidence on gender factors in the literature led to assumptions that the intervention design was gender neutral. Challenging assumptions of gender neutrality will be important for providing evidence of differential impacts. Igniting intellectual curiosity for generating gender-relevant research questions and peer-to-peer learning and debate are examples of promising strategies used in this workshop to encourage integration of gender equity considerations in research. We must collectively challenge the field to be more gender responsive for more robust research, effective interventions, and the achievement of the SDGs.

MACLEOD, Marin, University of Toronto, Canada

Innovative humanitarian response: UNHCR Jordan's biometric cash transfer program

Co-Authors: Elsa Assefa, University of Toronto; Natalie Boychuk, University of Toronto; Adam Sheikh, University of Toronto; Daniel Park, University of Toronto; Kirstyn Koshwin, University of Toronto

Issue: Over 600,000 Syrian refugees have been registered by UNHCR Jordan since the onset of the conflict, and this has necessitated an innovative programmatic response by the organization. UNHCR Jordan has implemented the world's first refugee cash transfer program that leverages iris scan technology, the organization's most cost-efficient program worldwide; ensuring that 95% of every dollar donated goes directly to refugees. Refugees are often marginalized and left behind, and 66% of Syrian refugees in Jordan are living below the poverty line. UNHCR Jordan's cash transfer program is efficiently providing critical services for many of these refugees, and monitoring reports suggest that 91% of refugees are 'satisfied' with this innovative means of receiving their cash transfers.

Objective & Methods: The objective of this qualitative research was to identify the key mechanisms facilitating the unprecedented efficiency of this innovative program. This objective was achieved through various key informant interviews with program implementers and partners in Jordan. Ensuring that refugees receive the maximum benefit from humanitarian aid is crucial to ensure their equitable and sufficient access to necessities that enable their overall health, and that prevent them from engaging in negative coping mechanisms which have a deleterious effect on their health.

Results: The preliminary results of the research indicate four primary mechanisms that facilitate the program's success. First, the intense collaboration among partners in the cash transfer space in Jordan, that has facilitated innovations such as the Common Cash Facility; second, the public-private partnership between UNHCR Jordan and the Cairo Amman Bank; third, the use of biometrics as a means of refugee verification; and fourth the implementation of the Vulnerability Assessment Framework to ensure that those most in need receive the cash transfer.

Lessons: Leveraging biometric data to facilitate the implementation of a cash transfer program has maximized efficiency, and is contributing to the increased well-being of marginalized refugee populations. Public-private partnerships can be an innovative and effective approach to reimagining humanitarian response. Close collaboration among international organizations and local partners is critical to ensure the successful implementation of a scalable cash transfer program for refugees.

Messages: UNHCR Jordan's innovative biometric cash transfer program is tackling poverty, and striving to improve health outcomes among marginalized Syrian refugees, as the protracted crisis continues. Providing for the most vulnerable Syrian refugees, in an efficacious and efficient manner, is a means of ensuring that this critical group is not left behind.

MAC-SEING, Muriel, Université de Montréal, Canada

Does qualitative research take people with disabilities seriously? gender, disability, reproductive health and social inclusion in sub-Saharan Africa

Co-Authors: Christina Zarowsky, Université de Montréal

Problem: Reproductive health remains a major global health issue for millions of women worldwide. In low and middle-income countries, the access to sexual and reproductive health (SRH) services is often compromised due to various barriers, notably in the sub-Saharan region where the maternal mortality rate and HIV prevalence averages are among the worst. Women and men with disabilities, representing 15% of the world's population, face additional discrimination and barriers to access which need to be better understood.

Objective and methods: This study examined the intersections between gender and disability related to reproductive health in sub-Saharan Africa in qualitative literature. We conducted a meta-synthesis, using a taxonomic analysis. An inductive and iterative approach has been adopted to allow exploration of new and emergent semantic variations in themes. Coding of themes has been supported by NVivo 11 Plus. The original qualitative studies and meta-synthesis were assessed through the COREQ and ENTREQ quality checklists, respectively.

Results: Ten qualitative studies from six sub-Saharan African countries were identified and analysed. Two main thematic areas, with sub-themes, emerged from the analysis: 1) experiences of disability in interaction with a SRH issue are 1a) lived differently among women and men, 1b) exacerbated by the type of disability, 1c) influenced by the type of barriers in access, and 1d) perceived differently depending upon actors involved; and 2) gendered roles of people with disabilities are also 2a) programmed by sociocultural normativity, including perceptions about sexuality, 2b) exacerbated by the hegemony of ableism, and 2c) influenced by the type of SRH issue people with disabilities experience.

Lessons: This meta-synthesis highlighted the intricate and multiple intersections between gender and disability in relation to SRH in sub-Saharan Africa. The sexual rights of women and men with disabilities are still largely absent from the literature when gender and disability are examined. Existing studies do not provide us sufficient information on the impacts of the exclusion of people with disabilities on their SRH and social participation in sub-Saharan Africa.

Main messages: There is a paucity of qualitative research on the intersections between gender and disability in sub-Saharan Africa, a region where the main SRH indicators are lagging behind; and where people with disabilities, still, are not exercising their basic SRH rights. An intersectional analysis could be a useful support to filling the knowledge gaps and developing future perspectives.

MAQBOOL, Hussain, Aga Khan University School of Nursing and Midwifery, Pakistan

The intersection of school corporal punishment and youth violence: baseline results from a randomized controlled trial in Pakistan

Co-authors: Rozina Somani, Aga Khan University School of Nursing and Midwifery; Rozina Karmaliani, Aga Khan University School of Nursing and Midwifery

Purpose: Violence against youth is a global problem. One form of youth victimization is school corporal punishment. The current study uses baseline assessments to examine the prevalence of school corporal punishment, specific to gender, and associated contextual correlates of peer violence and perpetration, parent corporal punishment and daily family life characteristics, and youth academic performance.

Methods: A cluster randomized controlled design is used to evaluate differential outcomes over a two-year intervention period. Forty fairly homogenous schools in the urban city of Hyderabad, which is located in the southern province of Sindh were chosen for randomization. Youth in the 6th grade, usually 12-14 years of age were selected as the target population. A cluster randomized controlled trial was required for intervention testing at the school level. Since schools are segregated by gender in Pakistan, we selected 20 schools in the intervention (10 boy schools and 10 girl schools) and 20 schools in the control (10 boy schools and 10 girl schools). School and Parent Corporal Punishment study instrument is used in the study.

Results: Boys report high levels of punishment at school (58.3%) and at home (28.6%) compared to girls at school (11.4%) and home (13.0%), $p < 0.001$. In addition, boys report high levels of peer perpetration (75.0%) and peer victimization (90.8%) compared to girls (49.9% and 75.3%, respectively), $p < 0.001$. Boys and girls who report high levels of school corporal punishment also report high levels of corporal punishment by parents. Both boys and girls who reported no school corporal punishment report better academic performance. Clearly a major gender difference exists for reported episodes of school and parent corporal punishment and associated youth to youth victimization.

Conclusion: This study highlights gender difference in the occurrence of corporal punishment and a positive correlation to home corporal punishment, youth to youth victimization, and poor school performance. To maximize youth functioning and academic performance, an urgent need exists for strategies to combat all forms of youth violence including corporal punishment in the school and home.

MARTIN, Angelica, Open Arms Patient Advocacy Society, Canada

Patient advocacy: building positive networks and relationships between patients, families, and healthcare professionals.

Co-Authors: Farwa Naqvi, Open Arms Patient Advocacy Society

Background/Issue: Open Arms Patient Advocacy Society (OAPAS) is dedicated to empowering patients and professionals to encourage their active collaboration in managing health concerns. Many of the patients we serve report difficulty and frustration navigating the health care system or obtaining clear answers when acting alone, particularly when in crisis due to concern over personal life circumstances, concern for the state of their health, and accessing appropriate treatment, among others. Our reports reflect that this is often the result of barriers in communication, and understanding the social reality or experience of the individual. Of particular interest are the experiences of marginalized groups such as immigrants and refugees, individuals or populations with mental health concerns, and individuals or populations with disabilities or functional limitations.

OAPAS patient advocates work with patients and health professionals to support positive relationship-building through direct involvement in system navigation, advocacy, and health education. All support is offered at a grassroots level, and on a volunteer basis.

Learning Objectives & Outcomes: OAPAS will guide delegates as they explore the following questions regarding the future of advocacy, and how it may inform future global health initiatives:

- How can we use advocacy-related data to inform policy that contributes to an equitable healthcare-seeking experience for all?
- How do we encourage academic endeavours to further explore the application of advocacy, with the aim of understanding its value as a potential global health intervention?
- How do individual experiences translate to larger global health implications, and how does advocacy influence individual and population health outcomes?

At the end of the workshop, delegates will have gained an introduction to:

- 1) Exploring the importance of the individual and cultural specificity of treatment plans.
- 2) Understanding patient and clinician approaches to care management.
- 3) Addressing barriers in communication related to patient health and health outcomes.
- 4) Understanding various co-occurring internal and external psychosocial factors that may interfere with the efficacy of advocacy in addressing treatment delay, or exacerbated illness.

Methods: This workshop will function as a "Gallery Walk", with a small group discussion component. OAPAS will begin the session with a presentation to introduce delegates to key themes in patient advocacy, and to provide guidelines for the gallery walk and small group discussion:

1. Delegates will be assigned to a group, and will explore a case study with their group. Each case will address an individual patient, who represents one assortment of a variety of possible combinations of health statuses, individually- and culturally-specific circumstances.
2. In small group discussion, delegates will be asked to prepare a plan according to guidelines provided by OAPAS to effectively advocate for each patient. One delegate in each group will be assigned to take notes about their advocacy plan on a flipchart for the group.
3. Delegates will then be asked to tour the room, and become familiar with the other case studies. OAPAS will then ask delegates to add suggestions or notes to other groups' advocacy plans based on their learnings.
4. OAPAS will ask delegates to reconvene as a large group, and guide discussion for each of the case studies and added suggestions.
5. OAPAS will deliver clarification and concluding remarks for each group before wrapping up the session with a second presentation to summarize the group's learnings, and scale the individual case studies to a broader global health context.

Main Message: Open Arms Patient Advocacy Society describes individual case studies occurring within a Canadian context from which we are able to derive key tools and positive behavioural approaches, which are some of the basic components and strategies used in the delivery of advocacy-related service. These tools and approaches may be adapted and scaled to other sociocultural contexts for successful system navigation and patient-clinician interactions, which may be used to address disparities in global health. OAPAS suggests that improved health outcomes among individuals, populations, and particularly marginalized groups may be achieved by:

1. Mediating conversations in patient-centered care: making meaningful exchanges of information, and validating both patient and clinician concerns.
2. Encouraging collaboration in the clinician-patient relationship.
3. Empowering patients, and providing them with the tools to independently manage their relationships with health care professionals.

MASUMU, Justin, National Pedagogic University, Democratic Republic of the Congo

Intégration des systèmes de surveillance des maladies en RD Congo: Analyse de la situation dans le secteur animal

Co-authors: Noriki Ikeda, JICA; Benoît Kebela, DLM

La majorité des maladies émergentes et ré-émergentes qui menacent la santé publique aujourd'hui sont d'origine animale. Dans certains cas, les épidémies chez l'homme sont précédées par des épizooties chez les animaux. Ainsi le renforcement de la collaboration entre les secteurs de la santé humaine et animale selon l'approche "One Health" est indispensable afin de permettre un dépistage précoce de tout cas d'épidémie chez l'homme. En RD Congo, le secteur de la santé animale est régi par les ministères de l'Élevage et Pêche (MINELP) ainsi que celui de l'Environnement (MINENV). Dans cette étude, nous avons procédé à l'évaluation du système de surveillance des maladies animales dans le but d'en dégager, d'une part, les points forts à capitaliser et, d'autre part, les points faibles qu'il faudra améliorer afin de le rendre plus performant. Après identification des acteurs impliqués dans cette surveillance, nous avons élaboré 17 fiches de collecte de données puis formé des enquêteurs avant de procéder à l'évaluation de 10 des 11 anciennes provinces du pays. Cette évaluation a concerné diverses structures des ministères chargés de la santé animale (MINELP et MINENV) ainsi que des personnes et structures qui œuvrent dans ce secteur (Parcs, Abattoirs/tueries, Fermes/détenteurs d'animaux domestiques, Frontières, Laboratoires, Vendeurs de viande, Université, Chasseurs, Pêcheurs et Détenteurs d'animaux). Nos résultats ont révélé une bonne représentativité de ce système à travers tout le pays, à part certaines institutions spécialisées comme les universités, les laboratoires, les parcs et les postes frontaliers qui sont localisés à certains endroits. Seules les structures du MINELP sont impliquées dans cette surveillance contrairement à celles du MINENV qui n'exercent aucune activité de surveillance des maladies malgré le fait que ce ministère a la charge des aires protégées et non protégées considérées comme sources d'un bon nombre de maladies émergentes. Les autres acteurs interviewés avouent détenir beaucoup d'information relative à la santé animale mais ils reconnaissent, pour la plupart, ne pas être impliqués dans la surveillance des maladies animales. Dans l'ensemble, le système de surveillance de maladies animales en RDC souffre d'un manque criant de formation et d'équipements. C'est principalement dans ces domaines que ce système doit être renforcé afin de l'amener au niveau du secteur de la santé publique qui est beaucoup mieux organisé sans quoi l'application de l'approche "One Health" ne saura être effectif en RD Congo. Les fiches développées dans cette étude peuvent être utilisées pour l'évaluation d'autres systèmes de surveillance des maladies animales.

McDonald, Judy, McLaughlin Centre for Risk Science, Faculty of Medicine, University of Ottawa, Canada

Operational readiness and judgement training for conducting research abroad

Co-authors: Renaud F. Boulanger, Centre for Applied Ethics, McGill University Health Centre, Montreal, QC, Canada; Theresa Gyorkos, Department of Epidemiology, Biostatistics and Occupational Health, McGill University, Montreal, QC, Canada

Co-Authors: J.M. McDonald¹, R.F. Boulanger², T.W. Gyorkos³

1 Faculty of Medicine, McLaughlin Centre for Risk Science, University of Ottawa, Ottawa, ON, Canada

2 Centre for Applied Ethics, McGill University Health Centre, Montreal, QC, Canada

3 Division of Clinical Epidemiology, Research Institute of the McGill University Health Centre, Montreal, Canada

Issue: While regulatory rules help to guide decision-making, they do not preclude good judgment. Training using online tutorials is not sufficient. Those less-seasoned in global health research require more dialogue, direction and focused training to foster a framework to ensure real-time, nimble responsiveness in the field. Based originally on work with Olympic athletes, a mental readiness Model of Excellence has been developed. Using this model, operational readiness studies in high-performance occupations have outlined effective practices that contribute to overall readiness in facing daily challenges. Teaching judgment is not about theories but about following “good” examples (i.e. seeing how someone whose judgment you trust handles difficult situations).

Objective: To examine case studies in the role of preparedness and judgment training for conducting global health research.

Methods: Pooling related operational readiness lessons together with survey data gathered at the 2015 22nd Canadian Conference on Global Health and the Global Health Young Professionals Summit can begin to explore job-specific, readiness skills for global health researchers, including those active in emergency settings. Material from interviews conducted with post-disaster researchers is also drawn upon for triangulation purposes.

Results and Lessons: Students and young professionals in global health defined competencies of exceptional mentors who conduct research abroad. Case studies focused on developing cultural understanding, facing challenges, being vulnerable and feeling confident. Responses highlighted concepts, realities and teaching points to promote preparedness, situational awareness, individual thinking and judgment when conducting research in low-and-middle-income countries. These themes are consistent with the responses and lessons learnt for post-disaster research settings.

Main Messages: Field work abroad, especially through public health emergencies, can involve applying values in different, and sometimes difficult, moral and legal contexts. Insights from experienced researchers may assist in better preparing for challenges in the field. Additional guidance might also be obtained from: a case-study inventory; a code of conduct for operational readiness; and more informed ethics training and evaluation.

MCLEAN, Jeffrey, University of Calgary, Canada

OneHealth focused needs assessment of Maasai pastoralists in the Monduli district of Tanzania

Co-Authors: Jacqueline Bowal, University of Calgary; Lydia Du Toit, University of Calgary; Logan Haynes, University of Calgary; Kelsey Kearns, University of Calgary; Cara van der Merwe, University of Calgary; Marissa Nahirney, University of Calgary; Mairead Whelan, University of Calgary; Jennifer Hatfield, University of Calgary; Elias Nyanza, Catholic University of Health and Allied Science; Jeremiah Seni, Catholic University of Health and Allied Science; Gabriel Shirima, Nelson Mandela - African Institute of Science and Technology; Frank van der Meer, University of Calgary; Karin Orsel, University of Calgary

Issue/problem: Ongoing research of the University of Calgary with Tanzanian partners has been focused on the Ngorongoro Conservation Area (NCA) of Tanzania for the past 8 years. To expand activities, the Monduli district of Tanzania was identified as a potential location for future projects. In collaboration with the Nelson Mandela African Institute of Science and Technology (NM-AIST) a needs assessment was conducted. Human and animal health concerns, sanitation and water availability/quality, and the structure of the health care system were assessed. Through identification and involvement of several local stakeholders different perspectives captured specific local needs.

The objective was to evaluate the potential for developing outreach activities that relate to OneHealth in the Monduli District. Relevant steps towards this Global Health goal included: Partnership building with the NM-AIST through meetings with the Dean, prominent researchers and post-graduate students. Potential locations were visited to meet with stakeholders. The locations included Monduli village, Mfereji and Salela. Stakeholders consulted include medical and livestock officers, district veterinary and health officers, veterinarians and health care workers. Translators attended to facilitate translation in Kiswahili and English.

Results: During meetings an informal discussion guided by animal and human health questions provided priorities for the region. Important themes for human health concerns included: lack of resources, deficiencies in education, limited understanding of health recommendations resulting in low compliance, and the importance of respiratory tract, waterborne, and zoonotic diseases. Discussion about animal health issues identified main concerns as: limited availability of resources, and anthrax and tick-borne diseases were presented as major production limiting diseases. The main concerns relating to water and sanitation were water scarcity during the dry season and sanitation related diseases like diarrhea and cholera. The health care system did not include disease surveillance, which was identified as a necessary addition to get a thorough overview of the health situation.

Lessons: Partnership building is a priority during the development of research projects in low and middle income countries and expanding the consultation to include community members will be needed to develop OneHealth initiatives in the Monduli district. This consultation will provide deeper insight in the challenges that were presented by the relevant stakeholders.

Messages: Collaboration with stakeholders is imperative in determining the feasibility of OneHealth focused initiatives. Continued discussion with stakeholders is essential for all Global Health research projects. Health workers that participated identified common concerns in Monduli district as 'lack of resources', zoonotic diseases and poor sanitation.

MEENA, Umme, United States Agency for International Development (USAID), Bangladesh

Why are eligible families not coming for permanent contraception in rural Bangladesh?

Co-Authors: Imteaz Mannan, Save the Children; Marufa Khan, Save the Children; Abdullah Khan, ICDDR,B; Monirul Ahasar, ICDDR,B; Sabrina Sharmin, ICDDR,B; Munia Islam, Save the Children; Ruksana Yasmin, Save the Children; Sheikh Billah, ICDDR,B; Afsana Karim, Save the Children; Joby George, Save the Children

Issue/Problem: Even though permanent contraception is affordable, safe, and heavily promoted for couples with two surviving children, utilization of permanent contraception services (Non scalpel vasectomy (NSV) and tubectomy) has consistently declined from year to year between 2011 and 2015. USAID supported MaMoni Health Systems Strengthening Project, led by Save the Children, sought to explore the barriers to utilization of service in three districts.

Objectives and Methods: Through government outreach workers, a purposive sample of 42 eligible non-users (men and women eligible for NSV/tubectomy who did not accept the service) were selected for FGD. In-depth key informant interviews (KII) were conducted with 27 Family Welfare Assistants (government outreach workers who counsel women on family planning). A protocol was submitted to the IRB of Jhpiego Corporation, an affiliate of Johns Hopkins University as part of a larger study, and an exemption was granted. Local approval was acquired from the Clinical Contraceptive Service Delivery Program (CCSDP) of Directorate General of Family Planning, Ministry of Health and Family Welfare.

Results: Most respondents relied on pills and injectable contraceptives for birth spacing and family planning. Permanent contraception was deemed appropriate for poor people, and not seen as desirable. Many couples said they used family planning in secret, and privacy was important to them. Some men were not informed on what method their wives were using. Women were more willing to undergo operation than men. The perception that vasectomy led to loss of physical strength and ability to continue manual labor was common. The providers reinforced the same challenges, with several mentioning their continued challenge to have access to women for counseling.

Lessons to date: Women were more willing to undergo operation than men. The perception that vasectomy led to loss of physical strength and ability to continue manual labor was common. The providers reinforced the same challenges, with several mentioning their continued challenge to have access to women for counseling.

Main messages: As the government of Bangladesh is committed to FP2020 and aligning its development goals to achieve the SDGs, increasing new user base, particularly men is a major priority. The national campaigns and strategies need to be reevaluated to popularize LARC and LAPM services and engage men in a meaningful way.

MORAN, Greg, Academics Without Borders, Canada

Building health research capacity in Sub-Saharan Africa

Building research capacity in developing world universities is a key, sometimes overlooked aspect of the broad theme of this conference – Leaving No One Behind: Reflections for Action in a Changing World. Two projects conducted by Academics Without Borders (AWB) in partnership with universities in countries in Sub-Saharan Africa have built health research capacity at a cost and with methods that fit the financial and cultural context of our partners.

In Uganda, Rwanda, Tanzania and Kenya, MicroResearch (MR) is building such capacity in partnership with regional universities and teaching hospitals and Academics Without Borders. The projects teach local interdisciplinary teams of health professionals to find sustainable, community-sensitive solutions for health problems.

Between 2008 and 2016, 27 workshops were conducted at 9 East African sites with 767 participants (47% female), most of whom were qualified doctors, nurses or midwives. By December 2016, 114 workshop teams had been formed, 87 projects submitted, 74 approved for funding, 29 completed, resulting in 24 publications. The MicroResearch education and training principles are now embedded curricula at six African university partner sites. These projects have led to local health care changes, enhanced a culture of inquiry, supported gender equity and built educational and research capacity.

The Aga Khan University programme in East Africa has been upgrading working nurses for the last 10 years in Uganda, Kenya and Tanzania, where numbers of qualified nurses fall far below that necessary to meet regional health needs. AWB has partnered with the AKU School of Nursing and Midwifery in East Africa since 2012. This project sought to support AKU nursing faculty to identify locally relevant research areas and to address the scarcity of community-based research strength in health sciences in the region.

The project faced several challenges among faculty, including the absence of a record of research and publication, limited time available for research activity, a self-image as teacher rather than researcher, very few with PhD qualifications, and very limited resources. The project results include four important lessons learned - 3 positive and 1 negative, an assessment of the sustainability of the project results, and a series of recommendations for next steps towards further strengthening and sustaining nursing research capacity at AKU.

The two cases illustrate AWB's project methodology – most importantly, placing its partners in the developing world at the center of project development, implementation, and evaluation. The projects are owned by AWB's partners.

MULUMBA, Moses, Center for Health, Human Rights and Development, Uganda

perceptions and experiences of access to public healthcare by people with disabilities and older people in Uganda

Introduction: In the year 2000, a set of eight Millennium Development Goals (MDGs) were presented as a way to channel global efforts into the reduction of poverty and the promotion of social development. A global discussion regarding how to renew these goals resulted into the Sustainable Development Goals and it is in this context that the Goals and Governance for Global Health (Go4Health) research consortium conducted consultations with marginalized communities in Asia, Latin America, the Pacific and Africa as a way to include their voices in world's new development agenda. The goal of this paper is to present the findings of the consultations carried out in Uganda with two groups within low-resource settings: older people and people living with disabilities.

Methods: This qualitative study used focus group discussions and key informant interviews with older people in Uganda's Kamwenge district, and with persons with disabilities from the Gulu region. Thematic analysis was performed and emerging categories and themes identified and presented in the findings.

Findings: Our findings show that a sense of community marginalization is present within both older persons and persons living with disabilities. These groups report experiencing political sidelining, discrimination and inequitable access to health services. This is seen as the key reason for their poor health. Clinical services were found to be of low quality with little or no access to facilities, trained personnel, and drugs and there are no rehabilitative or mental health services available.

Conclusion: Uganda must fulfil its international obligations and take progressive measures to meet the right to health for all its peoples, but especially allocate its limited resources to proactively support its most marginalized citizens. The growing impetus within the SDGs is to redress in-country health and other inequalities through a comprehensive systems approach is of importance in the Ugandan development context. This approach reflects the participant's perspectives, which also calls for a more equitable approach to health and development as opposed to a narrow, vertical focus on specific population groups, as was the case with the MDGs.

MUMTAZ, Zubia, University of Alberta, Canada

When sweepers provide maternity care: Is abuse built into the health care system?

Issue/problem: Global maternal health policy recommends skilled birth attendance in facilities as key for safe childbirth. However, it is increasingly recognized that improving access to delivery services does not guarantee better survival. Women and families continue to report experiences of poor quality, disrespectful and abusive care. While some argue that such care is rooted in fractured health systems and wider society, few studies have explored these linkages in depth. The present study sought to provide further insight into factors shaping (dis-)respectful maternal care within one rural community in Punjab, Pakistan.

Objectives and Methods: We conducted a six-month institutional ethnography in two rural health centers, one district hospital and one private practice. We observed facility functioning, 69 patient-provider interactions, and 24 births. We conducted interviews with 18 women postpartum, 25 providers, 5 managers and 67 villagers. Theory-driven analysis focused on disrespectful and abusive behaviour during intrapartum care.

Results: Despite availability of women physicians, nurses, and midwives, most births in study facilities were attended by female sweepers, ostensibly employed to clean the premises. We observed sweepers conducting frequent vaginal examinations with dirty, ungloved hands, applying fundal pressure, forcing patients' legs apart and sleeping on delivery room beds while women with labour pains waited on benches. Though officially unacknowledged, these untrained women provided unsafe and disrespectful care to the majority of laboring women, thereby negating the basic premise of facility-based safe childbirth. The skilled providers - poorly paid and always on-call - avoided birth attendance, considering it 'polluting', inconvenient, and not worth their time. Some preferred to channel patients towards their private practices where the birth was also likely to be attended by an unskilled sweeper/ayah .

Lessons to date: The health system replicated the wider society's hierarchical practices, where attending childbirth is considered polluting and the remit of low caste women. The sweepers, often low caste women, seamlessly merged their caste-based traditional roles of cleaners and birth attendants.

Main messages: Social and gendered hierarchies are being reproduced in the daily operation of health facilities through delegation of 'polluting' tasks, including hands-on intrapartum care, to members of low status groups. When skilled birth attendants defer critical tasks such as intrapartum care to untrained lower status workers, disrespectful and abusive care occurs and the quality of maternal care is compromised.

NABUGOOMA, Josephine, University of Waterloo, Faculty of Applied Health Sciences, School of Public Health and Health Systems., Canada

What will it take to improve the lives of adolescent mothers in rural Uganda? Reflections of adolescent mothers and community stakeholders

Co-Authors: Rhona M. Hanning, University of Waterloo, Faculty of Applied Health Sciences, School of Public Health and Health Systems

Issue/problem: As many as one third of adolescent girls in rural Uganda experience pregnancy and childbirth. These young mothers have disproportionately high rates of poverty, food insecurity, social isolation and poor health, and lack adequate access to education, health care and employment. Community-level action is needed to reverse the cycle of oppression for these girls and their offspring. There was need for a theory-based study that would reveal the evidence of needs of adolescent mothers in Uganda so as to inform further research, interventions, and avenues of capacity building towards enhancing adolescent maternal/child nutrition and health.

Objectives and Methods: This formative research examined, from the perspective of a range of community-level stakeholders, the needs, barriers and opportunities for improved nutrition and health of adolescent mothers. 102 respondents were recruited from target communities by purposive sampling, including adolescent mothers (n=25), family members (n=11), health personnel (n=20), educators (n=16), and area leaders (n=30). Interview questionnaires were based on the broad themes of the SCT, and thematic analysis of translated interview transcripts used Atlas.ti.

Results: The study revealed a range of needs, including education (e.g., practical training in making complementary feeds); love, care, family belonging, trust and encouragement; pre- and post-natal care; and opportunities for self-employment. Barriers included economic access to basic needs, e.g., food, shelter, hygiene products, or services; stigma and mistreatment within care settings; lack of start-up capital and markets for their products. Opportunities were identified for increased education, training and care delivery by village health teams, income skills development and resources through NGOs. Recommendations for capacity building within health, education, vocational training and community support sectors were generated.

Lessons to date: The pace of change for adolescent mothers in rural Uganda seems slow in relation to the economic and social challenges they face. This underpins the importance of research at the community level and the inclusion of knowledge users and decision makers in the process.

Main message: This formative research identified a range of broad and specific needs facing vulnerable adolescent mothers in Uganda. Participants identified feasible first steps to address barriers and build on opportunities to enhance health and well being.

NDAKI, Pendo, Catholic University of Health and Allied Sciences (CUHAS-Bugando), United Republic of Tanzania

Impact of Poverty on Antenatal care Clinic (ANC) Attendance in Misungwi district, Mwanza region North Western Tanzania

Background: Sustainable Development Goals (SDGs) aims at reducing maternal and newborn morbidity. Antenatal clinic visits for at least four times during pregnancy is among the strategies to reach the goal. A Radar Coverage survey conducted in Misungwi district on July 2016 indicated a lower proportion (47%) of mothers who attended the clinic for at least 4 times in their pregnancy period. This was lower than the National reported value of 51%. Misungwi district in Lake Zone has the worst MNCH indicators in the country. The purpose of this sub-study was to explore how poverty affects ANC attendance in Misungwi district.

Objective: The objective of this sub-study was to explore the effects of poverty and social exclusion on ANC attendance in Misungwi district, Mwanza region North Western Tanzania.

Methodology: Cross-sectional study design, explorative qualitative survey that involved 12 FGDs and 7 key informants' interviews of different levels in the health system, Health facilities and community members was involved to collect data on the barriers to ANC attendance. The study was conducted between July-August, 2016. Purposeful by category sampling technique was applied. Data was managed and analyzed using NVivo software.

Results: Four key themes emerged from the FGD and KII. "Long distance" from home to health facility led to low ANC attendance because families could not have money to afford transport. "Time cost at health facility" caused by shortage of health providers in which pregnant mothers had to spend long time at health facility, hungry since they could not afford having food. "Male dominance" caused pregnant women not to attend ANC, they have no decision-making role and financial ownership, depend solely on their husbands. "Lack of ANC education" led women to stay uninformed on why and when they should attend ANC because they cannot afford to attend to the health facility to get information and don't attend community gathering that emphasizes on ANC.

Conclusion: Long distance, time cost at health facility, male dominance, and lack of health education are poverty related issues that caused poor ANC attendance. Building a network of Community Health Workers (CHWs) at each village for health promotion purposes and conduct timely Health facility outreaches might help to might these community challenges.

Key words: Poverty, ANC, Maternal, Newborn and Child Health.

NELSON-PERSONNA, Magalie, Plan International, Canada

Contribution des enfants dans la lutte contre la tuberculose au Sénégal : l'approche « Enfants pour Enfants »

Co-Authors: El Hadji Mamadou Dioukhane, Plan International Senegal; Mamadou Ndiaye, Plan International Senegal; Fatoukine Wathie, Plan International Guinee; Sidi Assalama, Plan International Senegal; Moussa Sarr, Plan International Canada

Enjeu : Le Sénégal a un taux d'infection de tuberculose des plus élevés au monde avec un taux d'incidence de 139 pour 100.000 soit environ 21.000 nouveaux cas chaque année. Les enfants en représentent 15 à 20 %. Près d'un tiers des Sénégalais qui contractent la tuberculose ne sont pas diagnostiqués et ne reçoivent pas de traitement. Parmi les causes de ce faible taux de notification s'inscrit une connaissance limitée de la maladie et de sa transmission. Une emphase a été mise sur le volet communautaire de la lutte contre la tuberculose au Sénégal coordonné par Plan International. Des stratégies innovatrices sont mises en place pour le renforcement des connaissances de différents acteurs communautaires. Parmi celles-ci, Plan International a initié en 2016 la participation active des enfants pour susciter un changement radical et générationnel des comportements et les engager comme relais auprès de leurs communautés. C'est la sensibilisation des enfants par leurs pairs dénommée « Child to Child » (CTC) ou « Enfant pour Enfant »

Objectifs et Méthodologie : Cette approche vise à augmenter les connaissances des enfants sur la tuberculose et les engager dans la lutte. Des connaissances de base sur la tuberculose (signes, diagnostic, traitement et prévention) sont développées chez des écoliers élémentaires et des enfants en situation précaire. Ils élaborent par la suite un plan d'action de sensibilisation contre la maladie à l'école et dans leurs communautés. Ils sont encadrés durant tout le processus par les agents des secteurs santé et éducation et le réseau communautaire.

Résultats : 30 établissements scolaires et 15 daara ont tenu des ateliers de création artistiques sur la TB par les enfants permettant la sensibilisation de leurs pairs et des communautés. Suite au plan d'action des enfants, plus de 15 000 personnes ont été sensibilisées, 1278 cas présumés de tuberculose de moins de 15 ans orientés et 971 enfant-contacts référés.

Leçons à ce jour : L'implication des enfants est une stratégie prometteuse dans la réalisation des Objectifs de Développement Durable. Au Sénégal, ils ont montré des aptitudes réelles dans la lutte contre la tuberculose. Ils représentent des agents de changement de comportement par la sensibilisation de leurs pairs et leurs communautés.

Conclusion : La contribution de cette approche innovante est significative dans la sensibilisation et l'orientation des cas présumés de tuberculose au Sénégal. Les initiatives auprès des enfants scolarisés ou non devraient être promues à grande échelle dans la promotion de la santé pour tous.

NGOLOLE, Florence, National Institute for Biomedical Research, Democratic Republic of the Congo

Le déni de la Maladie à Virus Ebola traduit un sentiment d'exclusion des populations touchées

Co-Authors: Justin Masumu, UPN

L'analyse des aspects socioculturels dans le contrôle des maladies est en train de prendre de plus en plus d'ampleur depuis que l'on s'est rendu compte de l'importance de l'implication de la communauté lors de la surveillance et même pendant la riposte contre certaines maladies dites à potentiel épidémique. Parmi ces maladies, la maladie à virus Ebola est intimement liée en amont tout comme en aval aux implications socioculturelles avec des conséquences graves. L'une de ces conséquences demeure l'exclusion sociale des personnes infectées et affectées ainsi que leurs membres de famille. Dans cette étude, nous avons utilisé une approche documentaire en recherchant, dans la littérature, des données relatives aux implications socioculturelles de la maladie à virus Ebola durant les épidémies précédentes qui sont survenues en République Démocratique du Congo. Nos recherches ont révélé que les comportements positifs à adopter et à maintenir lors de l'épidémie de la MVE dans le but de réduire la propagation de la maladie y égard aux us et coutumes de la communauté atteinte sont souvent mis à défi par la communauté elle-même. Ainsi, dans beaucoup de cas, il se dégage un sentiment de rejet de toute stratégie de lutte qui va à l'encontre des pratiques culturelles voir les habitudes de la communauté. Il se dégage que le déni d'Ebola parmi les populations touchées par l'épidémie exprime une révolte de leur part et un sentiment d'exclusion plutôt qu'un refus des stratégies de riposte mise en place dans la lutte contre cette maladie. Comme conséquence, les communautés bafouent les techniques communicantes, les bonnes pratiques à adopter lors de l'épidémie, tout comme un «déni persistant» et le non-respect de l'avis des personnels de la santé. Cette même attitude a été remarquée en Afrique de l'ouest notamment en Sierra Leone, Guinée et Libéria. Pire encore, les méthodes mise en place pour arrêter la propagation de la maladie bloquent les communautés à consolider leur lien social. Et cela à pour conséquence une manifestation extrême et parfois l'aboutissement de différents processus de fragilisation des stratégies d'intervention mise en place. De nos investigations, il se dégage qu'en aval du contrôle de la maladie, il y a nécessité de développer de bonnes stratégies de communication sociale qui réintègrent les personnes touchées par la maladie dans la société. Comme leçon, nous retenons qu'il est impossible de trouver une solution durable à un problème de santé des communautés sans tenir compte de leur environnement culturel.

NHLEMA, Basimenye, Partners In Health - Malawi, Malawi

Leveraging implementation for impact evaluation: studying an integrated Community Health Worker model in rural Malawi

Co-Authors: Basimenye Nhlema, Partners In Health - Malawi; Ravi Gupta, Partners In Health - Malawi; Elizabeth Dunbar, Partners In Health - Malawi; Chiyembekezo Kachimanga, Partners In Health; Luckson Dullie, Partners In Health - Malawi; Katie Cundale, Partners In Health - Malawi; Lawrence Nazimera, Malawi Ministry of Health

Issue: Since 2007, Partners In Health (PIH), working with the Ministry of Health in Malawi's impoverished Neno District, has employed Community Health Workers (CHWs) to support HIV and TB patients. Though generally accepted to contribute to superior HIV outcomes in Neno, the impact of CHWs has not been measured. In 2016, to work toward Universal Health Coverage (UHC), the 'Household Model' was developed. Instead of assignments to HIV/TB patients, this polyvalent approach assigns CHWs to every household. Given this large program shift, we saw opportunity to design a rigorous and innovative study to investigate the impact of the Household Model.

Objectives/Methods: Using a stepped-wedge, cluster-randomized design—to allow for staggered trainings and estimation of causal effects—we investigate whether high HIV retention rates can be replicated for non-communicable diseases, and the Model's impact on TB and pediatric malnutrition case-finding, and uptake of family planning and antenatal care. Eleven facility catchment areas, population approximately 122,395, are arranged geographically into six clusters. Based on third party randomization, each cluster will cross over to the intervention. Clinical outcomes are based on routine data, and the research design includes: a) process data to measure fidelity of the intervention; b) financial data; and c) semi-structured qualitative interviews assessing community perceptions and CHW roles in social trust and capital.

Results: The opportunity for a rigorous impact evaluation triggered a comprehensive planning process for Household Model rollout. We created an extensive 'toolkit' geared toward CHW professionalization, including: training materials and skill-based competencies, job descriptions and aids, selection and supervision procedures, and data processes. Trainings commenced in January 2017, and the first cluster of CHWs began routine home visits in March, providing case finding, linkage to care, support for existing patients, and health education.

Lessons to date: The rigor associated with the Household Model research methods highlighted the importance of comprehensive planning and identified key procedural and documentation gaps. We identified several key components: meticulous methodology for training and evaluation; well-articulated CHW selection and supervision strategies; and a simple, yet methodical monitoring and evaluation plan.

Main Messages: Integrated CHW models may play a key role as countries with limited resources work to address broad burdens of disease. With diligent planning focused around professionalization of CHWs, it is possible to design programs to support efforts toward UHC, and in doing so, balance implementation with rigorous impact evaluation in order to maximize learning around clinical outcomes, societal benefit, and cost-effectiveness.

NSIO, Justus, Direction de Lutte contre la Maladie, Ministère de la Santé Publique, Democratic Republic of the Congo

Engagement communautaire dans la gestion des urgences de santé publique

Co-Authors: Noriaki Ikeda, Ministère de la Santé Publique, RD Congo; Gisèle Mbuyi, Direction de Lutte contre la Maladie, Ministère de la Santé Publique, RD Congo; Matthias Mossoko, Direction de Lutte contre la Maladie, Ministère de la Santé Publique, RD Congo; Stève Ahuka, Institut National de Recherche Biomedicale, RD Congo; Justin Masumu, Institut National de Recherche Biomedicale, RD Congo; Benoit Kebela, Direction de Lutte contre la Maladie, Ministère de la Santé Publique, RD Congo; Raymond Mufwaya, Agence Japonaise de Coopération Internationale (JICA), RDC

La surveillance épidémiologique porte le défi de détecter à temps les menaces et d'y riposter. En République Démocratique du Congo (RDC), elle est essentiellement réalisée en routine au niveau des structures sanitaires, suivant une approche syndromique de définition des cas à déclaration obligatoire et hebdomadaire, comme la Maladie à Virus Ebola (MVE). Dans un contexte de faible utilisation des services sanitaires (20-40%), cette surveillance passive est renforcée par l'implication communautaire au premier plan, dans une approche porte à porte et village par village. Ce système de surveillance est monté autour de l'Infirmier Titulaire (IT) du Centre de Santé (CS) qui supervise chaque relai communautaire (RECO) responsable de 10-20 ménages de son aire de santé (AS). Son efficacité lors de dernières flambées et le raccourcissement de l'intervalle de survenue des épidémies MVE interrogent sur le niveau de préparation de la surveillance à base communautaire.

L'étude menée par le Ministère de la Santé Publique (RDC) en période non épidémique, entre décembre 2015 et juin 2016, a évalué le système de surveillance dans 32 zones de santé à risque MVE. L'étude s'est entre autres focalisée sur les communautés de 72 aires de santé tirées aléatoirement de 82 centres de santé dont elles dépendent.

Les résultats montrent que chaque AS (100%) a des RECO actifs (15 en moyenne) et un comité de développement de santé (CODESA), à travers lequel la communauté participe activement aux activités de surveillance épidémiologique (90,3%) telles que : la sensibilisation/mobilisation/communication (100%) ; les visites à domicile (97,2%) ; les réunions (86,2%) ; l'orientation et/ou accompagnement de cas (84,7%) ; la recherche active des cas (77,7%) ; la distribution des intrants (56,9%). La non participation aux activités de surveillance épidémiologique se justifie principalement par le manque de connaissances et/ou l'absence de formation en la matière (66,6% formés les 12 derniers mois et 30,5% disposant de la définition communautaire de cas). Toutefois, 95,8% affirment avoir entendu de MVE et 11,1% déclarent avoir connu un phénomène ayant fait penser à la MVE les 12 derniers mois.

Le modèle basé sur l'implication communautaire dont le mérite a été reconnu dans la riposte à la MVE en RDC tire principalement sa force dans le dispositif de surveillance communautaire déjà en place en période non épidémique. Elle nécessite d'être renforcée, notamment à travers la formation des relais communautaires volontaristes en place, véritable atout pour la résilience du système de surveillance dans les pays fragiles.

OLATUNDE, Oluwasayo, Dalhousie University, Canada

Traditional birth attendants and non-conventional abortion practices among adolescents in Ibadan, Nigeria

Co-Authors: Olajide Ojo, University of Ibadan; Olusola Olufemi, Society for Good Health Nigeria

Unsafe abortion is a leading contributor to maternal morbidity and mortality in Nigeria. Because the highest rates of induced abortions occur in adolescent girls, they are at increased risk of unsafe abortions and associated ill consequences. Globally, an estimated 21.6 million girls and women undergo unsafe abortions each year. An abortion deemed as unsafe can be one that is induced in unhygienic settings, using non-medical tools and substances, or administered by an unskilled provider. Unsafe pregnancy terminations often result in complications ranging from injury, infection, haemorrhage, and death. In Nigeria, the abortion rate for unintended pregnancy approaches 56%, amounting to an estimated 1.25 million girls and women having abortions in 2012 alone, out of which 32% are adolescents.

Amidst legal, cultural, and social constraints, adolescents may resort to clandestine abortions, outside of formal health facilities and from unskilled providers such as traditional birth attendants (TBAs). With 1 out of 4 Nigerian females of reproductive age being an adolescent, efforts to safeguard girls from dangerous abortions will minimize avoidable disability and death. The proposed research will be undertaken in the city of Ibadan in south west Nigeria. It will explore the factors influencing adolescents to seek unsafe abortions outside of health facilities and from unskilled providers. The global health significance of the topic is in relation to guaranteeing universal access to sexual and reproductive health services.

A pilot study to investigate the factors influencing adolescent response to unintended pregnancy in Ibadan, Nigeria will be conducted. The objectives are to identify social, economic, and cultural determinants of adolescent abortion; determine adolescent perceptions and management of unintended pregnancy; and determine the extent of adolescent unsafe abortion with TBAs. To achieve these objectives, a cross-sectional research design will be adopted. A non-probability sampling method will be used to sample the populations of interest (adolescent girls and TBAs) across traditional urban areas of Ibadan. Interviews with semi structured questionnaire will be used to elicit information from 75 selected adolescent girls. Two focus group discussions (FGD) will be used to elicit information from TBAs.

The results of this study are preliminary. Its findings are expected to assist in developing strategies to inform reproductive and sexual health policy and programmes aimed at reducing unsafe abortion and improving access to sexual and reproductive health services in Ibadan, Nigeria and other parts of the world where this practice is still prevalent.

PANDAY, Sarita, GreenTara Nepal, Nepal

The contribution of female community health volunteers (FCHVs) to maternity care in Nepal: a qualitative study

Issue/problem: In resource-poor settings, the provision of basic maternity care within health centres is often a challenge. Despite the challenges, Nepal reduced its maternal mortality ratio by 80% from 850 to an estimated 170 per 100 000 live births between 1991 and 2011 and achieved the Millennium Development Goal 5. One group that has been credited for this achievement is community health workers, known as Female Community Health Volunteers (FCHVs) who form an integral part of the Nepalese public healthcare system. This qualitative study explores the role of FCHVs in maternal healthcare provision in two regions (the hill and terai). Between May 2014 and September 2014, 20 FCHVs, 11 health workers and 26 service users were purposefully selected and interviewed using semi-structured topic guides. In addition, four focus group discussions were held with 19 FCHVs.

Results: All FCHVs reported that they provided key health messages to local women through regularly held mothers' group meetings and referred them for health checks. The FCHVs were particularly serving to the most disadvantaged section of the society. Both service users and health workers credited FCHVs for their activities in improving maternal health in rural areas. The main difference between the two study regions was the support available to FCHVs from health centres. With regular training and access to medical supplies, FCHVs in the hill villages reported activities such as assisting with childbirth, distributing medicines and administering pregnancy tests. They also reported the use of local innovative approaches such as singing songs containing health messages and visiting mothers with food hampers. Such activities were not reported in the flatland region. In both regions, a lack of monetary incentives was reported as a major challenge followed by a lack of education of FCHVs.

Lessons: Our findings suggest that FCHVs, supported by health centres with emphasis on the use of local approaches, have the potential to deliver basic health for the most vulnerable groups and promote health-seeking behaviour so that serious delays in receiving healthcare could be minimised. However, FCHVs need to be reimbursed and provided with educational training in order to ensure that they work effectively. This study offers relevance of community health workers in resource-poor settings and has potential application in similar parts of the globe.

Main messages: FCHVs supported by government healthcare system are a key to delivering basic healthcare at remote villages. However, they need education & monetary incentives to function effectively.

PANESAR, Sonum, University of Calgary, Canada

Analysis of global health and global health governance academic literature through the lens of the social situation of disabled people

Co-Authors: Gregor Wolbring, University of Calgary

Issue/problem: Global health governance is concerned with equality and justice. Disabled people are encountering global health issues and have a vested interest in global health governance. Participatory action research (PAR) is often used in the contexts of health, inequity, impoverishment and marginalization and can be useful for empowering disabled people [1].

Objectives and methods: The objectives of this study were determining how the “global health” and “global health governance” academic literature covers disabled people, and determining how this academic literature covers “participatory research” (PR) and “PAR”. Three academic databases EBSCO ALL, Scopus, and Web of Science were searched September 2016, February, March and May 2017 for the presence of the terms “disabled people”/“people with disabilities” in articles that contained the term “global health” in their abstracts. The found articles were downloaded and qualitatively analyzed using ATLAS.ti7©. “

Results: Of the n=39357 documents found with abstracts mentioning “global health” n=38 articles contained “disabled people”, of which n=1 mentioned “PR” and n=0 mentioned “PAR”. N=138 articles mentioned “people with disabilities”, n=2 of these mentioned “PR” and n=1 mentioned “PAR”. N=3 articles mentioned “disabled people”, of which n=0 mentioned “PAR”/“PR”. N=14 articles mentioned “people with disabilities”, of which n=0 mentioned “PAR” and n=2 mentioned “PR”.

N=830 articles mentioned “global health governance” in their abstracts, of which n=3 mentioned “disabled people” and n=4 mentioned “people with disabilities”. N=0 of these articles mentioned “PAR”/“PR”.

We will also provide results of the content analysis of the positive articles at the conference, combined with the hit count results.

Lessons to date: The “global health” and “global health governance” academic literature rarely covered disabled people, and even less so in relation to PR/PAR. The articles that mention “global health” in conjunction with “disabled people”/“people with disabilities” highlight many global health issues disabled people experience, which we posit, deserve more coverage

Main messages: Nearly excluding disabled people from the “global health” and “global health governance” academic literature perpetuates the social marginalization and global health barriers disabled people face. It also negates the fact that disabled people have a vested interest in PAR and diminishes their chances of being involved in PAR. We posit that disabled people may be left behind while global health progresses.

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PENSA BRANCO, Michelle, SafelyFed Canada, Canada

Nurtured through the storm: infant feeding in emergencies

While much Infant and Young Child Feeding in Emergencies (IYCF-E) policy has focused on preparedness and capacity-building in low- and lower-middle-income countries, middle- and high-income countries are increasingly facing both natural and man-made disasters, along with welcoming sudden inflows of displaced populations, such as in the current European refugee crisis. Infants and young children are recognized as a uniquely vulnerable population in emergencies requiring special care and attention, but middle and high income countries do not have adequate policies and plans in place to serve to address IYCF-E. The World Breastfeeding Trends Initiative (WBTI) scorecard has consistently identified IYCF-E preparedness as very weak, particularly in high income countries such as the United Kingdom and the United States.

What is frequently obscured by the overall weakness of policy and planning in this area is the special vulnerability of populations who lack the social and financial resources to make up for what governments have not prepared to provide for. Families facing food and income insecurity prior to a disaster are less able to use personal resources to secure appropriate foods for their infants and young children or to obtain sheltering that meets their needs for privacy and safe food preparation. While all families face stress and uncertainty in emergency situations, parents who lack the financial, social and/or psychological resources to mitigate the impacts of the disruption of their normal daily life are especially vulnerable. In practice, IYCF-E crosses the boundaries of several areas of responsibility (health, social services, protection) and thus it is especially critical to ensure that all emergency responders have a minimum of training and that appropriate policies are in place to inform action when disaster occurs.

This workshop will provide context around best practices for IYCF-E, based on the Infant Feeding in Emergencies (IFE) Core Group Interim Operations Guidance as well as the Sphere Guidelines. Through the use of case studies and interactive group exercises, participants will learn:

- The key principles of IYCF-E in the areas of Health, Nutrition, Protection, Shelter and WASH
- Application of the Sphere Guidelines and the International Code on the Marketing of Breastmilk Substitutes
- Challenges of IYCF-E planning and delivery in the middle- and high-income context, particularly for populations already at-risk

The workshop will include presentation by the facilitators to provide foundational concepts. In several small group exercises, participants will deepen understanding of the key principles through case studies and problem-solving presented back to the group. This will also increase awareness of the participants own knowledge gaps and strengths. The room will be set out with central screen and microphone (no podium or raised stage) and tables for 4-6 participants who will each form a workgroup. There will be one travelling microphone. Each table will include handouts for participants and written instructions for group exercises.

Before the workshop, most participants will know that infants and young children are a particularly vulnerable group in emergencies. After the workshop, participants will understand:

- How IYCF-E is different than IYCF: what are the key interventions that make a difference
- Why middle and high-income countries are largely so poorly prepared and how that disproportionately impacts populations with existing food and income insecurity
- What individual organizations, communities and governments need to put into place to ensure a minimum standard of care and safety for infants and young child feeding during disasters

PÉREZ, Myriam Cielo, Université de Montréal, Canada

Implementation fidelity assessment in cluster-randomised trials of public health interventions in low- and middle-income countries: systematic review

Introduction: Cluster randomised trials (CRTs) are a key instrument to evaluate public health interventions. Fidelity assessment examines study processes to gauge whether an intervention was delivered as initially planned. Evaluation of implementation fidelity (IF) is required to establish whether the measured effects of a trial are due to the intervention itself and may be particularly important for CRTs of complex interventions conducted in low- and middle-income countries (LMICs). However, current CRT reporting guidelines offer no guidance on IF assessment. We examined current IF assessment practices within CRTs of public health interventions in LMICs.

Methods: We included CRTs of public health interventions in LMICs that planned or reported IF assessment in either the trial protocol or the main trial report (or an associated document). Search strategies used Medical Subject Headings (MESH) and text words related to CRTs, developing countries, and public health interventions. The MEDLINE/PubMed, CINAHL, and EMBASE databases were queried, to identify CRT reports in English, Spanish, or French published on or after January 1, 2012. To ensure availability of a study protocol, we included CRTs reporting a registration number in the abstract. For each included study, we compared planned versus reported assessment of IF, and recorded the dimensions of IF studied, and data collection methods used to evaluate each dimension. Risk of bias for individual studies was assessed using the Cochrane Collaboration Risk of Bias Tool criteria.

Results: We identified 90 CRTs of public health interventions in LMICs with a study protocol in a publicly available trial registry published from January 2012 to May 2016. Among these 90 studies, 25 (28%) did not plan or report assessing IF. The remaining 65 studies addressed at least one IF dimension; however, only three study protocols (5%) and ten main reports (15%) evaluated all four key fidelity components (content, coverage, frequency, duration). The proportion of overall agreement between the protocol and trial report concerning occurrence of IF assessment was 74%. Most studies had low to moderate risk of bias.

Conclusions: Fidelity assessment is not currently a systematic practice in CRTs of public health interventions carried out in LMICs. In the absence of fidelity assessment, it may be difficult to determine if CRT results are due to the intervention design, to its implementation, or to unknown or external factors that may influence results. In order to improve the internal validity and generalizability of trial findings, CRT reporting guidelines should promote IF assessment.

PIGEON-GAGNÉ, Émilie, Université du Québec à Montréal, Canada

Les représentations sociales de la maladie mentale au Burkina Faso : résultats préliminaires d'une étude ethnographique critique.

Co-Auteurs: Maurice Yaogo, Université Catholique de l'Afrique de l'Ouest; Ghayda Hassan, Université du Québec à Montréal

À ce jour, très peu de travaux de recherche se sont penchés sur l'expression de la maladie mentale dans des contextes socioculturels non-occidentaux limitant grandement la capacité des systèmes de santé de prendre en charge les conditions psychiatriques adéquatement dans ces contextes. Dans les pays à faible revenu et plus spécifiquement dans les pays de l'Afrique sub-saharienne, de nombreux déterminants sociaux, culturels, économiques, politiques et historiques limitent l'accessibilité aux soins de santé mentale. La présente étude s'intéresse à mieux comprendre, dans une perspective émic, quelles sont les conceptions socialement partagées de la « folie » ainsi que les représentations des « malades mentaux » au Burkina Faso dans le but de mieux comprendre l'exclusion sociale et les mauvais traitements vécus par ces derniers. Un total de 7 focus groups et de 15 entrevues individuelles - portant sur les perceptions de la maladie mentale, sur l'exclusion et sur les conditions de vie des individus avec un trouble mental - a été mené dans la ville de Bobo-Dioulasso auprès de membres de la communauté, de professionnels de la santé mentale et d'individus ayant un trouble mental. Les données obtenues ont été soumises à une analyse thématique. Nous avons été en mesure d'identifier trois principales conceptions de la maladie mentale : 1) la maladie mentale comme maladie organique, 2) la folie comme maladie spirituelle, et 3) la folie comme construction sociale. Nous avons identifié dans le discours des participants les causes associées à chacune de ces catégories populaires : l'exclusion sociale, les transgressions morales, la possession par un être surnaturel, la consommation de drogue, la pauvreté, etc. Cette présentation explicitera les modèles explicatifs de la maladie les plus fréquents et se conclura sur une réflexion quant aux possibles pistes d'actions pour améliorer la prise en charge et l'inclusion sociale des gens ayant des troubles mentaux dans ce contexte socioculturel (et possiblement dans des contextes africains similaires).

PRASHAD GAUTAM, Om, WaterAid Canada, Canada

An opportunity not to be missed: Hygiene Behaviour Change for Mothers and Newborns through Routine Immunization Programs

Co-Authors: Om Prasad Gautam, WaterAid UK; Yael Velleman (yet to be confirmed), WaterAid UK; Roma Chilengi, Center for Infectious Disease Research, Zambia; Senendra Raj Upreti (yet to be confirmed), Ministry of Health and Population, Government of Nepal

Diarrheal diseases are preventable. Yet globally, diarrhea, mostly caused by lack of safe drinking water, sanitation and hygiene (WASH), remains a leading cause of death among children under 5. Tragically for the 1 in 5 babies who die in their first month in the developing world, just being washed in clean water and cared for in a clean environment by people who had washed their hands could have prevented their untimely deaths.⁷

The World Bank states that hygiene promotion is one of the most cost effective health interventions and yet, to date, there remains a lack of interventions guided by behavioural science theory in support of hygiene behaviour change.⁹ Major advances in treating diarrheal diseases have been made, however, prevention remains challenging due to failures to increase access to WASH in areas with high disease burden. If everyone, everywhere practised good hygiene, the number of diarrheal deaths would be cut by 23%.⁸

Handwashing with soap alone can reduce childhood diarrhea by 30-47%,⁴ yet innovations for hygiene and sanitation promotion are largely ignored in favour of more complex and costly infrastructure schemes for sanitation and water. Hygiene is the often forgotten pillar of WASH that is essential to improving maternal and child health and reducing diarrheal disease.

Since 2009, the World Health Organization (WHO) has recommended rotavirus vaccination, a dominant cause of severe diarrheal disease in young children, as a routine immunization. While beneficial, the focus on vaccine solutions for diarrhea raises a concern of decreased emphasis on WASH as an essential measure for prevention. As such, preventing diarrheal disease remains challenging in areas of high disease burden due to failures to increase access to WASH.

Furthermore, evidence suggests that oral vaccines, including the rotavirus vaccine, have weakened efficacy if the vaccinated person is experiencing WASH-related enteric infections such as diarrhea and environmental enteric dysfunction (EED). EED is a chronic disorder of the small intestine that affects nutrient absorption in people living without basic sanitary facilities and are chronically exposed to faecal contamination. EED in infancy and childhood can lead to stunted growth and lifelong deficiencies in health and development.

GAVI, the Vaccine Alliance, estimates that, at the end of 2015, 36 million children globally had been vaccinated for rotavirus. WHO found that in societies where women are held in lower status, both boys and girls are less likely to be immunized due to lack of access to health services and vaccinations.⁵ Further, the WHO's Strategic Advisory Group of Experts on vaccines and immunisations has recently highlighted that there are "opportunities to link prevention and control efforts for these diseases, which will complement broader goals of improving living conditions, sanitation and access to safe water."² Established national immunization programs provide a key opportunity to engage mothers in hygiene behaviour change at the most vulnerable time in their child's life.

An initial 2012 study undertaken by WaterAid and the Hygiene Centre at the London School of Hygiene and Tropical Medicine, jointly funded by WaterAid and the Sanitation and Hygiene Applied Research for Equity (SHARE) DFID-funded consortium, explored feasibility of new and innovative approaches for hygiene promotion in Nepal. Nepal was selected geographically due to its high diarrheal disease burden, low levels of water and sanitation coverage and experience in successful implementation of immunization programmes. Also in 2012, Nepal's National Committee on Immunization Practices (NCIP) concluded that 'vaccine introduction for enteric vaccines (rotavirus, typhoid, cholera) should be one component of an integral child health program to decrease morbidity and mortality from diarrheal disease, including safe water, hygiene, sanitation, nutrition and integrated management of childhood illness.'

The study concluded that incorporating hygiene promotion interventions into immunization programmes is feasible and acceptable to stakeholders and the challenges were how, not whether, to proceed.¹ This assertion has now been further strengthened through formative research, creation of an innovative hygiene promotion package and the delivery and evaluation of a pilot program in Nepal through 2016/2017. Research and evaluation continues to assess the double dividend of creating a culture of positive hygiene behaviour for new mothers and infants while improving uptake and efficacy of vaccination programs.

Such innovation to integrating hygiene behaviour change and routine vaccinations has the potential to provide a holistic approach to mitigating diarrheal disease and improving child health.

This symposium will provide an opportunity to hear from experts in the fields of immunization, WASH and behaviour change. It will provide both a research perspective on innovations to integrate hygiene promotion at the time of immunizations and a practical case study from Nepal. In addition, it will highlight the opportunities and challenges for financing, governance, implementation and measurement of results of the approach. There is good reason to scale up hygiene as best practice in immunization programs – this symposium will help to demonstrate how it can be done based on experience in Nepal.

Learning Objectives:

- The role hygiene and sanitation play in disease burden, vaccine efficacy and reducing diarrheal disease in children.
- The behavioural science behind using routine vaccination programs and vaccine campaigns as an entry points for hygiene behaviour change informed by behavioural science.
- The opportunities and challenges of scaling up hygiene interventions as best practice and
- The role of stakeholder engagement and financing mechanisms to ensure program sustainability and success.

Expected Topics & Session Format:

The session will include a panel of 4-5 specialists (to be confirmed) in the area of WASH, hygiene behaviour change, health, vaccinology and health governance. Each speaker will provide a short presentation followed by a moderated discussion among the panelists along with a question and answer with participants. The expected topics to be covered by the panelists include:

1. Hygiene behaviour change informed by behavioural science theory.
2. Influence of WASH conditions on environmental enteric dysfunction (EED), diarrheal disease and maternal and newborn health.
3. Vaccine efficacy and the rotavirus vaccine.
4. Using national routine immunization programs as an entry point for hygiene behaviour change of mothers and newborns for a holistic approach to reducing diarrheal disease.
5. Case study of Nepal's scale up of hygiene behaviour change via the national immunization program.

Main Messages:

- 1) Hygiene behaviour change, the often forgotten pillar of WASH, is an essential element to improving maternal and child health and reducing diarrheal disease.
- 2) Established national immunization programs provide a key opportunity to engage mothers in hygiene behaviour change at the most vulnerable time in their child's life.
- 3) Integration of hygiene behaviour change with routine immunizations provides the 'double dividend' of creating a culture of positive hygiene behaviour for new mothers and infants while improving uptake and efficacy of vaccination programs.

PUNJANI, Neelam, Aga Khan University, Pakistan

Public health issue: Unsafe abortions

Problem: Unsafe abortion remains a neglected public health issue in Pakistan, even though thousands of women each year suffer, and sometimes die, from its consequences. Current evidence shows that the average Pakistani woman will have one abortion in her lifetime. Abortion is legal in Pakistan to save the woman's life or to provide "necessary treatment," however; safe abortion and post abortion care services are often inaccessible due to lack of knowledge, stigmatization, and lack of women friendly services.

Purpose: The purpose of this project was to sensitize young nurses/midwives and doctors who are providing abortion services to visualize abortion through gender lens and in turn motivate them to provide more women centered and right based care.

Methodology: To meet the objective advocacy programs were conducted in community setting targeting 20 young service providers of major medical institute. Pre-test survey of the program was followed by in-depth interview was done with some participants at their work place after few months of advocacy program. Advocacy meeting was also organized with the faculties and members of the curriculum with a focus on including a chapter in gender, rights and safe abortion.

The post test survey showed the increase level of knowledge to 80% among participants about abortion. In-depth interviews from participants revealed change in attitude about abortion stigma and increase awareness in providing more sensitive care to women seeking abortion.

Lessons to Date: Complications from unsafe abortions cause a serious global threat to women's health and lives. Therefore, advocacy to raise awareness on abortion and making it legal can prevent women from seeking unsafe abortions. Also, adding the topic of gender, rights and safe abortion in nursing, midwifery and medical education curriculum will make a difference in health care workers attitude.

Main Message: Abortion care is not yet a fully integrated or accepted part of midwifery and nursing. Therefore, advocacy trainings for health care workers are important tool that may influence policy and clinical practice and eventually increase numbers of abortion providers and reduce one barrier to women's access to safe abortion.

Purohit, Bhaskar, UQ School of Public Health, India

Opening the black box of transfer systems in public sector health services in a Western state in India

Issue: Limited research on Posing and Transfer (P&T) suggests that P&T policies and systems are either non-existent, weak, poorly implemented or characterized by corruption. Hence the current study aimed at opening the “black box” of P&T systems in public sector health services in India by assessing the implementation gaps between P&T policies and their actual implementation.

This was a qualitative study carried out in Department of Health, in India. To understand the extant P&T policies, a systems map was first developed with the help of document review and Key Informant (KI) Interviews. Next systems audit was carried out to assess the actual implementation of transfer policies by interviewing Medical Officers (MOs), the group mainly affected by the P&T policies. Job histories were constructed from the interviews to understand transfer processes like frequencies of transfers and to assess if transfer rules were adhered. The analysis is based on a synthesis of document review, 19 in-depth interviews with MOs working with state health department and five in-depth interviews with Key Informants (KIs). Framework analysis approach was used to analyze data using NVIVO.

Results: The generic transfer guidelines are weakly implemented indicating a significant gap between policy and actual implementation. The formal transfer guidelines are undermined by a parallel system in which desirable posts are attained, retained or sometimes given up by the use of political connections and money. MOs’ experiences of transfers were marked by perceptions of unfairness and irregularities reflected through interviews as well as the job histories.

Lessons: The generic transfer rules and ambiguity in how transfers are treated may explain the discrepancy between policy and implementation leading to systems abuse possibly having negative influence on MOs’ morale which could in turn affect distribution of MOs. Where possible, ambiguity in the rules should be avoided and a greater transparency on implementation of the transfer rules is needed. However, it may not be possible to make any significant improvements to P&T policies and how they are implemented until the external pressure that creates parallel systems is greatly reduced in translating HR policy into HR practice.

Main Message: Effective P&T policies and implementation may have important implications for organizational performance and may help to improve Human Resource (HR) policy and HR expertise. However, it may not be possible to make any significant improvements to P&T policies and how they are implemented until the external pressure that creates parallel systems is greatly reduced.

RUDRUM, Sarah, Acadia University, Canada

Male circumcision and social inclusion

Voluntary medical male circumcision is currently being promoted as an HIV prevention strategy in 14 sub-Saharan African countries that have high rates of HIV but low existing rates of circumcision. This intervention has been promoted by the WHO as part of an HIV strategy since 2007, based on evidence that circumcision reduces female-to-male transmission of HIV by 50-60% (Auvert et al., 2005; Bailey et al., 2007; Grey et al., 2007). Based on a discourse analysis study of the promotion of voluntary medical male circumcision in sub-Saharan Africa that focused on how circumcision is positioned in relation to behavioural interventions and gender relations, carried out in 2016-2017, this talk considers circumcision in relation to the conference theme, “poverty and social inclusion”. One important aspect of social inclusion is gender equity. Public health campaigns for male circumcision often imply a direct protection to women, despite the fact that, unlike other HIV prevention strategy, circumcision only directly protects the male partner. As well, the campaigns tend to promote circumcision as a route to male virility and attractiveness in ways that valorize ideologies of sex that contribute to women’s inequality, such as a view of intercourse as sexual conquest. The gendered nature of circumcision promotion will be explored with examples from the campaigns and evidence from the literature on HIV prevention strategies, making the case that where gendered inequities are reinforced via campaign materials, prevention for both men and women is likely to suffer. In relation to the push for Universal Health Coverage as a means of addressing poverty, I will discuss particular ways in which the approach to circumcision roll-out represents an avoidance of investing in equitable health care coverage. In particular, I argue that the challenge of rolling out a large-scale surgical intervention in countries with inadequate health systems has been sidestepped. This has occurred in two-ways: the reliance on international employees and organizations instead of investing in local health care infrastructure, and the introduction of a non-surgical circumcision tool. This tool, branded as the Shang Ring, means that the procedure can be offered by less-skilled health care workers than the conventional procedure. This innovation offers some advantages, but also demonstrates a strong attachment to vertical over horizontal approaches to global health challenges. I make the case that for universal health coverage to succeed, public health actors addressing disease-specific challenges such as HIV need to recognize its value and strategize accordingly.

SALUJA, Deepika, Indian Institute of Management Ahmedabad, Gujarat, India, India

Role of CHWs in India's attempt towards UHC: Evidence from India's National Health Insurance Program's implementation

Introduction: Community Health workers (CHWs) have played a crucial role in the design and delivery of health services at multiple levels of development across different parts of the world, most importantly in voicing the healthcare needs of the communities to the authorities. Through the operationalization of National Health Mission in India, CHWs have played an instrumental role in reducing maternal and infant mortality rates in specific and several other health outcomes in general.

Purpose: The question is no longer whether CHWs can be key agents in improving health outcomes, they are; rather it's how can their full potential be realized. This study attempts to understand the role of these CHWs in implementing India's largest health financing scheme and suggest how they can be better utilized in achieving the larger policy objectives.

Methods: One of the important processes in the implementation of the scheme- the enrolment process involving CHWs for outreach activities and monitoring purposes has been observed in detail. The study employs a mix of various qualitative tools like in-depth interviews with several stakeholders, field observations at the enrolment stations and reviewing several policy documents and other artifacts.

Results: The study reveals that on paper CHWs are assigned roles and responsibilities beyond their capacities, and no mechanism exists to ensure that they really understand their responsibilities. Issues of role ambiguity, lack of awareness and/or understanding of the assigned tasks, accountability deficits and accountability overload were found to be prominent in the field. The capacity building exercises conducted for these CHWs explaining what they are supposed to do, were found to play merely a symbolic role like an item checked in the to-do list.

Conclusion: The success of a programme is significantly determined by how efficiently its implementation is carried out, thereby putting a greater responsibility on the people who become the face of the policy to its citizens. CHWs being a significant component of the implementation team, their capacity building becomes all the more important while taking into consideration the multiplicity of tasks they are expected to do. India's new National Health Policy 2017 stresses this aspect and supports a certification programme for their (CHWs') preferential selection into nursing and other paramedical courses. However, to what extent, the policy becomes effective in strengthening the capabilities of these health workers is still an unanswered question.

SANCHEZ, SHERALD, McMaster University, Canada

A scoping review of sexual and reproductive health services for adolescents with refugee backgrounds: identifying gaps and highlighting opportunities for research to advance policy and practice

BACKGROUND: Over half of the global refugee population is comprised of children and adolescents. Adolescents, who are among the most vulnerable in crisis settings, have specific needs, such as sexual and reproductive health services. Despite this, no recent review of available services exists. Studies that examine the extent, range, and nature of available services are needed as a basis for organizing and offering appropriate services.

OBJECTIVE: The aim of the study is to map the current landscape of services available to meet the specific reproductive health needs of adolescents with refugee backgrounds, identifying gaps and providing guidance for future work to advance policy and practice. Scoping studies are useful in identifying available services for dispersed and vulnerable groups.

METHODS: A five-stage scoping study method with consultation exercise and qualitative content analysis has been conducted. The author reviewed articles from 1995 to 2017 addressing the topic. Literature was gathered from databases including Medline, CINAHL, and EMBASE. Grey literature from organizations working with the study population was also included.

RESULTS: Preliminary results demonstrate a significant lack of sexual and reproductive health services available to address the specific needs of adolescents with refugee backgrounds.

KNOWLEDGE TRANSLATION: The study will aim to produce the following knowledge translation items: a summary of findings for publication; a systems map illustrating the landscape of available services in the field; and a synopsis of identified good practices that will be shared with organizations working with refugees and refugee-like populations in Canada.

CONCLUSION: Delivery of reproductive health information and services to adolescents can be challenging in any setting. For adolescents with refugee backgrounds, this is dramatically worse as they grow up in settings characterized by violence, breakdown of family and social networks, and protracted situations of economic and political instability. Adolescents are exposed to numerous reproductive health risks such as pregnancy-related death and injury, HIV/AIDS and other sexually transmitted infections, unsafe abortion, and sexual and gender-based violence. At the same time, adolescents with refugee backgrounds have similar needs as their non-refugee counterparts. These experiences have implications for both the planning and the delivery of accessible and effective health services.

SCHOCK, Sarayna, Penn State ProduceRx and Penn State College of Medicine, United States of America

Healthcare-agriculture partnerships: Benefits for all

Background: Poor nutrition is a major influence on health. Patients are often aware of what their eating choices put them at risk for but are still unable to modify habits.

Setting: Penn State Health, an academic health system in Central Pennsylvania in partnership with four Community Supported Agriculture farms.

Time frame: Ongoing since August 2016

Objectives: Provide evidence of the benefits of a healthcare-agriculture partnership for all those involved

Methods: For the 2016 pilot study, 32 patients completed pre- and post-surveys based on the CDC's Behavioral Risk Factor Surveillance System Questionnaire. At the end of the 18-week program, focus groups were conducted to solicit qualitative feedback and thematic analysis was performed. Several ongoing studies for the current season are evaluating the (1) benefits of such a partnership for healthcare employees, (2) feasibility of the program in modifying nutrition behaviors of Spanish-speaking patients in an inner-city food desert, (3) biometric outcomes for patients, and (4) benefits to partner farms.

Global Health Significance: Both healthcare and agriculture are essential and their need is universal. The partnering of these two industries can lead to improved economies and nutrition on a global-scale. For immigrants and refugees arriving to Western countries, these programs can also provide a valuable connection to the land while supplying essential nutrition at a low-cost and allowing individuals to retain their preferred and cultural methods of preparing meals.

Results: With the pilot study, average program adherence was 38.3%. Participants lost a mean 14.3 pounds while reporting increases in consumption of certain types of vegetables. Focus groups revealed that participants felt the program was affordable, promoted accessible healthy eating habits, provided connections, and increased their willingness to try new foods. In reference to current ongoing research, preliminary results from questionnaires, adherence rates, and biometric outcomes will also be shared.

Lessons:

6. Agriculture has a role to play in impacting patient and community health.
7. Current research has shown the efficacy of such partnerships and areas for improvement in other settings and moving forward.
8. Healthcare-agriculture partnerships benefit all involved.
9. Specific foundational steps for program implementation can be translated to other health systems and community settings to replicate our program model elsewhere.

Main messages: Poor nutrition is a major influence on health. Both healthcare and agriculture are essential and their need is universal. With benefits for all those involved, one has to wonder, why aren't there more healthcare-agriculture partnerships?

SHARMA, Vandana, Abdul Latif Jameel Poverty Action Lab, Massachusetts Institute of Technology, Cambridge, Massachusetts, USA., United States of America

Illness recognition, decision-making and care-seeking for maternal and newborn complications: A qualitative study in Jigawa State, Northern Nigeria

Co-Authors: Jessica Leight, Department of Economics, Williams College, Williamstown, Massachusetts, USA.; Fatima AbdulAziz, Planned Parenthood Federation of Nigeria, Abuja, Nigeria.; Nadège Giroux, Paris School of Economics, Paris, France; Martina Bjorkman Nyqvist, Department of Economics, Stockholm School of Economics, Stockholm, Sweden

Issue/problem: Though Nigeria is home to 2% of the world's population, it accounts for more than 10% of the world's maternal and child deaths. The highest levels are in the north, where instability, violence and population displacement as well as poor health infrastructure, and low maternal health services use contribute to poor outcomes. While evidence on drivers of low health service use exists, less is known about recognition and care-seeking for maternal and newborn complications. We conducted qualitative interviews between June and November 2015 to explore the process and sequence of symptom recognition, decision-making and care-seeking among families experiencing maternal and neonatal complications in Jigawa State, Northern Nigeria.

Methods: This study included 40 event narratives (10 each for maternal deaths, perceived post-partum hemorrhage (PPH), neonatal deaths and neonatal illness). These interviews explored symptom recognition, perceptions of the causes of disease, decision-making, and barriers to and enablers of care-seeking. Data were transcribed verbatim, translated to English, then coded and analyzed using Dedoose software and a codebook developed a priori based on the study's conceptual model.

Results: Compared to maternal cases, much less care-seeking was reported for newborns, especially in cases that ended in death. Key decision-makers varied by case type. Husbands played the lead role in decision-making for maternal death and neonatal illness cases, while female relatives and traditional birth attendants led decision-making around PPH, and mothers were the principal decision makers in neonatal deaths. Demand for health services is high, but supply-side challenges including low quality of care, uncertain availability of health workers, and drug stock-outs are persistent. There is a strong belief that outcomes are controlled by God and frequent use of spiritual care, sometimes contributing to delays in seeking facility-based care.

Lessons to date: These findings suggest key differences in recognition of complications, decision-making processes and care-seeking patterns between maternal and newborn illness and death cases. Interventions that provide more targeted messaging specific to case and symptom type, are inclusive of family members beyond husbands, and address gaps in quality and availability of care are urgently needed. These findings are important for other settings with high maternal and newborn mortality and highlight the need for multi-level interventions which account for differences in recognition and care-seeking.

Main message: There are key differences in recognition of complications, decision-making processes and care-seeking patterns between maternal and newborn illness and death cases. To increase effectiveness, interventions should account for these differences.

Simon, Kwake, Plan International, Canada

La santé des enfants du nord du Cameroun: résultats et leçons apprises de la prévention du paludisme par la chimio-prophylaxie saisonnière

Co-Authors: Magalie Nelson-Personna, Plan International Cameroon; Bernard Gnahoui-David, Plan International Canada

Contexte: Le Cameroun est un pays où le paludisme est endémique avec une situation épidémiologique variable suivant les régions. A transmission continue dans le sud du pays, le paludisme est plus saisonnier dans les régions du nord où la morbidité et la mortalité sont plus élevées que les moyennes nationales. Régions peuplées et marquées par l'insécurité, les défis sanitaires sont énormes pour ces populations. En 2015, la morbidité du paludisme était respectivement de 37% et 35 % dans les régions de l'Extrême-nord et du Nord versus une moyenne nationale de 30%; les taux de mortalité hospitalière du paludisme étaient de 39% et 37% respectivement dans ces régions pour une moyenne nationale de 19%. Les enfants représentaient 79% de l'ensemble des décès. La stratégie de réponse du pays inclut différentes interventions préventives notamment l'utilisation des moustiquaires imprégnées d'insecticide à longue durée, la pulvérisation intra domiciliaire avec des insecticides rémanents, le traitement préventif intermittent de la femme enceinte. A celles-là s'est ajoutée en 2016, la Chimio prévention saisonnière (CPS) chez les enfants âgés de 3 à 59 mois dans les régions du Nord. Ce symposium présentera la stratégie utilisée pour cette chimio prophylaxie saisonnière du paludisme au nord du Cameroun en 2016, les résultats et les leçons apprises. Il pourra orienter l'implémentation de cette stratégie dans les pays d'Afrique où le paludisme reste un défi majeur à la santé des populations particulièrement des enfants et des femmes.

Objectifs d'apprentissage et participants visés : Ce symposium s'adresse aux praticiens en santé publique, en particulier ceux impliqués dans la lutte contre le paludisme au niveau des instances gouvernementales et non gouvernementales. A la fin de la session, les participants à travers l'étude du cas pratique de Cameroun auront :

- revu les différentes étapes de la mise en œuvre de la chimio prophylaxie du paludisme saisonnier
- Les défis et les opportunités de cette campagne
- l'efficacité de cette intervention dans la prévention du paludisme des enfants des communautés vulnérables.

Sujets:

- Contexte du paludisme au Cameroun et bref regard sur les différentes interventions mises en place (15 minutes)
- La stratégie et le mécanisme opérationnel de la chimio prophylaxie saisonnière (15 minutes)
- Les résultats (15 minutes)
- Les leçons apprises et les perspectives (15minutes)
- Questions & réponses (30 minutes)

Format: Les sujets feront l'objet de présentation sur power point en français par des présentateurs bilingues du Cameroun et du Canada.

Principaux messages :

- Bonne acceptation de la CPS dans les communautés
- 1.3 millions d'enfants de 3-59 mois soit 85.6 % des enfants de ces deux régions ont reçu les 3 doses prévues de la combinaison sulfadoxine-pyriméthamine-amodiaquine (SPAQ).
- Diminution du nombre de cas de paludisme chez les enfants respectivement de 67 % et 47 dans les régions de l'extrême nord et du Nord comparée à l'année précédente.
- Diminution du nombre de décès dus au paludisme de 74 % et 59 % dans ces mêmes régions.
- La chimio prophylaxie saisonnière est une intervention efficace maximisant l'impact de la lutte contre le paludisme chez les enfants de 3-59 mois.

Conclusion: Cette session utilisera les leçons apprises de cette première campagne de chimio-prophylaxie du paludisme saisonnier au Cameroun pour souligner la valeur ajoutée de cette intervention dans l'amélioration de la santé des enfants ainsi que certains aspects déterminants pour une bonne mise en œuvre et un impact maximal.

SKEMPES, DIMITRIOS, Swiss Paraplegic Research, Switzerland

Developing a human rights based indicator framework to assess country efforts to strengthen rehabilitation in health systems: a concept mapping study

Co-Authors: JEROME BICKENBACH, Queens University, Canada and University of Lucerne, Switzerland

Issue: Rehabilitation is expressly recognized as an essential element of universal health coverage and the right to health, yet, in many countries situation analysis and assessment of rehabilitation services is constrained by the absence of meaningful indicators. To meet the central imperative of leaving no one behind countries must be able to monitor how they have discharged their human rights obligations in relation to rehabilitation towards persons with disability.

Objectives and Methods: The aim of this study was to develop an expert guided indicator framework to assess countries' efforts and progress in strengthening rehabilitation in health systems in line with their obligations under the Convention on the Rights of Persons with Disabilities. Concept mapping was used to capture, aggregate and confirm the knowledge and opinions of a purposively selected heterogeneous group of relevant stakeholders. During an online brainstorming session, 59 individuals generated a list of 107 items thought to be useful for monitoring States compliance with their rehabilitation related obligations under the disability treaty which were subsequently sorted by a select group of 37 experts from the original panel into non overlapping categories. 42 participants rated the indicators for importance and feasibility. Descriptive statistics of rating data and multivariate analyses of sorting information were conducted to explore patterns and themes in the data and create a conceptual model for rehabilitation sector review and assessment. Facilitated group and individual discussions with experts helped verify and interpret the results.

Results: Application of multidimensional scaling and hierarchical cluster analysis revealed a conceptual structure of 11 domains or "clusters". The clusters with the highest importance ratings were Legal Commitments and strategic priorities, Monitoring and accountability, Evidence informed and rights based policy programming and Workforce development. The least important clusters were Disability Statistics and Social Mobilization and Research. The correlation between importance and feasibility was moderately positive ($r = 0.58, p < 0.1$). A major division was between governance and system related clusters. Participants also perceived indicators of professional development to be conceptually distinct from workforce indicators.

Lessons to date: The model enables a comprehensive view of the most essential legal, policy and programmatic factors that must be addressed when conducting rights based analyses of rehabilitation services. The framework and indicators can inform the development of monitoring tools to assist health agencies, professional organizations, consumer groups and research consortia to improve and harmonize the collection of data on rehabilitation services in consistency with human rights standards.

SMITH, Allister, McGill University, Canada

Value sensitive design for humanitarian action: Integrating ethical analysis in the development and implementation of information and communication technologies

Co-Authors: John Pringle, McMaster University; Matthew Hunt, McGill University

The development and implementation of new information and communication technologies (ICTs) is leading to many improvements in humanitarian action. For example, the World Food Programme has trialled iris scanning as a means of confirming identity when providing food allowances in refugee camps. Elsewhere unmanned aerial vehicles are delivering aid supplies and biological samples. These and other emerging technologies also raise ethical questions that warrant attention throughout the process of designing, developing, rolling out, and evaluating humanitarian ICTs.

Humanitarian contexts are complex, rapidly-changing and characterized by uncertainty. Ethical issues associated with humanitarian technologies include ensuring accuracy, protecting privacy and security, responding to inequalities, demonstrating respect for individuals and communities, protecting relationships, and addressing expectations. Value Sensitive Design (VSD), an approach to technology innovation that explicitly incorporates values into the design process, presents an opportunity to integrate an ethics lens in humanitarian development.

Our objective in this project was to create a VSD framework that could be applied to the design and application of emerging humanitarian ICTs. We developed the framework based on 1) a review of literature on humanitarian ICTs, ethics in innovation, and the application of VSD, 2) our team's experiences in software design and engineering, humanitarian aid, and ethics, and 3) discussions with technology developers, humanitarian workers and policy-makers. Our humanitarian VSD framework can be applied by ICT developers and humanitarian organizations, and used by those with both technical and non-technical backgrounds, to support the ethical analysis of emerging technologies across the innovation cycle.

Our VSD framework acts as a tool to account for, and document, ethical considerations associated with an ICT application. To do so, it identifies ethical questions during each phase of the innovation cycle (identified by the Humanitarian Innovation Fund as problem recognition, ideation, development, implementation, and scaling the solution) and explains how the ethical questions relate to the ethical commitments of humanitarian organizations and other stakeholders. The framework can be applied to both technologies that are adapted for humanitarian use and de novo applications.

In this presentation, we illustrate the framework by analyzing an emerging ICT: the use of biometrics to identify refugees. This analysis showcases how our framework can draw attention to salient ethical considerations in order to support careful analysis and appraisal of a technology's ethical merits and any sources of concern. Doing so makes these considerations visible to support discussion and debate, and can also support developing strategies to mitigate risks.

SOMANI, Rozina, Aga Khan University School of Nursing and Midwifery, Pakistan

Magnitude of workplace violence towards nurses at private and government healthcare settings in Pakistan

Title: magnitude of workplace violence towards nurses at private and government healthcare settings in Pakistan

Issue/problem: Workplace violence towards nurses is a worldwide problem. Among all healthcare workers, nurses are at a greater risk of being subjected to workplace violence. The present study identified the magnitude of the issue of violence towards nurses at the healthcare settings in Pakistan.

Objectives and Methods - This study aims to identify the prevalence and characteristics of physical and psychological violence experienced by nurses working in all the In-patient units and the Emergency Departments of two private and two government healthcare settings in Karachi, Pakistan. This Cross-sectional study included 458 nurses from selected healthcare settings in Karachi, Pakistan. A simple random sampling method was used for the study. The instrument used for collecting the data was jointly developed by International Labour Office (ILO), International Council of Nurses (ICN), World Health Organization (WHO), and Public Services International (PSI). The primary investigator and the research assistant interviewed the participants to complete the study tool.

Results (effects/changes) The present study found that workplace violence was prevalent among 82% of the nurses. The reported prevalence of physical violence was 16.4%, verbal abuse 77.1%, bullying/ mobbing behavior 33.8% and 10% for sexual violence. Prevalence of workplace violence was found to be higher in the private healthcare settings, among young female nurses with less work experience. These nurses specifically belonged to the Medical Surgical units, Intensive Care Units, and Emergency and Psychiatric departments. Most of them were working in shift duties. The most common perpetrators of physical violence towards nurses were found to be patients and their relatives, and for psychological violence it was patients' relatives and healthcare staff.

Lessons to date: This pioneer study is an attempt towards the implementation of one of the World Health Organization's (WHO) goals, that is, a violence free healthcare environment. The study also put forward some evidence based recommendations; based on the findings, for the government, the nursing services, nursing educators, and for future research.

Main messages: Violence free healthcare settings is right of every employee. We need to break the silence. This is the right time we need to put forward some evidence based strategies which can reduce the violence from the health sectors.

SPAGNOLO, Jessica, School of Public Health, IRSPUM, University of Montreal, Canada

Effectiveness of a mental health training program offered to general practitioners working in Tunisia: a randomized controlled trial

Co-Authors: François Champagne, School of Public Health, IRSPUM, University of Montreal; Nicole Leduc, School of Public Health, IRSPUM, University of Montreal; Wahid Melki, Razi Hospital; Faculty of Medicine, University of Tunis El-Manar; Fatma Charfi, Mongi-Slim Hospital; Faculty of Medicine, University of Tunis El-Manar; Ann-Lise Guisset, World Health Organization; Michèle Rivard, School of Public Health, IRSPUM, University of Montreal; Myra Piat, Douglas Mental Health University Institute; McGill University; Marc Laporta, Montreal WHO-PAHO Collaborating Center for Research and Training in Mental Health; McGill University

Issue: Tunisia is experiencing a rise in the prevalence of mental health conditions and youth suicide. To address this growing need, health system reform aims to create proximity mental health services, namely by training general practitioners (GPs). GPs have been chosen as targets of the ongoing reform given that one third of their consultations are related to mental health, despite often lacking specific knowledge and skills in this field. Thus, an innovative mental health training based on the Mental Health Gap Action Programme (mhGAP) Intervention Guide (IG), developed by the WHO, was implemented in the Greater Tunis Area between February-April 2016. The effectiveness of the program was examined using a randomized controlled trial (RCT) with a delayed treatment control design. Participants were 112 GPs, randomized to either Group 1 (n=52, training in February-March 2016) or Group 2 (n=60, training March-April 2016). Knowledge and attitudes about mental illness, as well as self-efficacy in detecting, treating and managing mental illness in primary care were assessed at 3 times: 1) baseline questionnaires were completed by 52 GPs in Group 1, and 60 GPs in Group 2; 2) a second set of pre-training questionnaires, following Group 1's training, was completed by 48 GPs in Group 2, serving as the control measure; and 3) post-training questionnaires were completed by 44 GPs in Group 1, and 43 GPs in Group 2. To our knowledge, this is the first attempt to implement the mhGAP-IG in Tunisia, and one of the first in a French-speaking nation. In addition, this is the first randomized controlled trial conducted to measure the impact of a mental health training in Tunisia. Findings will respond to one of the main priorities of global mental health: carrying out RCTs in low- and middle-income countries, especially French-speaking, to generate knowledge that has practical value within such settings. Results: Post-training, in both groups, there were statistically significant increases in knowledge about mental illness and self-efficacy to detect, treat, and manage mental illness in primary care, as well as a decrease in stigmatizing views about mental illness. Lessons: Findings suggest that a training based on the mhGAP-IG may enhance the recognition, positive views, and management of mental illness in primary care. Main messages: 1) This trial strengthens clinical practice, and builds research capacity. 2) Implementing the mhGAP-IG may be a useful way to address the growing mental health needs in Tunisia and beyond using already existing resource.

STEELE, Vivienne, University of Guelph, Canada

Maternal antenatal care attendance among Indigenous Batwa and non-Indigenous Bakiga women in Uganda

Issue/problem: Sustainable Development Goal #3 aims to reduce the global maternal mortality ratio to less than 70 per 100,000 births by 2030. Most maternal deaths in developing regions are caused by complications which could be prevented by health care interventions provided during antenatal care (ANC). In Uganda, persistent high rates of maternal mortality are linked to inadequate utilization of ANC; for example, women in rural areas of Uganda are two times less likely to attend ANC than women in urban areas.

Objectives & global health significance of the topic: This study aims to examine and characterize determinants of ANC attendance for Indigenous Batwa and non-Indigenous Bakiga women in south-western Uganda. The results of this study are intended to contribute to a better understanding of the disparities in ANC attendance between Indigenous and non-Indigenous women in rural regions in Uganda, but also globally.

Methods: A community-based, mixed-methods approach was used to collect both quantitative and qualitative data during June to August 2015. Quantitative data were collected from Bwindi Community Hospital ANC records for 2012-2013 (n=2299 entries) and summarized using descriptive statistics. Qualitative data were collected by conducting semi-structured focus groups (n=15) with women from Batwa and Bakiga communities in the hospital's catchment areas, and in-depth key informant interviews (n=8) with health care workers from the hospital and the communities. Thematic analysis was conducted on the qualitative data to identify themes.

Results: Preliminary results indicate that ANC attendance was low, with 29.8% of patients attending the recommended number of visits, and less than 5% of all patients recorded as Batwa women. Women described a multitude of barriers that influenced ANC attendance, including distance to hospital, limited transportation options, inability to afford care, and lack of spousal support throughout pregnancy. While many of the emerging themes were described by both Batwa and Bakiga women, Batwa women highlighted the role of traditional beliefs more often than Bakiga women did.

Lessons to date: Many barriers to ANC attendance exist, and some are likely to play a larger and clearer role than others. While both Bakiga and Batwa women face many barriers, the role of traditional knowledge is complex and requires further analysis.

Main messages: ANC attendance is low in rural southwestern Uganda, and especially low among Indigenous women. A multitude of barriers to accessing ANC services exist, which need to be addressed in order to improve ANC attendance.

STEVENS, Denise, MATRIX Public Health Solutions, Inc.,

Engaging communities to make the case for NCD prevention: The app that maps communities' health assets and barriers

Background: Non-communicable diseases (NCDs) account for 70% of deaths globally (40 million people annually). NCDs are increasingly recognised as diseases of inequality, disproportionately impacting disadvantaged communities. Addressing the risk factors of tobacco use, poor diet (including harmful alcohol use), and physical inactivity can curb the NCD epidemic. However, prevention remains underfunded, with health interventions often imposed on communities. What is needed is an innovative process to shift decision-making to local communities, while also reducing inequalities in the broader determinants of health. CHESS™ (Community Health Engagement Survey Solutions) is that process. Emerging from research in India, China, Mexico and the United States, CHESS™ has been implemented in eight London boroughs and two United Kingdom communities.

Methods: CHESS™ promotes community-centred prevention by engaging communities in a data-driven investigation about health and the built environment. Using the CHESS™ application, community members collect quantitative data on local assets and barriers that are conducive to good health (or not!). Community members interpret this data during insight sessions. Personal stories provide vital context about social, economic and health inequalities. These quantitative and qualitative results inform evidence-based recommendations, guided by public health expertise, for interventions that make it easier to be healthy. The community presents their recommendations to local decision-makers in a compelling argument for change. CHESS™ leverages social capital and mobile technology to address NCD causes and equity issues, to make the healthy option the easy option for all.

Results: One London borough received £150,000 from Sport England; while a north London borough was awarded over £2 million to improve physical activity opportunities for young people. Another project led to two new playgrounds co-designed with local parents and healthy breakfasts for schoolchildren.

Lessons to date: CHESS™ has demonstrated the importance of community-led data-driven strategies to create meaningful, sustainable change. The highly adaptable CHESS™ process can also be tailored for urban, rural, developed and developing country settings, as well as cultural variations. Although CHESS™ was designed for NCD risk factors, it can address other community issues (e.g., crime, water, environmental factors) and be utilised for urban planning.

Messages

- 1) NCD prevention requires engaging with communities to co-create public health solutions, while also addressing equity issues.
- 2) CHESS™ leverages community engagement and mobile technology to inform evidence-based recommendations guided by community members and public health expertise.
- 3) CHESS™ effectively convinces policymakers to invest in NCD prevention in communities, with over £2 million awarded to London boroughs to date.

TEJPAR, Ali, Global Strategy Lab, University of Ottawa Faculty of Law, Canada

Canada's violation of international law during the 2014-2016 Ebola outbreak

Co-Authors: Steven Hoffman, Global Strategy Lab, University of Ottawa Faculty of Law

The devastating 2014-2016 West African Ebola outbreak challenged the authority of the World Health Organization (WHO) to enforce the legally-binding International Health Regulations (IHR) that govern pandemic responses. Specifically, under IHR Article 43, state parties can only implement additional health measures beyond WHO's recommendations if public health rationales or scientific evidence justify such measures. Yet at least 58 state parties enacted additional health measures, mainly travel restrictions to/from Ebola-affected countries. This article explains why Canada's visa restrictions targeting Ebola-affected countries failed to meet the IHR's requirements and therefore violated international law. In particular, Canada's response went against public health authorities' consensus views, the best-available scientific evidence on disease transmission, and WHO's recommendations. As a historic global health champion, Canada must lead by example and abide by international laws – including the IHR – instead of picking-and-choosing which laws to follow and thereby encouraging other countries to do the same.

TRAN, Thi Hong, Hanoi University of Public Health, Viet Nam

The accuracy of causes of death recorded in the national routine health management information system in Vietnam: challenges and potential solutions

Key messages:

- In Vietnam, the NRHMIS plays an important role in providing the information on COD for the production of national vital statistics.
- High quality information on COD depends on different factors including system design, personnel, regulation and supervision.
- Incorporating verbal autopsy methods in the NRHMIS should be a practical solution for improving the accuracy of COD.

Issue. There are limitations regarding the availability and quality of causes of death (COD) data at national level in Vietnam. In 2014, Vietnam made a commitment to improve the Civil Registration and Vital Statistics system during a Ministerial conference. The health sector has been assigned the responsibility for producing the COD data and ensuring their quality but it has a lack of knowledge in this area. There is an urgent need to know the accuracy of the COD recorded by in the national routine health management information system (NRHMIS), and the challenges and solutions for improving the current system.

Objectives. This study examined the accuracy of COD recorded in the NRHMIS in Vietnam and identified challenges which affect the recorded COD. Potential solutions to make improvements were ascertained.

Methods. Qualitative methods were applied to be able to provide in depth answers for the proposed objectives. Four focus group discussions with 26 commune health workers and five in-depth interviews with district and provincial health officers were successfully carried out. Interviews were recorded using a tape recorder and notes were taken. The tape recordings were transcribed for thematic analysis.

Results. The majority of COD were recorded inaccurately. General terms were used to describe deaths which resulted in a lot of ill-defined causes. The major challenges identified were non-standard data collection methods; a lack of tools and guidelines on COD; and deficiencies in understanding of the importance of the data collection by health staffs. Integration of standard data collection tools (such as use of a verbal autopsy instrument) and guidelines on COD into the current system are important actions to enhance the accuracy of COD recorded in the NRHMIS. In addition, staff education is necessary, along with regulation and supervision from higher levels.

Lesson learnt: The health sector in Vietnam has an important role in strengthening the civil and vital registration system. This study has identified current problems. Principles and practices have been identified which will contribute to strengthening the system so that the government can design more effective public health policies and measure their impact.

TUCK, Jodi, McGill University, Canada

Weaving indigenous health competencies across the nursing curriculum: an integrated approach to the truth and reconciliation

Co-Authors: Glenda Sandy, Laval University; Lia Sanzone, McGill University; Françoise Filion, McGill University

Issue/problem: For centuries, colonization of Indigenous people, what is now Canada, led to policies of genocide and forced assimilation resulting in many other atrocities. These policies have seriously endangered the survival of indigenous nations and prevented them from living on their traditional lands, practicing their traditional ways. The health implications of these policies are far reaching. Despite the resiliency of indigenous people the accumulated damage will take generations to recover from. The Truth and Reconciliation Commission (TRC) is an important step in addressing some of the injustices that have created the current situation for Indigenous people in Canada. The calls to action from the TRC address what nursing schools need to do to begin the healing process. The importance of Indigenous Health competencies is clearly defined.

Objectives – This oral presentation will describe how one nursing school is responding and integrating the recommendations from the Truth and Reconciliation calls to action. Discussing the integrated approach to weaving Indigenous Health competencies throughout the curriculum rather than having a specific course dedicated to Indigenous health.

Results (Effects/Changes):

- Concepts of indigenous health and history were integrated in Practices scenarios of an Inquiry based curriculum in every term of study.
- Integrating core indigenous competencies in the curriculum from the ANAC/CASN Cultural Competence and cultural safety in Nursing Education: A framework for first nations, Inuit and Métis nursing
- Analyzing our curriculum for colonial underpinnings and the acknowledgement of the truth of Indigenous history

Lessons to date: It is essential to have Indigenous nurses guiding and advising on changes. Integrating Indigenous health in not just about educating students on these important issues it is also about making our curriculum accessible to indigenous students and prospective Faculty.

Many of the lessons to be learned about caring for indigenous populations can help nurse's better care for all people, though several are unique.

Main messages: The strength of and integrated approach to indigenous cultural safety and core competencies in curriculum

TURCOTTE-TREMBLAY, Anne-Marie, University of Montreal Public Health Research Institute, Canada

Merging health equity measures with performance-based financing to leave no one behind in Burkina Faso : a mixed methods study

Co-Authors: Idriss Ali Gali-Gali, Association Action Gouvernance Intégration Renforcement (AGIR); Manuela De Allegri, Institute of Public Health, Medical Faculty, Heidelberg University; Valéry Ridde, University of Montreal Public Health Research Institute

Problematic : User fees and the poor quality of healthcare contribute to low service utilization in Burkina Faso. The government, supported by the World Bank, implemented an innovative intervention that combines user-fee exemptions for indigents with performance-based financing (PBF). Research suggest that complex interventions may trigger changes that were not targetted by program planners but this topic remains neglected. Our objective is to document the unintended consequences of this intervention.

Methods : We used the theory of diffusion of innovations to conduct a concurrent triangulation mixed methods study. For the qualitative component, we conducted a multiple case study based on 4 healthcare facilities in one district in Burkina Faso. Data was collected between Jan.-May 2016 using non-participant observation, 92 semi-structured interviews and informal discussions with various types of stakeholders. We coded the data using QDA Miner and conducted thematic analysis using a hybrid deductive-inductive approach. For the quantitative component, we used descriptive statistics on the evolution of service utilization to validate and expand qualitative results.

Results : Local actors re-invented elements of the intervention over which they had control to increase its relative advantage or adapt to implementation challenges. Some individuals who did not meet the local conception of indigents were selected to the detriment of others who did. Healthcare providers argued that distributing free medication led to financial difficulties and drug shortages, especially given the low fee for service and long payment delays. Both qualitative and quantitative data show that healthcare workers adopted various measures to limit free services delivered to indigents. These measures led to conflicts between indigents and providers. Ultimately, selected indigents received uncertain and unequal coverage.

Conclusion : The severity of the unintended consequences undermines the effectiveness and equity of the intervention. Decision makers will have to address these unintended consequences if the intervention is prolonged and expanded to reduce health inequities.

U. MUKANGWIJE, Pulchérie, Handicap International Federation, France

Fighting sexual violence against us: through our eyes, we, children with and without disabilities, in sustainable development goals era

Background: Based on the results of a pilot project implemented in Burundi, Madagascar, Mozambique and Tanzania in 2010 by Handicap International and Save the Children to address the vulnerability of children with disabilities against sexual violence, and with the support of OAK Foundation, “UBUNTU Care” project was designed in 2012 in two phases, three years each. The project aims to address the root causes and to mitigate the consequences of violence against children, especially those with disabilities in Kenya, Rwanda and Burundi. A short documentary has been produced in the frame of the advocacy activities. The video is one of different tools used to support the strategy of the project, which is to translate effectively the international commitments in regard of children’s rights, in particular the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities into practical actions on the ground through improved response mechanisms to Sexual and gender based violence against children at all levels.

Learning objectives

- Presenting the advocacy tool with children’s messages to fight sexual violence against children with and without disabilities;
- To discuss strategies used to create a friendly environment for children with and without disabilities;
- To empower children with and without disabilities in fighting sexual violence as individuals, groups and communities;
- To develop the content of children’s education and community mobilization to fight sexual violence against children;
- Addressing causes of sexual violence according to children;
- Identifying key issues, stakeholders and levels of action to address sexual violence against children.

Topics: The topics and discussion points covered by the video are rights of children, needs and gaps in protecting children against sexual violence; causes and solutions to fight sexual violence according to children in the video, with a particular focus on those with disabilities; creation of children’s committee and task force to fight sexual violence in each country, how children performed through magnet theater, photo novella and street interviews; participation of children in all four axis of the project.

Main Messages: Participants sensitized, mobilized and guided about tools and strategies showing how children are empowered and considered as key stakeholders in their own protection; why a Community Based Rehabilitation approach is important in raising awareness, promoting inclusion, skills development, eliminating stigma, and facilitating access to health, education and legal opportunities; and how coordination and advocacy roles and structures should better contribute to equal treatment of children with and without disabilities.

U. MUKANGWIJE, Pulchérie, Fédération Handicap International, France

Inclusion des personnes handicapées dans la riposte au VIH, une priorité du Conseil national de lutte contre le sida au Sénégal. Cas du projet ACCESS

Co-Authors: Davide Olchini, Fédération Handicap International

Enjeu ou problème : Au Sénégal, l'inclusion des personnes handicapées (PH) constitue une priorité de développement. Les PH sont prises en compte dans la Stratégie Nationale VIH depuis 2011. Les données probantes sont quasi inexistantes, rares sont les actions inclusives. Ce gap revêt des enjeux majeurs en termes de financement, planification, évaluation et pérennité des interventions. Les infrastructures et services ne sont pas accessibles au niveau physique et de la communication. L'élimination des barrières en matière de santé requiert l'adaptation de l'environnement en fonction des besoins spécifiques des PH. Dans ce cadre, Handicap International et SWAA-Sénégal ont implémenté le projet « ACCESS : des services VIH inclusifs pour l'accès universel », financé par l'Initiative 5% du Fonds mondial de lutte contre le sida, la tuberculose et le paludisme.

Objectifs et méthodes : Inclure le handicap dans la réponse VIH par l'identification et la suppression des barrières d'accès et accessibilité; mener une étude auprès des PH sur l'infection au VIH, connaissances, attitudes et pratiques ; développer et transférer les compétences en réadaptation fonctionnelle pour les soins et services en faveur des personnes vivant avec le VIH ; développer un mécanisme de suivi-évaluation du VIH inclusif ; développer un outil de plaidoyer.

Résultats (effets ou changements) : 804 PH enquêtées (âge≥15 ans) ; 47,6% ont entre 25-49 ans ; 25% dépendent d'une tierce personne ; 35,9% n'ont aucune instruction ; 55% sont sans revenus ; 2,7% (N=793) ont été dépistées séropositives au VIH; différence significative du taux d'infection au VIH selon les groupe d'âge, niveau d'instruction, type de déficience et état matrimonial; maintien de comportements sexuels à risque ; outil de plaidoyer pour la réalisation d'une étude nationale bio-comportementale ; mise en accessibilité physique et communicationnelle dans les hôpitaux, centres et postes de santé ; prise de conscience des prestataires quant à leurs attitudes et comportements envers les PH, affectant l'utilisation des services.

Leçons tirées à ce jour : L'importance de participer au dialogue national mené par le Fonds mondial : décisions éclairées sur l'inclusion du handicap ; passer d'une perspective régionale à une perspective nationale en moins de trois ans ; engagement du CNLS; nécessité de communiquer et sensibiliser sur les normes en accessibilité au-delà du secteur santé.

Principaux messages : Prendre conscience des défis et opportunités d'inclusion des PH ; développer des synergies et partenariats ; plaidoyer pour des politiques et stratégies inclusives pour un développement durable, où les PH sont des acteurs clés.

VAN DER WAL, Ran, McGill University, Canada

Structural support programs in Botswana do not benefit marginalized young women

Co-Authors: Anne Cockcroft, McGill University; CIET Trust Botswana; Miriam Kobo, CIET Trust Botswana; Neil Andersson, McGill University; CIET Trust Botswana

Background: HIV incidence remains high in Botswana, disproportionately affecting marginalized young women (15-29y; out-of-school and unemployed). Structural factors such as poverty, lack of education, gender-based violence prevent them from applying HIV prevention choices. CIET Trust and the National AIDS Coordinating Agency are undertaking a structural intervention, implemented as a stepped-wedge cluster trial (INSTRUCT). It includes workshops to help young women to access existing government support programs offering community service placements, and educational and livelihood programs. These programs could contribute to the social and financial empowerment of young women, and enable them to act on HIV prevention choices. Previously, few young women have benefitted from these programs.

Objective: To explore why marginalized young women don't benefit from available government support programs in INSTRUCT's first intervention district.

Methods: We undertook 25 semi-structured interviews with marginalized young women who had attended workshops and interviewed eight first line service providers. Analysis relied on Framework and Nvivo.

Results: Although the workshops motivated young women to apply to government support programs, they experienced difficulties when they did. Some programs' eligibility criteria were incompatible with young women's competencies. Other programs had easier application processes but long waiting lists and backlogs of up to three years. Additionally, young women identified negative service provider attitudes, lack of feedback, and unaffordable upfront costs as reasons why they could not benefit from the programs. Service providers identified young women's lack of commitment as the main barrier to success, but acknowledged structural barriers such as lack of access to land and water, and poor coordination between programs. They complained that upstream challenges, including slow disbursement of funds and lack of material and human resources, also hampered effective service delivery.

Discussion and Conclusion: Giving young women access to government support programs could reduce their HIV risk, but the programs need to make changes to ensure access for young women. Many marginalized young women currently do not benefit from these programs; they were not designed to reach this group. Perspectives of marginalized young women could inform adjustment of government support programs. If the INSTRUCT intervention stimulates increased demand from marginalized young women, government programs will need to find ways to respond effectively, even without major increases in resources. Findings from our research can inform the Government of Botswana in efforts to improve the reach of their programs to young women.

VISSANDJEE, Bilkis, University of Montreal, Canada

Domestic Violence and Women of Reproductive Age in India: An Innovative Contribution to Primary Health Care Nursing Practice

In India, government and private sectors co-exists within the health care system, the latter being the most utilized by all social classes of the population. Women and men living below poverty line are at higher risk of poor access to health care and financial instability.

Gender-based violence (GBV) is an internationally-accepted term used to describe any violence that is the result of normative gender role expectations as well as the unequal power dynamic between each gender. Because women tend to be more often the victims of an unequal relationship with men, GBV has come to stand for physical, psychological and sexual violence against women and girls. During pregnancy, DV has been reported to be between 13-16% in India.

All these determinants and risk factors are linked one way or another to the concept of gender. Expectations around both women and men's roles and proper behaviors within Indian society can contribute to maintain in place the issue of DV and to render the population more vulnerable to it. Most of the reviewed interventions on health and women's empowerment have been conducted at the outskirts of primary health care nursing practice by NGOs, local organizations and inter-sectorial partners. All these interventions resonate with the purpose of self-help groups or women's groups which have been set up across India in both slum and village areas by government and non-government organizations.

The aim of this presentation is to highlight the potential contribution of primary health care nursing for gender equity promotion and DV prevention. In order to do so, a first objective is to better understand the social determinants of DV in India. Gender inequity is documented as both an individual and a community risk factor. Accordingly, a second objective was to identify 'best practices' that foster women's empowerment in primary health care nursing. The Dil Mil trial was selected and adapted to primary health care nursing as part of an innovative intervention to prevent DV and promote gender equity.

The project highlighted that nurses have all the required competencies to promote women's health and act on social determinants of DV by conducting an intervention such as the Dil Mil. Selected competencies such as clinical leadership, professional collaboration and population health promotion confirm nurses' capacity to engage in health promotion, to collaborate with ASHAs, ANMs and Anganwadi workers as well as inter-sectorial partners and to conduct preventive actions rather than solely crisis-based interventions.

WALLACE, Lauren, McMaster University, Canada

Priority Setting for Maternal, Newborn and Child Health in Uganda: Reflections for action

Co-Authors: Lydia Kapiriri, McMaster University

Issue/Problem: Despite continued investment, Maternal, Newborn and Child Health (MNCH) indicators have remained relatively poor, particularly in LICs. Poor health outcomes could be explained, in part, by the broad nature of the MNCH agenda, including an ever-expanding landscape of technological innovations. Such an agenda necessitates clear and transparent mechanisms for prioritization that equitably involve diverse stakeholders and ensure follow-through from policymaking to implementation. While a growing number of frameworks examine priority setting for MCNH, there is a paucity of approaches that follow through the prioritization process to implementation, or that take into account the social, economic and political context, making it difficult for policy makers to improve decision-making processes. Using Kapiriri and Martin's (2010) conceptual framework for evaluating priority setting, this paper provides an in-depth examination of priority setting for MNCH in Uganda at the national and sub-national levels between 2010 and 2015. This is a qualitative prospective study that draws on 55 interviews and a review of policies and media reports.

Results: Priority setting for MNCH in Uganda was guided by explicit tools, evidence and criteria. However, the public and the districts were insufficiently involved in policymaking. Implementation was constrained by an unequal allocation of resources between child health and maternal health interventions, a weak health system and the limited institutional capacity of the Ministry of Health. To a great degree, Kapiriri and Martin's framework and sources of information provided viable guidance for evaluating priority-setting processes for MNCH, however, some parameters of successful priority setting, such as wastage of resources, could not be measured since the means of verification were not available.

Lessons: Stronger institutional capacity at the MOH and equitable engagement of key stakeholders in decision-making processes, especially the public, and implementers, would improve understanding, satisfaction and compliance with the priority setting process, and facilitate the implementation of well-developed policies. Kapiriri and Martin's framework has the potential to guide priority setting evaluation efforts in other contexts, however, evaluation should be built into the planning cycle such that information on priority setting is gathered throughout.

Main messages:

- Using the example of priority setting for MNCH in Uganda, Kapiriri and Martin's framework was able to identify good practices and challenges
- Strengths of priority setting for MNCH in Uganda include the use of relevant tools, evidence and criteria; inclusive stakeholder participation and implementation are challenges
- Rather than ex-ante approaches to evaluate priority-setting, real-time evaluation should be integrated into the planning cycle

WILCOX, Elizabeth, University of British Columbia, Canada

Promoting the occupational health and safety of health workers in high risk settings: A three-country comparative case study to better understand the enabling factors and barriers to the implementation of HealthWISE

Co-Authors: Simphiwe Mabhele, International Labour Organization; Paulo Romao, International Labour Organization; Jerry Spiegel, University of British Columbia; Ida Tsitsi Chimedza, International Labour Organization; Muzimkhulu Zungu, National Institute for Occupational Health; Annalee Yassi, University of British Columbia

Issue/problem: Health workers are in short supply worldwide, especially in areas of higher need such as in Southern Africa, where high population prevalence of tuberculosis and of HIV create high risk settings. International organizations have attempted to develop strategies and tools to improve their occupational health and safety (OHS). One such tool is HealthWISE, a participatory, quality improvement tool, jointly developed by the International Labour Organization and the World Health Organization. Its implementation, however, has been poorly studied. Since February 2016, we have been observing the implementation of HealthWISE in selected hospitals in Mozambique, South Africa and Zimbabwe.

Objectives and methods: A three-country comparative case study was conducted to better understand the enabling factors and barriers to the implementation of HealthWISE in selected hospitals in Mozambique, South Africa and Zimbabwe. Activities including planning meetings, Training-of-Trainers (ToT) workshops, action plan development, and check-in visits were observed. Field notes, videotapes of the ToT workshops, monthly reports, and questionnaires supported the analysis. The Promoting Action on Research Implementation in Health Services (PARIHS) framework, which describes successful implementation as a function of evidence, context and facilitation, structured the examination of enabling factors and barriers.

Results: Hospitals and participants were selected by local co-investigators and partners. Implementation began with three-day ToT workshops, where 78 participants were trained across the three countries. Action plans detailed activities related to building capacity and raising awareness about OHS. Preliminary findings indicate that while evidence to support OHS improvements is strong, implementation was constrained by context-related factors such as the steps in obtaining approvals for the research and determining funding flows. The ILO-NIOH-UBC partnership was key in moving activities forward.

Lessons to Date: Key steps prior to implementation included strengthening partnerships with stakeholders, and engaging with local team members and participants to better understand OHS issues. Key steps in implementation included training to build local capacity and to empower participants with knowledge and skills to recognize and creatively address workplace issues, and supporting the development of individual hospital action plans that reflected workplace priorities while recognizing resource constraints. Administrative hurdles took time to address.

Main messages: Conducting a three-country comparative case study helped to better understand the enabling factors and barriers to the implementation of HealthWISE in selected hospitals in Mozambique, South Africa and Zimbabwe. While evidence in all three countries supported the need for OHS improvements, context-related factors presented challenges. Strong and sustained partnerships and communication were key.

ZAKUS, David, Ryerson University, School of Occupational and Public Health, Canada

Promoting Global Citizenship

How are we doing in global health and development? What are we learning as students and professionals? What should we as Canadians be doing to achieve the SDGs in Canada and in making our contribution around the world - now that we are 1000 days into it? How do we even know what to do, especially given the complexity and enormity of the problems? Looking back over more than 35 years of active engagement in global health, both in the field, in NGOs, government, publishing and academia, I will present the concept of Global Citizenship, and the need for Canadians to embrace it more fully and begin to practice it more widely in order to have a practical and effective working framework for engagement, in any field, whether social, biological, technological or environmental.

Global Citizenship refers to the world perspective whereby those engaged in either local and/or international affairs are fully cognizant of both their rights and duties, and integrate the perspectives of cultural humility and safety. Generally, we are committed to reducing harmful burdens and limiting their impact on those affected and on society in general. The differences among countries and cultures, and within countries, on issues of equity and equality in trying to reduce disparities are central. With a further focus on gender, marginalized and vulnerable populations global citizenship will be presented as both the beginning and continuity for the development of our capacity as Canadians, whether young or old, to make the difference we are capable of making and in a sustainable way.

This presentation will provide a background of the major issues today in global health and environmental wellness by first focusing on the drivers of globalization and global responses to major problems. Ultimately, the case will be made for working towards and achieving global citizenship among students and professionals, which focuses on creating a more just and equal world, and what actions can be taken towards this. Concrete examples related to global disease burden, social determinants of health, maternal and child health, and environmental destruction will be briefly presented and analyzed to stimulate critical analysis and promote the development of further global citizenship among us all, regardless of where we are at in this journey.