The Human Factor
Social sciences in global health research

ITM Colloquium 2014
24-27 November
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ITM 56th International Colloquium
24-27 November 2014
Antwerp, Belgium

ABSTRACT BOOK

Conference locations:

Institute of Tropical Medicine, Campus Rochus
1. Entry, Sint-Rochusstraat
2. Registration and information desk
3. Oral sessions in Aula Janssens (1st floor)
4. Poster sessions in the hallway
5. Lunch, coffee breaks and closing reception in the Forum
6. Overflow room for oral sessions in Auditorium Rochus
7. Karibu resto
8. Glass Room of the BNP Fortis Bank (entry through Wapper)
   Walking dinner (see page 147)
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Background

The extent to which human beings accept and take up biomedical interventions is one of the most decisive factors for their effectiveness and efficiency. Addressing these and other sociocultural factors is key to improving population health in an equitable and ethical way. Nevertheless, the evidence base of most health interventions lacks the contribution of social science research. Typically, global health programs are designed as a set of standardised strategies with limited regard to highly variable contextual factors, including how people at the receiving end interpret and act upon health and illness. Failure to address such issues may even compromise the strategy itself, as is seen in the spread of antibiotic resistance due to inadequate prescription and consumption. When disease elimination is at stake and every individual may have to be reached, socio-anthropological insights become even more vital.

Providing effective and innovative scientific solutions to these and other global health challenges requires moving beyond conventional disciplinary borders. Researchers from various disciplinary backgrounds, therefore, need to look and work beyond their scientific universes, appreciate the synergies between quantitative and qualitative research methods, and combine technological as well as social innovation to optimise disease control and health care.

Objectives

The aim of the colloquium is to show how the collaboration of the social sciences with other health sciences can improve global health research. The colloquium will feature state-of-the-art social science research in global health, examine its transdisciplinary impact on other health sciences and explore ways towards a more holistic evidence-base for the control and elimination of poverty-related diseases.
Conference Programme

Monday 24 November

13:00-14:00 | Registration

The general opening, focus session and reception are open to the press. (Members of the press can register by contacting Roeland Scholtalbers).

14:00-15:15 | Academic Opening session

- Anne Buvé, Institute of Tropical Medicine, Belgium
- Bruno Gryseels, Director, Institute of Tropical Medicine, Belgium
- Koen Peeters, Institute of Tropical Medicine, Belgium
- Jean-Pierre Olivier de Sardan, Institut de Recherche pour le Développement, France

**The vital need for a qualitative approach to health systems. Reflections from LASDEL’s experience in West Africa**

- Peter Smith, Imperial College, UK

**Improving policy and practice for infectious diseases: the role of economic thinking**

- Patricia Kingori, ETHOX Centre, University of Oxford, UK

**Research realities and the everyday experiences of clinical trial fieldworkers in western Kenya**

15:15-16:00 | Coffee break (Karibu)

16:00-18:00 | Focus session–Ebola: The Human Factor in a Dehumanising Disease

Global experts with extensive field experience will discuss the importance of the social sciences in dealing with Ebola outbreaks. As Ebola is transmitted exclusively via bodily fluids, understanding human behaviour plays an important role in fighting the disease. The necessary isolation of patients, as well as the painful and often fatal course of the disease, call for social research taking into account the human factor of this dehumanising disease. Lessons learned will contribute to identifying crucial answers in the current and future epidemics.

Chair

- Erika Vlieghe, National Ebola coordinator, Belgium
Speakers

- Jean-Jacques Muyembe-Tamfum, Institut National de Recherche Biomédicale, Kinshasa, Democratic Republic of Congo
- Sylvain Faye, Université Cheikh Anta DIOP de Dakar
  Practicing anthropology in the Ebola epidemic in West Africa: lessons learned from recent experience in the Guinea bush
- Vinh-Kim Nguyen, Université de Montréal, Canada
  Rethinking Ebola in historical and social perspective.
- Melissa Parker, London School of Hygiene and Tropical Medicine, UK
  The Ebola Response Anthropology Platform: some of the challenges of providing anthropological advice in real time
- Alice Desclaux, Institut de Recherche pour le Développement, France
  Analysing success in the management of the EVD outbreak in Senegal: Insights, challenges and temporalities

18:00-19:00 | Opening reception (Karibu)

Tuesday 25 November

08:30-09:00 | Morning coffee

9:00-11:00 | THEME 1–TOWARDS INTERDISCIPLINARY AND TRANSDISCIPLINARY RESEARCH

Real-life health problems know no disciplinary bounds. Responding to current global health challenges therefore requires solution-oriented research. Transdisciplinarity is based on the collaboration between different disciplines and on the integration of other, non-academic, stakeholders in the process (e.g. civil society, policy, private sector). But how should this be done? This panel explores operational definitions and concepts of transdisciplinarity in global health. It discusses common problems and misconceptions and aims at identifying strategies that help make research across and beyond disciplinary lines work.

Chairs

- Joan Muela Ribera, Partners for Applied Social Sciences (PASS), Switzerland
- Susanna Hausmann, Partners for Applied Social Sciences (PASS), Switzerland

Speakers

- Lenore Manderson, University of Witwatersrand, Johannesburg, South Africa
  Responding to the Cascades of Marginality and Illness
- Frank Kessel, University of New Mexico, USA
  From Definition(s) to Transdisciplinary Practice: Some Historical, Conceptual, and Contextual Complexities
- Laurent Vidal, Institut de Recherche pour le Développement, France
  A stimulating ambiguity: when anthropology meets biomedicine
- Caroline Jones, University of Oxford, UK
  Researching emerging global health challenges: opportunities for transdisciplinary research to break through our restrictive gaze?
- Julie Balen, University of Sheffield, UK
  “From ‘know-do’ to ‘how-why’: interdisciplinary collaboration and the co-production of knowledge to bridge the gap(s) in global health”
11:30-13:00 | THEME 2--SOCIAL SCIENCE CONTRIBUTIONS TO GLOBAL HEALTH RESEARCH

Panel 1--How can transdisciplinarity improve global health research and interventions?

Looking at concrete examples of successful or failed collaborations between social scientists and other health researchers, and at unexamined effects of health interventions (e.g. “clinical trial shopping”), this panel focuses on how the collaboration with the social sciences improves global health research and interventions.

Chairs

- Umberto D’Alessandro, Medical Research Council, The Gambia
- Melanie Bannister Tyrell, Institute of Tropical Medicine Antwerp

Speakers

- Susanna Hausmann, Partners for Applied Social Sciences (PASS), Switzerland
  **Obstacles for financing transdisciplinarity - some insights from the donor side**
- Robert Pool, University of Amsterdam, The Netherlands
  **An anthropology in/of a clinical trial: what it revealed and what you can/cannot/should do with the results**
- David Hendrickx, Telethon Kids Institute, University of Western Australia, Australia
  **The specifics of health research in marginalized populations.**
- Umberto Pellecchia, University of Siena, Italy
  **Unpredictable children. Local meanings and uses of family planning in a refugee camp, South Sudan**

13:00-14:00 | Lunch (Forum)

13:30-14:45 | Lunch Session: Mixed Methods Fusion–Interactive session on less known social sciences methods and their applications in health research.

This workshop is limited to 25 participants. To register for this session, please contact Koen Peeters. (kpeeters@itg.be)

Chairs

- Gert Verschraegen, University of Antwerp, Belgium

Speakers

- Axel Marx, KU Leuven, Belgium
  **Introducing QCA for health research**
- Jaak Billiet, KU Leuven, Belgium
  **Contributions of social science methodology to quantitative health studies**
- Tine Verdonck, Institute of Tropical Medicine, Belgium
  **Qualitative aspects of quantitative research.**

13:00-15:00 | Poster session (Theme 1, 3, 4, 5 & 6)

More information on the content can be found after the oral presentations under the respective themes)
15:00-17:00 | THEME 3–VANTAGE POINTS ON DISEASE ELIMINATION STRATEGIES

How can insights emerging from both the social and the biomedical sciences be combined to develop a more effective approach to disease elimination? Are strategies such as mass drug administration, systematic testing or surveillance using new technologies acceptable and sustainable? Can the mass distribution of preventive measures (e.g. bed nets) achieve the required coverage for elimination? Does the goal of elimination justify potentially coercive measures? These questions will be addressed with reference to current elimination strategies of neglected tropical diseases, HIV/AIDS, malaria.

Chairs
- Katja Polman, Institute of Tropical Medicine, Belgium
- Sarah O’Neil, Institute of Tropical Medicine, Belgium

Speakers
- Umberto D’Alessandro, Medical Research Council, Gambia
- Edwin Michael, University of Notre Dame, USA
  - Managing Neglected Tropical Disease Control: Complexity, Uncertainty, and Governance
- Melissa Parker, London School of Hygiene and Tropical Medicine, UK
  - The ‘Other Diseases’ of the MDGs: rhetorics and realities of mass drug administration for the treatment of lymphatic filariasis in Tanzania
- Steve Harvey, John Hopkins University, US
  - We’ve got the vaccine, so now what? The social science agenda for malaria prevention, control, and maybe(?) elimination

Wednesday 26 November

08:30-09:00 | Morning coffee

09:00-11:00 | THEME 4–WORKING WITH COMMUNITIES: LEARNING FROM THE PAST AND PLANNING FOR THE FUTURE

Since the Alma-Ata declaration in 1978, community participation has become a cornerstone of international health and primary health care. However, the gap between political discourse and effective practice is widening. This session will focus on what has been learned from social science research on working with communities, for example in the control of vector-borne diseases such as dengue and malaria. How can we meet challenges in empowering communities? What “working definitions” of “community” are there and what are their strengths or weaknesses? Can effective community-based interventions be “scaled up” to broader levels?

Chairs
- Dennis Pérez, Institute of Tropical Medicine “Pedro Kourí” (IPK), Havana, Cuba
- Pierre Lefèvre, Institute of Tropical Medicine, Belgium
Speakers

• Susan Rifkin, University of Colorado, USA  
  People Don’t Behave the Way We Think They Should: Reflections on 40 years of Practice and Theory of Community Participation in Health

• Jo-An Atkinson, Australian Prevention Partnership Centre, Sax Institute, Australia  
  Scaling-up community participation for communicable disease control and elimination.

• Johanna Gonçalves Martin, University of Cambridge, UK  
  Learning to walk the paths of health: Becoming a Yanomami health agent in Venezuela.

• Maria Eugenia Toledo, Institute of Tropical Medicine “Pedro Kouri” (IPK), Havana, Cuba - Added value of community empowerment in dengue control: Lessons learned from implementation practices in Cuba

• Gorik Ooms, Institute of Tropical Medicine, Belgium  
  Community participation as a core obligation to realize the right to health: to be included in the health SDG or not?

11:30-11:30 | Coffee break

11:30-13:00 | THEME 5–RESEARCH ETHICS: IN WHOSE INTEREST?

Panel 1–Research Ethics: why “standard procedures” won’t do

Chairs

• Anne Buvé, Institute of Tropical Medicine, Belgium
• Halidou Tinto, Clinical Research Unit of Nanoro (CRUN), Burkina Faso

Speakers

• Raffaella Ravinetto, Institute of Tropical Medicine, Belgium  
  Clinical Research Challenges in the South

• Angus Dawson, University of Birmingham, UK  
  Research Ethics & Responsibility: Guidance not Regulations

• Adamu Adissi, Addis Ababa University, Ethiopia  
  A tool to catch contexts’ specificities: the rapid ethical assessment

• Jennifer van Nuil, University of Liverpool, UK  
  Balancing Benefits and Rumors: Informed consent and participation in clinical research in Kigali, Rwanda

13:00-14:00 | Lunch (Forum)

13:30-14:45 | Lunch Session: Trans Global Health Café

In this session PhD-students from the Erasmus Mundus Joint PhD program are invited to discuss the challenges and opportunities in their transdisciplinary studies with experts in the field (session open to everyone but reservation required)

This workshop is limited to 25 participants. To register for this session, please contact Koen Peeters (kpeeters@itg.be)

13:00-15:00 | Poster session: Presentation of the selected posters (Theme 2)

More information on the content can be found after the oral presentations under the respective themes).
Panel 2—Global health and clinical research: empowerment, exploitation or partnership?

Medical research is vital to identifying effective interventions in global health. The current Good Clinical Practices Guidelines fail to include patients and communities as the key-actors in clinical research. Yet, involving patients and communities, and understanding their sociocultural context, is a crucial element for the ethical and scientific conduct of research. For example, blood sampling in medical research may raise different concerns in different contexts, ranging from fears that samples are being sold or exploited commercially to fears of the blood being used for sorcery. Such concerns can become powerful barriers to the conduct of research and the implementation of effective interventions. How can interdisciplinary research help addressing such ethical challenges?

Chairs
- Yodi Mahendradhata, Gadjah Mada University, Indonesia
- Raffaella Ravinetto, Institute of Tropical Medicine, Belgium

Speakers
- Patricia Kingori, Oxford University, UK
  Research realities and the everyday experiences of clinical trial fieldworkers in western Kenya
- Béatrice Godard, Université de Montréal, Canada
  Ethical issues in international clinical research: understanding, respecting and addressing local cultural patterns
- Lesong Conteh, Imperial College, UK
  Beyond the clinical trial: a health economics perspective
- Soori Nnko, Mwanza Intervention Trials Unit/NIMR, Tanzania

19:00-22:30 | COLLOQUIUM DINNER

Glass Room of the BNP Fortis Bank (entry through Wapper) - see map on page 147
Thursday 27 November

08:00-09:00 | Morning coffee

08:30-11:00 | THEME 6–THE SOCIAL LIVES OF MEDICINES

As commodities medicines have a ‘social life’. They travel the world and have a far-reaching impact on patients, communities and local health systems. In parallel to standardized prescriptions within the regular supply chain, medicines are exchanged between people, bought at local markets, informally traded, stored at home for future use, and often used for purposes initially not foreseen. What meanings do local people and health professionals attribute to medicines and under what conditions are they exchanged and dispensed? How does this influence treatment seeking itineraries and adherence, and with what global consequences (such as antibiotic resistance)?

Chairs

- Benedetta Schiavetti, Institute of Tropical Medicine, Belgium
- Koen Peeters, Institute of Tropical Medicine, Belgium

Confirmed key speakers

- Anita Hardon, University of Amsterdam, The Netherlands
- Erika Vlieghe, Institute of Tropical Medicine, Belgium
  Social dimensions of antibiotic prescribing: a physicians’ perspective
- Adelaide Compaore, Clinical Research Unit of Nanoro (CRUN), Burkina Faso
  “There is Iron and Iron...” Burkinabe Women’s Perceptions of Iron Supplementation: A Qualitative Study
- Clare Chandler, London School of Hygiene and Tropical Medicine, UK
  Beyond silos versus systems: an exploration of the requirements of malaria rapid diagnostic tests
- Ian Harper, University of Edinburgh, UK
- Patrick Cloos, University of Montréal, Canada
  The contribution of critical medical anthropology in global health: the case of antimicrobial resistance.

11:30-11:30 | Coffee break
11:30-12:30 | THEME 2–SOCIAL SCIENCE CONTRIBUTIONS TO GLOBAL HEALTH RESEARCH

Panel 2–Bringing life to health systems: perspectives from social scientists in global health

Health systems are all about people and their institutions. They are social systems, embedded in larger social worlds, connecting care providers and users, their families, communities and transnational networks. The social sciences contribute to health systems research by analysing the underlying socio-cultural and political logics, for example by identifying barriers to effective health interventions, unearthing the decision-making processes within hospitals, or analysing why public accountability is poor. Increasing our understanding of the practices of patients, health professionals and health organizations can lead to better problem analysis, improved study designs and more effective and efficient health policy and management.

Chairs
- Sara Van Belle, Institute of Tropical Medicine, Belgium
- Julie Balen, University of Sheffield, UK

Speakers
- Karina Kielmann, Queen Margaret University, Edinburgh, UK
  Directly observing tuberculosis control: health systems actors and the ‘view from below’
- Clare Chandler, London School of Hygiene and Tropical Medicine, UK
  Beyond silos versus systems: an exploration of the requirements of malaria rapid diagnostic tests
- René Gerrets, University of Amsterdam, The Netherlands
  “If a boss is friendly, I want to work better because I feel free”: How management practices shape workplace communication, motivation and performance in a Tanzanian malaria project
- Shelley Lees, London School of Hygiene and Tropical Medicine, UK
  Can women’s narratives on emergent HIV biotechnologies gained during medical research reveal future practice and possibilities?

12:30-13:30 | CLOSING SESSION–WHERE DO WE GO FROM HERE?

Rapporteurs will present the main findings of the six thematic sessions looking for answers to the question: where do social sciences in global health research go from here? A cartoonist will also display his take on the discussions in a set of drawings produced during the conference.

13:30-14:30 | Lunch (Forum)

15:00-17:00 | Closed sessions (on invitation only)
- Pierre Lefèvre, Institute of Tropical Medicine, Belgium
Academic opening session


Another book (La rigueur du qualitatif. Les contraintes empiriques de l’interprétation socio-anthropologique, Louvain-La-Neuve, Academia-Bruylant, 2008; to be published in English by Palgrave, 2015) deals with methodological and epistemological issues, concerning the policy of fieldwork and the empirical constraints of anthropological interpretations.

He’s currently working on an empirical anthropology of public actions and modes of governance in West Africa, i.e. on the delivery of public services and public goods by African administrations as well as by international organizations, local councils, NGO’s or development projects. His interest is focused on informal regulations (cf. a forthcoming book: The game of the rules. Real Governance and Practical Norms in Sub-Saharan Africa, edited with T. de Herdt, Routledge, 2015). He is in charge of a new LASDEL research program on “Neglected problems in African health systems; a need for reforms”, funded by IDRC. He is also scientific director of a master in medical anthropology at the University of Niamey.
The vital need for a qualitative approach to health systems. Reflections from LASDEL’s experience in West Africa

Fifteen years of research by LASDEL and its partners in West Africa in the health field have documented a series of phenomena missing from virtually all official reports and also not well understood by means of the available quantitative data. For example, the poor relationships between caregivers and patients; the opposition of most health personal to the exemption of user fee policies and the declining quality of care frequently induced by the difficult implementation of these policies; significant differences between the procedures taught to midwives and their actual practices; informal regulations of posting and transfer procedures; the failure of supervisions; etc. The concept of “practical norms” is useful in this regard to investigate this gap between official standards and the actual practices of health personal, that are at the origin of a number of the “neglected problems” of health systems, and have major negative effects on the quality of the services delivered. Practical norms are implicit, latent, but they regulate practices non-compliant with professional norms and they are at the core of the professional and organisational cultures of health workers.

The fact that African health systems (and more broadly States) are aid-dependent and the major role of external funding (“development rent”) partially explain the extent of these deviations. This is also the origin of the strong contradiction among health personal, between public speech (intended for northern partners) and private speech (closer to practices). It is the recourse to private speech (open interviews in natural contexts), as well as the direct observation of practices, which precisely characterizes the qualitative socio-anthropological approach, and its comparative advantage on some issues, producing data in “natural settings”, and allowing a description and analysis of interactions and everyday “real” behaviour.

Shouldn’t the necessary reform of health systems start from these realities rather than from prefabricated external models? Isn’t it more efficient to try improving or modifying existing practical norms than continuously adding new layers of official norms? From such a perspective, the promotion of evidence-based policies must consider qualitative data to be as convincing as quantitative data. The future clearly appears to be the development of mixed methods, which implies certain scientific and partnership conditions, on both sides, to be able to go beyond declarations of intent.
Patricia Kingori, PhD, is a Wellcome Trust Biomedical Society and Ethics Fellow at the Ethox Centre, University of Oxford. Her disciplinary background is in Medical Sociology and her current research interests intersect a sociology of science and medicine, and a critical examination of ethics. Patricia is particularly interest in the frontline practitioners of medical research, the politics of health and the meaning of research and guidelines in practice. Her work has focused on the views, values and experiences of fieldworkers and similar frontline research staff involved in collecting data and interacting with research participants. This has taken place in East Africa but has recently extended its focus to South East Asian and West African countries. Patricia has recently co-edited a special issue of Social Science and Medicine entitled Bioethics in the Field (2013) which explored some bioethics guidelines in practice. She is working on another special issue in the Journal of Anthropology of Medicine entitled “The Museum of ‘Failed’ Research: HIV and AIDS research and the analysis of failure” (2015) which examines what constitutes failure in HIV research.
What types of questions are we asking?

The calls for medical researchers and scientists to work more closely with social scientists are not new. In fact, the very formation of anthropology as a discipline has been in translating the customs and practices of “the other” to scientists for many decades. This suggests that there has not only been a long standing interest in the “human factor” and its role in the practice of science among scientists but also that a well-established position has been created for social scientists in biomedical research.

This position has a number of opportunities and drawbacks for social scientists undertaking contemporary global health research. Social scientists are given access to research institutions to conduct qualitative examinations and ethnographies providing different insights and interpretations of research. The methods and concepts employed by social scientists are increasing familiar to those from a biomedical background, so much so that it is not unusual for biomedical researchers to refer to ‘cultural’ factors in discussing interventions and research and request that social scientist be involved in research to explore this feature. This multi-disciplinary approach is valuable but it often frames the types of questions that social scientists ask and the time in which they have to investigate existing ideas thoroughly and explore new concepts. This position is increasingly producing particular types of relationships and explanations which are worthy of contemporary critique.

The purpose of this paper is to explore the position and relationships of social scientists in contemporary global health research and the types of questions that we ask.
Ebola: The Human Factor in a Dehumanising Disease
(Focus session)
Prof. Sylvain Landry FAYE

Prof. Sylvain Landry FAYE is a socio-anthropologist and lecturer and the current head of the Sociology Department of the Cheikh Anta DIOP University of Dakar.

Holder of a PhD in social and cultural anthropology from the Victor Segalen University Bordeaux 2, he is specialized in medical anthropology, management of health systems research (Free University of Brussels, School of Public Health) and monitoring and evaluation of health programs.

He capitalizes on fifteen years of research on therapeutic innovation in the field of malaria control, maternal and neonatal health, malnutrition, hygiene and sanitation in Senegal. He has to his credit some thirty international publications on these issues. In addition, he has been involved in several evaluations of health programs in the sub-region (Senegal, Niger, Chad, Mauritania, Mali and Guinea Conakry) and conducts quantitative and qualitative acceptability surveys and user satisfaction surveys with first line healthcare facilities. He has also analysed health governance in the context of decentralization of health districts in African countries.

Trainer in research methodology in social sciences and medical anthropology in the Masters of public health, Prof. Faye also supports health intervention teams for the implementation of health development projects or for the management of medical emergencies (WHO Team for Response to Ebola in West Africa).

Notes
Practicing anthropology in the Ebola epidemic in West Africa: lessons learned from recent experience in the Guinea bush

Since March 2014, the three countries bordering the Mano River (Guinea Conakry, Liberia, Sierra Leone) have experienced an Ebola virus epidemic, quite specific in its expression: it affects both urban and rural areas, has several outbreaks widely distributed over the country and crosses borders. Since August, the situation has become progressively worse, with high morbidity and mortality both in the general population and in the health personal. The most noteworthy aspects are the distrust of epidemiological protocols and violence by the populations against humanitarian teams and local workers involved in the Ebola response. In this context, anthropologists have been asked to intervene to help identify the factors explaining these behaviours and facilitate the medical teams’ approach to the communities.

From our recent experience of being involved as an anthropologist, we will discuss the contributions of the discipline to the management of the response and challenges faced by the social sciences. Anthropological investigations have provided answers to the classical demand for cultural translation and mediation requested by medical teams. They have shed light on the human, social and political factors justifying the behaviour of distrust and have permitted medical teams to humanize and adjust their approaches to the local realities. However, beyond the medical demand, the anthropological perspective also addresses the blind spots in the response and other issues occluded by the emergency situation and especially the consequences of the “dehumanization” induced by the epidemic on social processes: in Guinea, Ebola amplifies the demographic dynamics and is straining social and family solidarity because of the attitudes of distrust and practices of social distinction. The epidemic is also redefining “social borders” within families and communities and induces a crisis of confidence towards the healthcare system already weakened by the high rate of infection in health care personal. More fully, this epidemic induces us to think about the figures of otherness and the ethics of trust in a country already tested by ethnic and political divisions. Finally, the social sciences contribute both to managing the emergency and reflecting on the challenges of the post-emergency situation.
Vinh-Kim Nguyen

Vinh-Kim Nguyen is an HIV physician and medical anthropologist. As both a practitioner and researcher, he is concerned with the relationship between science, politics and practice in global health. Since 1994 he has worked extensively with community organizations responding to the HIV epidemic in West Africa as a trainer and physician. This work informed his anthropological work on the global response to HIV with a concern for the forms of triage and sovereignty they embody. He continues to follow the evolving scientific and political response to HIV in his current work which focuses on molecular epidemiology, global health and social theory. He practices at Emergency and holds chairs in Global Health in Montréal and Paris and is a Professor of Anthropology at the University of Amsterdam.

Notes
Rethinking Ebola in historical and social perspective.

Tragically, the ebola epidemic in West Africa echoes earlier epidemics of trypanosomiasis that raged through the same region at the beginning of the colonial era, and were met with Pasteurian eradication campaigns that at times used coercive measures to diagnose and treat patients by administering toxic and ineffective treatments. Strong evidence exists that structural adjustment programs conducted in the area from the 1980s fatally compromised health systems and generated the civil wars in Liberia and Sierra Leone. Mistrust of foreign interventions to control the epidemic have a profound historical basis. Given these lessons from the past, what might be directions going forward? I suggest that alternatives to the isolation camp model need to be explored, notably through working with grassroots efforts and community organizations to strengthen education and home-based isolation and care. Drawing on the lessons we have learned from the HIV epidemic, greater emphasis should be placed on mobilizing survivors as actors in the response to the epidemic. Concrete examples will be given based on fieldwork conducted in the affected countries in November 2014.
Melissa Parker

Melissa Parker is Reader in Medical Anthropology at the London School of Hygiene and Tropical Medicine. She has undertaken multi-disciplinary and collaborative research in African and European settings. A unifying theme is the study of global health and international development. Research questions have typically emerged from extensive periods of ethnographic fieldwork, and engage with global health policies and practice. Topics investigated include HIV/AIDS in the UK, mental health in war zones, health-related quality of life in Kenya, female circumcision in Sudan, and the control of neglected tropical diseases in Sudan, Uganda and Tanzania.
The Ebola Response Anthropology Platform: some of the challenges of providing anthropological advice in real time

The Ebola Response Anthropology Platform was established in October 2014 with the intention of providing a co-ordinated, adaptive and iterative response to the epidemic. By drawing on existing anthropological expertise, and undertaking targeted fieldwork, it is hoped that current efforts to contain Ebola will be enhanced by providing clear, practical, real-time advice about how to engage with socio-cultural and political dimensions of the virus and build locally-appropriate interventions. Some of the challenges of providing advice on issues such as the role of mass communication; strategies for enabling people to come forward for testing at the first sign of illness; and culturally acceptable and safer burial practices are discussed.
Focus session - Ebola: The Human Factor in a Dehumanising Disease

Alice Desclaux

Pr, Anthropologie de la santé
Directrice de recherche IRD, UMI 233 TRANSVIHMI CRCEF, Dakar, Sénéga

Notes
The social sciences are usually called upon in public health settings when technical measures must be adapted to sociocultural contexts and when biomedical means are not sufficient to manage prevention and care. The Ebola outbreak in Senegal showed a different situation: the WHO acknowledged the Senegalese health system’s management in September–October 2014 of a single confirmed case of EVD, without any secondary transmission amongst 74 contact cases, as a success. This evolution generated rapidly evolving demand from Senegalese public health actors for analysis of the social aspects of the epidemic. It also required a specific approach from social scientists to define research objects and questions for analysis, partly common and partly in contrast to the neighbouring countries still in crisis and hit at an incomparably high level. This presentation, based on an on-going research program about EVD and the social production of trust in Senegal, will (1) discuss the contribution of social science analysis at various epidemiological stages (EVD epidemic risk, crisis and “post-crisis” situations), (2) present research questions particular to a situation of “successful” management of the outbreak, and (3) argue for a comparative, multi-level and multi-site approach and discuss its challenges. Finally, it will discuss temporality in research—a key issue when a critical and contextualized analysis of biomedical achievements and a quick applied appraisal of “lessons learned from experience” are both needed.
Towards interdisciplinary and transdisciplinary research
(Theme 1)
Theme 1: Towards interdisciplinary and transdisciplinary research

Lenore Manderson

University of Witwatersrand, Johannesburg, South Africa

Lenore Manderson, PhD, is professor in the School of Public Health at the University of the Witwatersrand (South Africa) and visiting Professor of Anthropology with the Institute for the Study of Environment and Society at Brown (USA). She is a medical anthropologist, and has contributed also to sociology, the social history of medicine and public health, undertaking field research, training and publishing extensively across these disciplines in Australia with immigrant, indigenous and Anglo-Australians, in Ghana, South Africa and various countries in Southeast and East Asia. Professor Manderson previously held positions in Australia as Professor of Medical Anthropology (Monash, 2006-2013), Professor of Women’s Health (Melbourne, 199-2005) and Professor of Tropical Health (Queensland, 1988-1998).

Notes
Responding to the cascades of marginality and illnes

We have become increasingly aware of and concerned with the interrelationships of structural disadvantage, context, biology and disease. There are a number of methodological challenges involved in going beyond description of these multiple factors. I use the example of the social, economic and biological determinants of cardio-metabolic disease in Sub-Saharan Africa to highlight the conceptual as well as pragmatic complexities involved in understanding the development and chronicity of the disease. This complexity necessarily dictates an interdisciplinary research program, including research partnerships within academic settings and with components of civil society, despite the difficulties epistemologically and in prioritising the focus of work when the questions that impact poor health are so complex.
Frank Kessel and Patricia Rosenfield

University of New Mexico, USA

Frank Kessel is a professor in the College of Education, and a Senior Fellow in the Robert Wood Johnson Foundation Center for Health Policy at the University of New Mexico. Previously he served for 12 years as Program Director for the Culture, Health and Human Development Program at the Social Science Research Council in New York. Also responsible for SSRC initiatives at the intersection of the social, psychological and bio-medical sciences, he has consulted with Canadian groups engaged in inter-disciplinary research on health, advised the National Cancer Institute on its “Science of Team Science” initiative, and has now contributed to various national and international conferences and publications in the area of Inter/Trans-Disciplinarity. A Fellow of the American Psychological Association and the Association for Psychological Science, Kessel received his Ph.D. from the University of Minnesota and his M.A. at the University of Cape Town, and has held academic positions at the University of Houston, the University of Alberta, and the University of Cape Town. Among his publications: Interdisciplinary Research: Case Studies from Health and Social Science.

Notes
From Definition(s) to Transdisciplinary Practice: Some Historical, Conceptual, and Contextual Complexities

Is the apparent failure to integrate a rich range of disciplines into social-problem-oriented research and associated programmes and policies a function of a lack of agreement on what constitutes “transdisciplinarity” (e.g., in global health)? Our aim will be to suggest that, although the issue of definition is not trivial, various other complex dynamics need to be scrutinised. And we will attempt to shed light on those by considering an earlier “Golden Age” of cross-disciplinary work (at least in North America) and by suggesting a conceptual frame that might facilitate the meaningful engagement of various communities of practice, both within and beyond the academy.
Laurent Vidal

Institut de Recherche pour le Développement, France

Laurent Vidal is an anthropologist, senior researcher at France’s Institute of Development Research (IRD), where he is a former director of the Department of Social Sciences. A specialist in health issues in Africa, his work over the past two decades has brought together research on development questions in the field of health (with focus on HIV/AIDS, malaria, tuberculosis, maternal health...in Cameroon, Côte d’Ivoire, Senegal) with critical analysis of the practice of research itself. He leads a social sciences and public health project on HIV and coinfections in Cameroon, where he is Associate Professor at Catholic University of Central Africa. He has published fifteen books and fifty papers. Among his recent books in 2014: Anthropology in the Making. Research in Health and Development, New-York, Routledge (Series: Routledge Studies in Anthropology), 182 p.; Le sida au Cameroun : nouvelles militances et société civile (dir.), Paris L’Harmattan, 159 p.; Expériences du partenariat au Sud. Le regard des sciences sociales (dir.) Editions IRD, 352 p.

Notes
A stimulating ambiguity: when anthropology meets biomedicine

My aim is to show how to discuss a research project with health professionals, which both allow to conduct research and are the objects of study; another ambiguity lies in the type of methodological discussions we may have with health professionals: project construction, restitution, consequences... These discussions are negotiations in which both parties want to preserve their knowledge base, their prerogatives. These situations must be understood by the researcher as moments to rethink his approaches.

Finally one must ask to what extent the issues and results of these discussions are shaped by the type of research questions (health practices), or whether instead they are characteristic of any anthropological approach.
Caroline Jones

University of Oxford, UK

Caroline Jones is a senior social scientist at the KEMRI-Wellcome Trust Research Programme in Kenya. She has a PhD in anthropology (exploring the diet, subsistence activities and perceptions of health among the Yolngu of north east Arnhem Land, Australia) and 20 years of experience working in sub-Saharan Africa on the uptake and provision of health care with particular attention on malaria. Much of this research has involved initiating and leading social science research projects within broader multidisciplinary public health research programmes. More recently the focus of her research has shifted to critical studies of the development and implementation of public health interventions, employing an ethnographic approach to explore the human, political and technical issues that shape outcomes. A key role in her current position is to contribute to building Kenyan and regional expertise to develop and lead such research.

Notes
Researching emerging global health challenges: opportunities for transdisciplinary research to break through our restrictive gaze?

Our current views and approaches to infectious diseases are shaped by ‘silo thinking’, limiting our ability to respond to both the existing and evolving challenges in global health. In this presentation, I will provide two examples of new challenges associated with the ancient disease malaria (emerging zoonotic malaria and insecticide resistance) and describe my involvement in the development and conduct of transdisciplinary research addressing these two evolving challenges. Reflecting on the practical and intellectual encounters, confrontations, and questions revealed by these experiences, I will contemplate possible strategies for promoting transdisciplinary research to enlarge our field of vision.
Theme 1: Towards interdisciplinary and transdisciplinary research

Julie Balen

University of Sheffield, UK

Julie is a Lecturer in Global Health at ScHARR. Her academic interests sit broadly within the field of health policy and systems research (HPSR). Julie’s work examines system-wide challenges and opportunities posed by neglected tropical diseases (NTDs) and emerging infectious diseases (EIDs), for which she has conducted operational/implementation research across Asia and sub-Saharan Africa. This includes work on the integration of various ‘vertical’ control programmes and ‘horizontal’ health systems strengthening approaches.

Julie has become increasingly interested in management and leadership in health, and human resources for health. As such, she is also studying part-time for an MBA. Her work draws on trans-disciplinary concepts and mixed-methodology tools for global health research. Julie’s team of PhD students work on the impact of biomedical knowledge (Maelle deSeze) and the role of biomedical professionals and other stakeholders (Samuel Lassa) in evidence-informed health policy making across West Africa.

Notes
From ‘know-do’ to ‘how-why’: interdisciplinary collaboration and the co-production of knowledge to bridge the gap(s) in global health

It is frequently acknowledged that there is a ‘know-do’ gap in global health – a mismatch between scientific advances and their application in policy and practice. This results in wasted resources and missed opportunities, posing particular challenges for resource-poor settings where public health needs are considerable. Much has been written about knowledge translation (KT) as a means of accelerating the use of research evidence and innovations to strengthen health systems and improve health outcomes. A complicated process involving “the synthesis, exchange and application of knowledge by relevant stakeholders” (WHO, 2005), KT emerged in the field of medicine in the mid-to-late 1970s, when evidence-based healthcare was recognized as a critical concern in clinical settings. Broadening initially into the social sciences, KT also occupies an important agenda for health policy and systems research, and the idea of systematically using “best evidence” in the policy cycle permeates global health organizations and initiatives. Whilst bridging this gap is a welcome goal, it has been argued that a majority of KT strategies primarily focus on research-based knowledge, often transferred uni-directionally. We therefore call for moving beyond thinking about what we know and what we do – bridging the ‘know-do’ gap – to thinking about how we know it and why we do it – bridging the ‘rigor-relevance’ gap. Some have claimed that this is fundamentally impossible because “researchers and the researched inhabit separate social systems” (Kieser and Leiner, 2009). Conversely, our empirical studies that draw on the social sciences and the co-production of knowledge between academic researchers and users of research evidence – challenging embedded knowledge hierarchies of the expert versus the layperson – test the viability of such concerns. Here we present opportunities and challenges of joining rigor with relevance, based on our study of leadership and health systems and on the personal experiences of those involved in the research.
Theme 1: Towards interdisciplinary and transdisciplinary research

POSTER 1
Spatial analyses for assessing health interventions

Emmanuel Bonnet – Institut de Recherche pour le Développement – UMI 236 RESILIENCES / IDEES Caen CNRS 6266 – France
David Zombré – CrCHUM Montréal
Bertrand Meda – CrCHUM Montréal
Valéry Ridde - CrCHUM Montréal

For many years, the geography of health and its methods have contributed to a reflection on the geography of diseases and the geography of health care with a view to carrying out a social and spatial examination of the health care offer, inequalities in provision of health care to populations as well as the distribution of diseases. However, geographic approaches are under-represented in evaluative research and the practice of assessing interventions whereas other disciplines employ them to refine their analyses and understanding of the interventions studied. Contributions made by the geographic approach are conceptual as much as methodological, and most notably by way of spatial analysis.

Spatial analysis is an approach that seeks to explain a localised phenomenon (a geographic unit) from an understanding of its situation in relation to other units. The analysis of spatial differentiations consists, therefore, in understanding why there is a difference in health conditions between several districts of a town, by taking into consideration both the physical properties of an area (infrastructure, transport), as well as the social organisation or indeed the environment. Spatial analysis uses methods and tools that are complementary to the qualitative and quantitative approaches used in public health. Geographic methods make it possible to produce spatialised results in the form of spatial and mapping statistics. Spatial analysis uses elements to evaluate if the effects of interventions are the same throughout an entire area while examining if the potential differentiations are indicative of inequity. It makes it possible to assess the socio-spatial dimensions of health conditions or other effects expected from public health interventions at various scales and therefore to move from the identification of a situation to a global analysis of an area in which an intervention takes place. This capability to complete the understanding of phenomena, to localise and quantify them is a means to improving the evaluation of interventions as well as strengthening the actions wherever questions of equity are most relevant.

Three examples in Burkina Faso will be presented to illustrate the input of spatial analysis in the examination of health interventions: the analysis of exemption from payment for health care on the part of the destitute; the effects of subsidised provision for childbirth on the use of health services and neonatal mortality; the long term effects of free services on the use of health care. These findings help to obtain a better estimation of the needs of vulnerable populations and to target the most exposed places with the aim of improving the health of populations.
To Protect ‘Vulnerable Populations’, or to Address ‘Vulnerabilities’ ? : Towards a Social Science Paradigm in Global Health

Nabeel Mangadan Konath

Abstract: In Global Health, ‘Vulnerable People’ and ‘Vulnerable Populations’ are accorded high importance. There are historic reasons behind this importance and they have shaped many of our current debates significantly. However, even amidst calls for increased protection for vulnerable populations, a growingly significant segment of scholars argue otherwise: some even maintaining that the concept is futile. My study explores the reasons behind these controversies from a social science point of view and examines whether and how the concept of vulnerability can be useful.

We can see an important aspect in protection of vulnerable populations as addressed in many deliberations, especially in ethics of biomedical research: that it’s either very superficial or tokenistic if not paternalistic. Guidelines, Regulations, Publications and often research ethics reviews tend to focus the discussions towards pre-categorized groups called “vulnerable populations” or “vulnerable categories” of people rather than the different types of vulnerabilities of individuals in their environments.

On one hand, a lot of people with vulnerabilities tend to be overlooked since they do not belong to these pre-categorized groups. Secondly, just because people ‘belong’ to such groups, we tend to overprotect them – for example, women, children, elderly, etc. While the former situation can lead to the argument that everyone is vulnerable, the latter situation denies the benefits of global health research from some groups in the name of their protection. Both these arguments defy the usefulness of this important concept.

We can overcome this paradox if we move our focus away from “vulnerable populations” and concentrate on the potential “vulnerability factors”. This is explained using a conceptual diagrammatic model of consent, which shows how prospective participants decide to participate or not based on their relative perceptions of risk and benefit. Different vulnerability factors of an individual can have varying degrees of push-pull effects on the risk-benefit perception threshold of this decision making model. There are certain limitations of this model too especially at this conceptual stage. Drawing from this conceptual model, there must be more empirical research on vulnerability factors using social science methods and community engagement.
Can local knowledge expand the visions of Global Health on Education?

Patricia Ferreira

Global health is entangled with the dynamics of knowledge production and exchange. One of the main contributions of the social sciences for global health is the discussion about “what sorts of knowledge and scientific framing “count” in health contexts” (Adams, 2010). Often, this diversity of contexts covered by global health initiatives exposes the complexity of managing health promotion and education programmes with the purpose of health practice as a means of improving living conditions and delivering health care (Farmer, 2006).

In the project “New approaches to research on social determinants of health”, a collaboration between the Centre for Social Studies of the University of Coimbra (Portugal) and the Research Laboratory of Epidemiology and Social Determination of Health of the Institute for Clinical Research Evandro Chagas (Oswaldo Cruz Foundation, Rio de Janeiro, Brazil), we discussed new configurations of health promotion interventions resulting from learning experiments in the field of infectious diseases. We asked the patients of IPEC to register their visions on health, environment and society through a combination of photographs and their captions and to share them through a photographic exhibition. The event became a privileged setting for the mutual engagement of a range of actors, including HIV patients, their families, health professionals, educators and researchers, where different forms of knowledge and experience were exchanged and reconfigured.

Through an interdisciplinary approach from epidemiology and social sciences, we aimed to explore what kind of engagement with biomedical and knowledge-based experience these educational activities promoted and to open spaces for new dialogues and configurations of health promotion and education on HIV infection.
Poster 4
Linkage between livelihoods, wealth categories and vulnerability to zoonotic diseases in arid and semi-arid lands of Kenya

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Background of the study: Some of the major factors that influence the occurrence of zoonotic diseases are vector dynamics, environmental conditions, climatic conditions and weather patterns. However, humans form an integral part of this system due to their land use patterns, livelihood strategies and animal husbandry practices. These activities cause humans to be in close and frequent interaction with their ecosystems though the nature and frequency of these interactions vary according to the socio-ecological differences among others. A proper insight is needed of the various determinants of differential prevalence rates of disease within relatively homogenous communities. Poverty and wealth affect final disease outcome asymmetrically because economic duress restricts the potential for ameliorative action hence an understanding of the mechanistic processes linking land use and socio-economic conditions with disease enables prediction of future trends and control or mitigation. The key objective of this study was to establish how different local people interact with ecosystems as they pursue their livelihoods and how this influences the risk of exposure to infectious diseases.

Methods: This study was conducted among small holder farmers in an irrigated area (Bura and Hola irrigation schemes of Tana River district) and non-irrigated area (Ijara district) all situated in the northeastern part of Kenya, to compare the differences in livelihoods, ecosystems and potential exposure to disease. The study population included the local people (differentiated by gender, age, and livelihood activities). Data were collected through participatory methods in August to November 2013 carried out in 40 focus group discussions (14 in the Irrigated areas; 26- in the non-irrigated area). Different asset bases were used to categorize households into high, medium and low level wealth categories. These included education levels, livelihood strategies and activities, food security and livelihood outcomes.

Results: Preliminary results indicate that across the two districts, the majority (90%) of the households were considered to fall in the middle (28%) and low (62%) wealth groups, with most of them living in medium sized to small basic houses mainly made of local material. They were reported to utilize firewood and charcoal for cooking and kerosene for lighting as opposed to their rich counterparts who mainly used charcoal, for cooking and solar and torches for lighting.

People in the irrigated areas were mainly involved in crop farming with limited numbers of sheep and goats while those in the non-irrigated areas were predominately livestock keepers. Rich households were distinguished by their high numbers of livestock (>50) and household goods while those in the low wealth group had less than 5 livestock and mainly sheep and goats only and also owned fewer household goods. Ability to access safe clean drinking water (piped, treated or bottled) was seen as a characteristic that differentiated the wealth categories in irrigated and non-irrigated areas. In both areas, households in the middle and lower wealth categories mainly engaged in casual labor in the farms, herding, charcoal burning, collecting firewood, grass and water for sale as opposed to those in the rich who were engaged in formal employment or business.
Theme 1: Towards interdisciplinary and transdisciplinary research

In terms of gender, in irrigated areas, women were reported to be more engaged in planting and weeding while men in watering, spraying and guarding of the farms when the crop is ready. In non-irrigated areas, the livestock activities were more gendered with milking and looking for fodder and water for livestock, caring for calves and sick animals being activities undertaken by women. Herding, treating and assisting in birthing were mainly men related activities. Livelihood activities were seasonal in both districts. In terms of education in both the study areas, the rich households had their children schooled beyond secondary school level while those in the two lower groups could afford to educate their children only up to secondary school or below. On the side of nutrition, those in the high wealth category in both the irrigated and non-irrigated areas were reported as able to consistently afford adequate nutrition as opposed to the other wealth categories. The key human diseases common in the two study areas were malaria, typhoid, pneumonia and bilharzias. Brucellosis was mentioned only in the non-irrigated areas. Rift valley fever was also mentioned as an emerging disease affecting both humans and livestock especially in non-irrigated areas.

Conclusion and recommendations: The livelihood strategies within the study region are mainly natural resource based activities (farming, charcoal burning) hence mostly exposing people in the middle and lower wealth category to frequent interactions with various ecosystems harboring different disease vectors. This places them at risk of contracting diseases albeit at different levels. Communities are not homogeneous and therefore for effective disease control and management, there is need to develop appropriate targeted interventions for vulnerable groups that also take into consideration people’s livelihood strategies. In the case of zoonotic disease outbreaks, targeted appropriate control measures are important to curtail the spread of disease. Hence this information is useful to guide on who is given priority with regard to interventions in an outbreak situation.
Theme 1: Towards interdisciplinary and transdisciplinary research

Poster 5

Seunghyun Yoo, DrPH, MPH; Healthy Workplace Project Group; HePCEM Research Team

Presenter Bio

Seunghyun Yoo, DrPH, MPH, is Associate Professor of Community Health Promotion at the Graduate School of Public Health, Seoul National University, South Korea. Her research interests include urban health, community collaboration, built environment and health, participatory research, qualitative research, and mixed-methods design. Currently she is involved in a number of community health research projects on topics including healthy workplaces, health promoting daycare setting for young children, community environment and low-income urban elderly, experience of obesity prevention and control, and collaboration process for regulating alcohol advertisement on city bus in Seoul. She received a BS in health education from Ewha Womans University (Seoul, Korea), and an MPH in health education and communication from Tulane University (New Orleans, LA, USA). Yoo earned her doctoral degree in community health sciences also from Tulane University.
Social science contributions to global health research
(Theme 2)
Susanna Hausmann

Partners for Applied Social Sciences (PASS)

PhD, MSc, MBA
PASS-International

Trained as an epidemiologist and medical anthropologist, Susanna has been working over the past 20 years in Global and Public Health. She has done field work on health-seeking behavior and social science aspects of malaria and neglected diseases. She has published on vulnerability and access to care. Before joining Swiss Agency for Development and Cooperation in 2012, she was a lecturer and senior researcher at Autonomous University of Guerrero in Mexico, where she was involved in a Dengue community engagement project. From 2003-2010, she was Deputy CEO of UBS Optimus Foundation, responsible for its Global Health Research grant strategy. As a Founding Member of Partners of Applied Social Sciences (PASS) International, Susanna has been teaching Medical Anthropology Applied to Public Health in Antwerp and Glasgow.

Notes
Obstacles for financing transdisciplinarity - some insights from the donor side

In research of infectious diseases affecting most vulnerable populations, transdisciplinarity is not well established. One of the reasons can be traced back to the emergence of the ‘military’ metaphor of the disease and its logical response of a ‘race for innovation’. In contrast to non-communicable diseases and other health-related conditions, the communicable diseases are seen as clearly delineated ‘targets’ that are ‘detectable’, ‘fightable’ and ‘eliminable’ with ‘magic bullets’ and ‘magic weapons’. Under this dominant viewpoint of disease, the role of anthropologists working in multi-disciplinary teams is often limited to find strategies of how to bring such disease-specific life-saving technologies to target populations.

Viewpoints of other stakeholders have little in common with this reductionist perspective of disease. Lived experiences, political interests, socio-economic and environmental determinants all define the specific circumstances of disease. Transdisciplinarity provides an approach that responds to such specific circumstances. But social scientists need to ‘make their case’ and donors must be responsive to address transdisciplinarity if such circumstances are acknowledged at center of attention. A concrete example of a dialogue with a philanthropic donor will be exposed.
Theme 2: Social science contributions to global health research

Robert Pool
University of Amsterdam, The Netherlands

Robert Pool is an anthropologist and professor of Social Science and Global Health at the University of Amsterdam, where he directs the Health, Care and the Body programme group and the Long-Term Care Partnership, and co-directs the Centre for Social Science and Global Health. Much of his research has focused on HIV and malaria prevention in Africa, which also involved the integration of anthropological methods in clinical trials. His current projects include an ethnographic study of community health resources in Uganda, a large programme of research on long-term care and dementia in the Netherlands, and an anthropological project on elective death.

Notes
An anthropology in/of a clinical trial: what it revealed and what you can/cannot/should do with the results

MDP301 was a large clinical trial carried out in four African countries to test the effectiveness of a candidate vaginal microbicide gel in preventing HIV transmission. The trial had an integrated social science component that aimed to study adherence, sexual and other behavior relevant to the trial outcome, acceptability of the gel, understanding of the trial procedures, etc. In this presentation I will focus on a number of findings from the social science research that were not covered by the original objectives but that had (and have) methodological, practical and ethical implications for such clinical studies: (1) the way in which what is being measured is negotiated during a research process that is ostensibly neutral and objective, and (2) the way in which trial participants appropriated the aims of the study relating to women’s empowerment and the efficacy of the microbicide gel. Finally I will discuss how the clinical trialists received these ‘alternative readings’ and what the implications of this are for such multidisciplinary collaborations.
David Hendrickx

Telethon Kids Institute, University of Western Australia, Australia

David is a social scientist (MSc in Sociology) based in Perth where he is currently undertaking a PhD with the University of Western Australia, the Telethon Kids Institute and its Centre for Research Excellence in Aboriginal Health and Wellbeing. His doctoral work focuses on identifying ways of improving the control of skin infections in Western Australia’s remote Aboriginal communities.

From 2009 to 2012 David worked as a researcher at the Institute of Tropical Medicine in Belgium, where he was involved in various qualitative studies that documented community and healthcare provider attitudes and practices regarding various neglected tropical diseases, mainly in rural areas of DR Congo, Nepal and Indonesia.

His research interests include the control of infectious diseases in remote low-resource settings, and the role of social determinants and socio-cultural factors in health service provision in such settings.
On the clinical management of infectious diseases of poverty in remote, low-resource settings.

A discussion of four qualitative studies on healthcare provider attitudes and practices.

The realisation that the control of infectious diseases in developing countries extends beyond the mechanistic implementation of purely technical interventions is not a new one. In recent times an overall acknowledgement of the need to expand notions of disease control to incorporate an understanding of the socio-cultural context in which such programs are implemented has become well established. An effective disease control strategy is one that manages to be in line with the lives and sociocultural context of those it is targeting, thereby ensuring maximum effectiveness and sustainability.

This presentation will explore some of the specific considerations and challenges that arise when implementing infectious disease control strategies and associated research projects in the context of marginalised populations in otherwise well-off countries. Examples of such settings are the notoriously frail health and wellbeing of indigenous populations in affluent societies such as Australia and Canada, as is that of nomadic populations such as the Roma in Europe.

This presentation will provide an overview of these challenges, while also highlighting social science approaches that provide a framework for engaging with such communities in the context of infectious diseases control. Finally, we will also illustrate how lessons learnt from these settings are applicable to disease control in other contexts, including low-resource settings in developing countries.
Umberto Pellecchia

University of Siena, Italy

Umberto Pellecchia holds a Ph.D in Social Anthropology, orientation African Societies, at University of Siena, Italy. He spent 15 months fieldwork in the forestal areas of South-Western Ghana, focusing his researches on the local notion of personhood and authority. Outcomes of the dissertation have been published on international journals. In 2008 he starts his work with medical humanitarian organizations as medical anthropologist, while maintaining scientific interests. In 2010 he edited Il Potere e la Cura, a collection of essays on the relationship between health and socio-political inequalities. In 2012 he joined Medecins Sans Frontieres – Brussels as anthropologist. He carried on five missions in South Sudan, Egypt and Liberia.

Notes
Unpredictable children. Local meanings and uses of family planning in a refugee camp, South Sudan

Examining narratives and practices of contraceptives uses and family planning (FP) in Doro Refugee Camp, South Sudan, this study portrays the different expectations of health agencies and beneficiaries on reproductive health. Doro Camp is located on northern part of South Sudan and hosts since 2011 almost 50,000 refugees from Blue Nile State.

The topics discussed are based on three months of ethnographic research where both communities practices and medical interventions of Medecins Sans Frontieres (MSF) have been examined with an anthropological perspective. Residents in Doro have been interviewed on their opinions about children spacing, use of contraceptives and general family organization. The FP program of MSF has been questioned too in its socio-cultural implications. The core question the study addresses is which idea of family a FP program addresses. Definitions of family, believed universal by the medical science, are locally more fuzzy, negotiated, and dependent on socio-economic circumstances. Family is locally based on the idea that births are not predictable in their numbers as expected by medical science, and are not unconditionally determined. Contraceptives for spacing are strategically used to avoid pregnancies in perilous periods (i.e. during scarcity of food) and the “control” on fertility involves a number of parents that exceed only sexual partner.

Indeed far from an alleged medical neutrality, FP meets on the ground peculiar understandings strongly related to moral economies (e.g. gender issues) and social organization and hierarchies (e.g. parenthood, belongings). This is especially true in precarious settings – such as refugee camps – where the lives of the residents are shaped by high instability, sudden changes and volatile social networks.

The analysis raises arguments on to which extend bio-medically designed programs make sense in culturally diverse environments, and how to create a space of community involvement on sensitive issues.
Axel Marx

KU Leuven, Belgium

Axel Marx is Deputy Director Leuven Centre for Global Governance Studies, KU Leuven. The Leuven Centre for Global Governance Studies is an interdisciplinary research centre of the Humanities and Social Sciences of University of Leuven (Belgium). The Centre was founded in 2007 and Axel has been involved as a research manager and senior researcher since its foundation. It was set up to promote, support and carry out high-quality international, innovative and interdisciplinary research on global governance. In addition to its fundamental research activities the Centre carries out independent applied research and offers innovative policy advice and solutions to policy-makers on multilateral governance and global public policy issues. The Centre promotes pioneering projects in law, economics and political science and actively initiates and encourages interdisciplinary, cross-cutting research initiatives in pursuit of solutions to real world problems. In addition to its fundamental research, GGS carries out independent applied research and advises policy-makers on multilateral governance and global public policy issues. It regularly organizes conferences, seminars and debates on these issues, including a summer school. It works with academic and policy partners from all over the world, including the European Parliament, the European Commission, the European External Action Service, the Committee of the Regions, the OECD, UNIDO, UNCTAD, the World Bank and the WTO. The Centre currently employs 30 full time in-house staff and researchers.

Notes
Theme 2: Social science contributions to global health research


Introducing QCA for health research

This seminar introduces Qualitative Comparative Analysis (QCA) and why one would be interested in the method in the first place. The aim is to show the potential use of QCA in understanding causal complexity and gaining leverage out of multi-case study research. It covers the origins and the logical foundations. The seminar will also introduce QCA as a step-wise approach and will discuss some of the technicalities of the method.
Jaak Billiet was until 2007 full professor in social methodology at K.U. Leuven. Until 2011, he was member of the central co-ordination team of the European Social Survey. The ESS team obtained the prestigious Descartes Prize for collaborative research in Europe. Jaak Billiet also played a central role in the implementation of the fourth wave of the European Value Study in 2008-2010. Jaak Billiet’s methodological research deals with quality improvement of survey research, in particular validity assessment, response effects, modelling measurement error, measurement equivalence, and non-response bias. This research is mostly in the context of substantial research in the domains of ethnocentrism, political attitudes, and religious orientations. Last ten years, it has a longitudinal and comparative character. Billiet obtained the Francqui chair at the Free University of Brussels in 1993, and he is member of the Flemish Royal Academy of Sciences & Arts (Belgium).
Contributions of social science methodology to quantitative health studies

Qualitative field research methods are increasingly recognized and valued for the understanding of human behavior, attitudes and values related to health. The contribution of basic concepts and approaches specific to quantitative social science methodology to health research is less understood. We will show how the understanding of basic notions of measurement error and the care for measurement quality of questions used in health research may improve the validity of conclusions in health studies.
Tine Verdonck

Institute of Tropical Medicine, Belgium

Tine Verdonck is assistant professor at the Unit of Epidemiology and Control of Tropical Diseases, Department of Public Health, Institute of Tropical Medicine Antwerp. She holds a medical degree from the University of Leuven and a PhD in medical sciences from the University of Antwerp. Tine has participated in clinical and epidemiological research at the Universidad Peruana Cayetano Heredia in Lima, Peru (2000-2011) and at the Institute of Tropical Medicine of Antwerp (2011-2014). This research has been developed in a context of international collaboration or capacity building. The main research topics are clinical manifestations and diagnosis of infectious diseases using quantitative approaches and observational study designs. Tine is also involved in teaching basic epidemiology and statistics in postgraduate courses for health professionals.
Qualitative aspects of quantitative research.

Undoubtedly, strictly designed quantitative and experimental studies such as randomized clinical trials have made substantial contributions to medical knowledge. On the other hand, more than half of the publications in clinical speciality journals describe observational research. Also in this observational research, the default approach has become quantitative, and terms such as P-values, simple random samples, odds ratios and confidence intervals are used to convince the audience. I am of the opinion that each quantitative study also contains qualitative elements, which tend to be underestimated and underreported, perhaps because these are unfamiliar grounds to researchers with a strictly quantitative background. These qualitative elements include among others: the research motivation, the theory underlying the research question, the justification of the study design, the selection of the study site, the a priori suspected sources of bias, the evaluation of the assumptions of statistical tests, and the process of causal and normative inference. During the talk, this point of view will be further developed on the basis of concrete examples of published quantitative studies.
Clare Chandler

London School of Hygiene and Tropical Medicine, UK

Clare Chandler is a Senior Lecturer in Medical Anthropology in the Department of Global Health and Development at the London School of Hygiene and Tropical Medicine. She is currently on a fellowship through the LSHTM’s Institutional Strategic Support Fund with the Wellcome Trust. Her research interests lie at the interface of anthropology and global health, studying social aspects of malaria, health care delivery, public, private and community health care access, diagnostics, use of medicines and pharmacovigilance in low-resource settings. The focus of her work has been in Tanzania and Uganda, as well as in other areas of Africa and Asia. She is experienced in interdisciplinary research, and is concerned with re-shaping questions around global health intervention and impact and she is committed to strengthening the quality of social science in global health research.
Beyond silos versus systems: an exploration of the requirements of malaria rapid diagnostic tests

Malaria control is dominated by a ‘tools’ based approach – bed nets, spraying, chemoprevention, chemotherapy and most recently diagnostic tests (RDTs). This approach fits well within a system that requires tangible inputs and countable outputs, and much attention in research is focused on the numbers of units delivered and establishing causality with indicators of impact, and establishing value for money. This approach is often pitched as disease-specific ‘silos’, and distinguished from a ‘health systems’ approach. In global health rhetoric both appear important, but disconnected, being the realm of different experts. This talk looks at the points of connection between so-called ‘silo’ and ‘systems’ approaches from the perspective of the requirements of malaria RDTs. These tests are pitched as simple, and mobile, and therefore ostensibly bypass the human error and infrastructure challenges that are seen to hamper good case management. In practice, the tests demand substantial skills and infrastructure to improve care. Through the lens of RDT use, this paper will explore what is made visible of the requirements in creating health care, attempting to move beyond a dichotomy of silos or systems.
René Gerrets

University of Amsterdam, The Netherlands

René Gerrets is Assistant Professor at the Department of Sociology and Anthropology at the University of Amsterdam. His research interests are at the intersection of anthropology, global health and development. Centered in Tanzania, his past research studied the rise of ‘partnership’ as a dominant organizational form in the field of international health, using malaria as a lens to explore the shifting relations between science and governance. Similarly located in Tanzania, his current research examines how biomedical institutions dating established during the colonial era generate memory through the material remains they left behind. His new research examines the role of malaria indicators in global health governance.
“If a boss is friendly, I want to work better because I feel free”: How management practices shape workplace communication, motivation and performance in a Tanzanian malaria project

It is increasingly recognized that the motivation and performance of people working in health interventions can influence the running and the outcomes of such endeavors – for better but also for worse. Hence, improving staff motivation and performance have come to be viewed as critical elements in boosting the success of health interventions and, more generally, in strengthening health systems. Reflecting this shift, in various resource-constrained settings there have been more efforts aimed at enhancing the motivation and the performance of workers, particularly in public-sector health facilities. In comparison, little attention has been paid to motivational issues involving staff in research interventions such as clinical trials. Moreover, disentangling the relationship between the motivation of workers and their performance is complex and highly variable, shaped by direct and indirect variables, some of which are context-specific. This talk addresses both issues by examining how workplace dynamics affected motivation and performance among staff in a malaria drug trial in Tanzania. Drawing on long-term ethnographic fieldwork, it discusses how variations in managerial styles influenced communication between supervisors and fieldworkers and, over time, affected core practices such as data collection.
Theme 2: Social science contributions to global health research

Karina Kielmann

Queen Margaret University, Edinburgh,

I am a medical anthropologist with training in anthropology (B.A. University of Sussex; M.A. McGill University) and public health (Ph.D. Johns Hopkins University Bloomberg School of Public Health). Since 2001, I have worked on tuberculosis and HIV care in India, Zambia, and South Africa. In these settings, characterised by emergent chronic and drug-resistant illness strains, new diagnostic technologies and complex treatment options are transforming the understanding of these illnesses, the respective roles and agency of patients and providers in care, and the potential for long term engagement with the health system. Yet for many, access to quality care remains elusive. My interests are to understand how individuals negotiate the terms of illness, social costs, and outcomes within increasingly diversified landscapes and moral economies of care.
Directly observing tuberculosis control: health systems actors and the ‘view from below’

Beyond the promise of new diagnostic technologies and drugs, the real challenges of managing tuberculosis (TB) in the era of drug resistance and HIV are often articulated as contextual or health systems barriers. The technical requirements of new demands on the health system – integration of services, point-of-care testing, partnerships with non-state actors – present a reconfiguration of conventional patient-provider relationships and provider dynamics in TB care. In this talk, I highlight the importance of a dynamic, bottom-up view of the health system that enables closer examination of the processes through which instrumental goals in delivering TB services are attained (or thwarted). Selected case studies from the world of TB control in India and Southern Africa form the backdrop for a discussion of the critical roles and social relations of health systems actors. I examine how these actors’ relative power, agency, and capacity to negotiate both material and social resources help account for the relative ‘success’ and sustainability of interventions intended to improve services for patients affected by TB, TB/HIV co-infection and multi-drug resistant (MDR)-TB.
I am a medical anthropologist with training in social sciences (BSc. and MRes London Metropolitan University) and medical anthropology (Ph.D. University of London). Since the 1990s I have conducted research in Tanzania focusing on maternal health, HIV, HPV, and more recently on gender-based violence. My main interest concerns the historical trajectory of women’s agency and responses to poverty, illness, and violence over this period.
Can women’s narratives on emergent HIV biotechnologies gained during medical research reveal future practice and possibilities?

There continues to be a focus on the development of biomedical technologies in response to the HIV epidemic including anti-retroviral medications (ARV) for treatment, which are now emerging as preventive technologies, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), microbicides, as well as treatment as prevention (TasP). These technologies have not come to exist in isolation but draw on existing social and political discourses that both privilege and frame their development. In particular, the development of microbicide gels has been championed by feminist activists, who have drawn on ideas about the sexual lives and agency of African women that are linked to risk and vulnerability. The development of these biotechnologies requires randomised control trials, which can also be seen as technological. HIV prevention trials are also a social practice in which technologies such as microbicides are transferred from the global to the local; that is from laboratories to individual women’s bodies, which are themselves situated in particular local complexities. Drawing on an anthropological study conducted in the context of a microbicides clinical trial, this paper sets out to explore Tanzanian women’s narratives concerning this emergent HIV prevention technology, how this was articulated alongside their own concerns with gender, power and sexuality. Finally, the paper will discuss what such insights can tell us about the future practice and possibilities of this biotechnology if made widely available to Tanzanian women through health care systems.
Poster 1
The burden of unpaid bills in private hospitals settings in rural Boyo, Cameroon: An anthropological study

Asahngwa Constantine

Introduction
Although inhabitants of rural Boyo are aware of their vulnerability to unannounced sickness, they hardly prepare for sickness or do so in a sustainable way. Some people seek health from hospitals and are unable to pay the cost after care. Debtors are withheld within hospital premises by hospital authorities, and their stay can last up to a year. The prevalence of the phenomenon of bill penders or debtors seems to be a heavy burden to service providers and patients. The objectives of this study were to Investigate (i) Factors responsible for the accumulation of unpaid bills (ii) The burden of unpaid bills on service providers and patients (iii) coping strategies used by service providers and patients (iv) Why bill penders have not joined the Boyo Mutual Health Organization (BMHO) and (iv) Implications of the burden for the BMHO, community health financing and Cameroon’s health system.

Method
Observations, indepth interviews and focus group discussions were conducted with 21 bill penders, 17 health service providers (managers, nurses, doctors, finance officers, social workers, security guards) and 5 staff of BMHO scheme in two private faith-based rural hospitals in Boyo from October, 2012 to June, 2013. Data was analyzed thematically and Ethical Approval was obtained from the Cameroon Bioethics Initiative.

Findings
Lack of a sickness preparation culture, unwanted pregnancies, accidents, high cost of treatment, disrupted family ties and non membership to the BMHO accounted for accumulated unpaid bills. Unpaid bills represent social, economic and health burdens for patients and service providers. While service providers lamented on loss of huge finances and insecurity (prostitution, stealing, noise, alcoholism smoking), patients complained of poor living conditions (hunger, poverty, imprisonment, abandonment, witchcraft attacks, risk of new infections). Negotiations, cancellations, escape, manual labour and humanitarian assistance are some of the coping strategies. Limited finances, ignorance of BMHO, lack of interest and huge cultural expenses are some of the reasons why patients have not joined the scheme. The BMHO is limited needs to be strengthened to expand coverage and achieve health protection.

Conclusion
Unpaid bills have economic, social and health burdens to service providers and patients. Out of pocket payments impede equal access to health services despite the existence of BHMO. The performance of BMHO needs to be improved in order to expand coverage and offer financial security as a health financing tool within Cameroon’s health system at Health District levels.
Poster 2
Quality of life and experiences of obstetric fistula in Bangladesh

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Introduction
Obstetric fistula is primarily caused by obstructed labour, leaving women incontinent. Obstetric fistula greatly affects multiple aspects of women’s lives, physically as well as their psychological, social, and economic states. While many studies on surgical fistula closure have been reported, few have examined the quality of life (QOL) of women following surgery for fistula. This study aimed to identify factors associated with QOL and to describe further details of the experiences of women with obstetric fistula who underwent surgery.

Methods
This study used a mixed method. In a quantitative survey, 113 women were recruited through the hospital records of fistula surgery in rural Bangladesh for a community-based survey. QOL was assessed using the SF-36 questionnaire. Demographic, obstetric, and fistula-related information were also collected. In a qualitative study, 15 women were purposively selected for in-depth interviews to investigate the experiences of fistula.

Results
Recent experiences of discrimination, marital status of separation or divorce, internalized stigma, and stillbirth were associated with poor QOL. Forty-two percent of women reported that their economic condition remained the same or worse compared with before surgery. Qualitative information indicated that some women who had been cured had a positive perspective, but others had mixed feelings or still suffered from emotional pains. The failure in role as a wife and mother, particularly childlessness related to fistula, has familial, social, emotional, and economic consequences. Abusive attitudes during illness by the husband, in-laws, and neighbours appeared to be strongly connected with long-term psychological distress. Economic hardship because of separation from a spouse, accumulated financial burden for seeking care for obstructed labour by various practitioners before referring to hospital, caesarean section at hospital, and treatment for fistula repair were the major factors contributing to further impoverishment.

Conclusions
A comprehensive approach for fistula care is required that includes socio-economic and psychological assistance after surgery.
Maternal and perinatal health policy in low income countries (LICs) promotes institutional deliveries. However, quality of maternity care is often found to be substandard in LICs, and persistently high maternal and perinatal mortality ratios are considered indicators of poor health system functioning. Enhancing accountability is considered one avenue to strengthen health systems. However, there is little in-depth examination of how accountability ‘works’ on the ground, in specific moral landscapes and in concrete social interactions infused with power differentials (Freedman & Schaaf 2013). This multidisciplinary study examines ‘organic’ accountability relationships between health workers, women, their male partners and relatives in Malawi through the ‘lens’ of pregnancy complications and loss in childbearing (maternal mortality; abortions; perinatal deaths). In 2013, we collected narratives of loss, care seeking, provision of care and quality issues through 58 semi-structured interviews and 15 focus groups with health providers, women and men with a loss experience and community members. Thematic analysis illuminates how especially women are held accountable for loss and ‘inappropriate’ health seeking behaviours through symbolic, behavioural and verbal mechanisms. Detailed discursive analysis reveals more subtle, implicit ways in which providers and community members allocate accountability and blame for loss. This study demonstrates how health workers and maternity clients draw on, and reproduce, local notions of accountability, entitlements and blame in their interactions. Thus, to understand the use and provision of maternity care we need to acknowledge that health workers and (potential) service users are relational beings embedded in wider social and health system contexts and moral discourses. Providers, clients and their relatives reproduce and navigate moral landscapes, influenced by ‘top down’ accountability mechanisms. These moral landscapes may affect women’s satisfaction with care, health workers’ job satisfaction and health system functioning. They need to be acknowledged by health policy makers seeking to improve maternal and perinatal health.
Poster Changing Perceptions of Peruvian Patients and their Family Members Pertaining to an HTLV-1

Authors: Cassandra Garbutt, Catalina Garcia, Elsa Gonzalez Lagos, Martin Rodriguez, Carlos McFarlane Pecol, and Cesar Quevedo Penaloza.

Abstract: Human T-Lymphotrophic Virus Type 1 (HTLV-1) is a neglected public health issue, negatively affected the needs and emotional experiences of the patients. Evidence suggests that HTLV-1 is prevalent in Peru and could affect 1-2 percent of the total population. This retrovirus can enable the onset of severe diseases, such as HTLV-1 associated myelopathy/tropical spasticparapresis (HAM/TSP), infective dermatitis, and adult T-cell leukemia (ATL). Most seropositive individuals remain asymptomatic, which can enhance transmission rates. We invited HTLV-1 patients, whom had more than one year of diagnosis and were treated at a specialized service in Lima, and some of their family members to participate. Sampling was purposive mainly under a snowball technique according to suggestions of health staff and participants. Data collection included non-participatory observation at the center and some participants’ homes, and voice recorded and semi-structured in-depth interviews designed to understand the impact of HTLV-1 diagnosis in daily life. The analysis was iteratively performed, with use of analytic memos and transcriptions of the interviews; the latter were coded based on content analysis. We present preliminary results from an ongoing qualitative research study of 51 participants: most (38/51) were women, with median age 48 and 11 having HAM/TSP, including 5 in wheelchairs. In the case of participants with HAM/TSP, we reached saturation for the following: a prolonged and complicated medical journey in search of a diagnosis that could extend for years and generate misinformation and even anguish; the alternation between denial and acceptance with regards to the evidence of progression of physical impairment; and, whenever applicable, the relief provided by means of vesical self-catheterization and its clear positive effect on the sense of gaining control for outdoor activities, which was quite unexpected from the perspective of health providers whom were more focused on the patients’ walking capacities. Additional findings for which saturation has not yet been reached suggest an array of coping tactics, the influential role of some health staff, the impact of HAM/TSP on work activities, and the perception of family support, which could differ from the actual available support. The patients’ perception of familial support ranges from feelings of a protective and caring environment to one of rejection, which seems to depend on previous familial conflict unrelated to the diagnosis. Ultimately, the results can be useful for the implementation of awareness and prevention programs, providing better health services and facilities for individuals affected by HTLV-1, and enabling healthcare professionals to provide appropriate care.

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Poster 5: From Scratch: Oncology in Rwanda

Darja Djordjevic

Abstract: In Africa, the effects of the HIV/AIDS pandemic, rapidly expanding industrial and extractive economies, uncontrolled economic growth, environmental and lifestyle changes, and the rising age of populations with better access to medicine have occasioned rising rates of cancer. Rwanda’s national cancer program has been hailed as a unique example of how to build clinical oncology into a public healthcare infrastructure. In my current fieldwork I address three sets of questions: 1. What historical, economic, social, and political factors have shaped the development of the country’s cancer program? 2. How do local clinicians and patients experience cancer as a treatable chronic disease? And how is that experience affected by the development of a national oncology infrastructure and new biomedical technologies? 3. As an instance of the transnational private-public partnerships characteristic of global health interventions in postcolonial Africa, what successes, limitations, and challenges does this cancer program present for envisioning oncology programs elsewhere in the global south? What are the ethical, political, and epistemological stakes involved in different models of cancer care? This project will contribute to a new chapter in medical anthropology and global health, one focused on rising rates of cancer in contemporary Africa. I shall argue that Rwanda’s cancer project is an exercise in the construction of a new sense of sovereignty, rendered through the politics of life as onco-nationhood; that it is an effort to create a postcolonial polity whose citizen body is gifted care of a international caliber provided by a paternal state. In a critical moment of post-traumatic social reconstruction, national biomedicine is becoming the entity through which government seeks to fuse sovereign statehood and nationhood in the cause of a healthy Rwandan future. Theorizing this relationship holds at least one key to developing an anthropology of cancer in contemporary Africa.
Poster 7
Thermal care for newborn babies in rural southern Tanzania: a mixed-method study of barriers, facilitators and potential for behaviour change

Donat Shamba

Abstract: Background: Hypothermia contributes to neonatal morbidity and mortality in low-income countries, yet little is known about thermal care practices in rural African settings. We assessed adoption and community acceptability of recommended thermal care practices in rural Tanzania.

Methods: A multi-method qualitative study, enhanced with survey data. For the qualitative component we triangulated birth narrative interviews with focus group discussions with mothers and traditional birth attendants. Results were then contrasted to related quantitative data. Quantitative data (n=22,243 women) on the thermal care practices relayed by mothers who had delivered in the last year.

Results: 42% of babies were dried and 27% wrapped within five minutes of birth mainly due to an awareness that this reduced cold. The main reason for delayed wrapping and drying was not attending to the baby until the placenta was delivered. 45% of babies born at a health facility and 19% born at home were bathed six or more hours after birth. The main reason for delayed bathing was health worker advice. The main reason for early bathing believed that the baby is dirty, particularly if the baby had an obvious vernix as this was believed to be sperm. On the other hand, keeping the baby warm and covered day-to-day was considered normal practice. Skin-to-skin care was not a normalised practice, and some respondents wondered if it might be harmful to fragile newborns.

Conclusion: Most thermal care behaviours needed improving. Many sub-optimal practices had cultural and symbolic origins. Drying the baby on birth was least symbolically imbued, although resisted by prioritizing of the mothers. Both practical interventions, for instance, having more than one attendant to help both mother and baby, and culturally anchored sensitization are recommended.
Poster 8

Cholera epidemic in Haiti: how can solution-oriented anthropological research nurture intervention strategies?

Authors

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Upon the outbreak of an epidemic of cholera in Haiti in October 2010, an exploratory qualitative study was conducted among the Haitian population faced for the first time with this disease. The objective was to identify representations about cholera and local practices that may influence the evolution of the epidemic and the implementation of a medical response by the organization Médecins Sans Frontières. The data collected between November 2010 and January 2011 come from observations, individual (n=129) and collective (n=16) interviews and were subjected to a thematic content analysis.

Most of the representations and practices we identified fit into preexisting etiologic and therapeutic models and voodoo beliefs: blurred line between natural and mystic disease; combination of these two aspects of the disease and possible shifts from one to the other; complementarity of treatments and versatility of therapists; sense of powerlessness and ambivalent attitudes towards those who are reputed to hold therapeutic responsibility and power; idea of a transmission of contagious diseases through air and smells; fear of evil spells, especially of powders which are strongly associated with cholera; concerns about the dead whose spirits might affect the living. Subsequent intervention strategies were adapted to the socio-cultural context.

Limitations of our research are due to the emergency context and the combination of anthropological investigation and health promotion. However, we emphasize the relevance of such a solution-oriented approach which allowed the identification of resistances to which the intervention strategy was adjusted. We also stress the need to adapt anthropological tools and methods to emergency contexts, especially now that the demand is growing from the humanitarian field.

Taking into account the likely evolution of cholera into an endemic disease in Haiti we conclude with suggestions for future anthropological investigation to sustain efforts in refining health promotion activities from a socio-cultural perspective, including food, health and sanitation habits, the strength of mystic beliefs about cholera and the dead, the aggressiveness towards those who are suspected of transmitting cholera, the perception and use of treatment units, and regional variations regarding conceptions, attitudes and behaviours.

Keywords: Haiti, epidemic, cholera, health promotion, anthropology
**Poster 9**

**Global Public Private Partnerships in Real-Life: a story of policy actors, institutions and context**

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**Abstract:** Global Public Private Partnerships (GPPPs) are flourishing on the global health governance landscape. These mechanisms are widely celebrated for enhancing multi-sectoral engagement and deliberative decision making; the so-called ‘halo-effect of partnerships’. However, their conduct in real-life represents more of a complex state of affairs that is not well explored. Their ‘embeddedness’ within national contexts is especially less understood.

This study explores how the real-life interaction between policy actors within GPPPs is influenced by institutional and contextual factors in developing countries. The study is guided by a theoretical lens adopted from social science theories that seek to explain the relationship between actors’ agency, institutions and contextual factors. In this regard, the relationship between these factors is framed as a dynamic interaction mediated by ideas, meanings and narratives (a dialectical relationship).

The study employs an instrumental case-study design that focuses on the country coordinating mechanism (CCM) of the Global Fund in Ethiopia, with a view to generating an in-depth understanding of how such globally designed partnership mechanisms manifest in real-life, in developing countries. This qualitative study includes 44 key-informant interviews, non-participant observation of CCM meetings and document analysis. Accordingly, the findings that relate to participants’ perceptions of the manner of actors’ interactions within and around the CCM, the ‘critical themes’, were analysed interpretively, against the pertinent institutional and contextual factors in the setting.

The identified critical themes relating to actors’ interactions include: compromises to safeguard the ‘national interest’; dominance of clinical care over population-based interventions; actors’ perceptions of each other (a public sector that gets its way, a timid civil society, a cautious donor community, and a private sector missing in action); and a perception of ‘an effective system best left to its own devices’.

The institutional factors that appear to reinforce these themes include: ‘consensual decision-making’ adopted as a CCM rule; Global Fund principles of country ownership, partnership, performance based funding and zero tolerance to fraud; and the composition of the CCM in Ethiopia. Contextually relevant factors include: the nature of the Ethiopian State; history of AIDS in Ethiopia; poverty alleviation as a political pledge; tight regulation of civil society; and civil society organisations’ inherent representation and coordination crisis.

The import of theoretical perspectives from the social sciences has enabled useful ways of analysing participants’ accounts of their lived experiences of ‘partnering’, within a globally designed partnership mechanism, in a developing country setting. Specifically, the emphasis on understanding the interplay between actors’ agency, the institutions that govern their interactions and the wider contextual factors, has enabled the unravelling of a complex web of factors that influence observed trends in actors’ interactions.
Poster 10
Ethnographic approach to the evaluation of intervention strategies against dengue fever in Yucatan, Mexico

Josue E. Villegas

Abstract: At the present time in Yucatan, there is no mechanism that is efficient or systematic enough for the evaluation of the various interventions that the state government performs for the control and prevention of dengue fever. In spite of this, the effectiveness of such interventions in the official speech and media is that the disease has been reduced by 50%. However, ethnographic studies carried out since 2010 by a group of anthropologists (coordinated by myself) of the Autonomous University of Yucatan, have showed different results. First, there are many social perceptions about the effectiveness of the interventions that people experiences, identify and values in their daily lives. Second, there are the acceptance and the changing meaning processes that these people express in response to such governmental actions. Third, the familiar and local experiences regarding the access to healthcare service when there are dengue fever outbreaks. The results show that these social actors exhibit low expectations about the complete or partial success of the prevention and control programs against dengue fever and that, eventually, end up adapting several of the interventions to their economic necessities and not to the family health care. This paper shows these results and makes a proposal for implementing alternative strategies for the prevention and control of dengue disease.
Norms and Discourses on Heterosexual Anal Sexual practice among high risk groups and general population in Tanzania: Implications for HIV prevention

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Introduction
The risk of contracting HIV through heterosexual anal sex (HAS) is significantly higher than from vaginal sex intercourse. Discourses are coherent sets of beliefs available to specific populations to discuss particular topics and they are likely to shape people’s thinking and behaviour. Little has been done to understand the norms driving the practice of HAS and how people talk about it. A better understanding of discourses on HAS would offer useful insights for measurement of the practice as well as designing appropriate interventions to minimise the risks inherent in the practice.

Methods
This study employed qualitative approaches involving 24 focus group discussions and 81 in-depth interviews. The study was conducted in 4 regions of Tanzania, and included samples from the general population and among high risk groups (fishermen, truck drivers, sex workers, food and recreational facilities workers). Discourse analysis was conducted with the aid of NVIVO 10 software.

Results
Six discourses were delineated in relation to how people talked about HAS. Secrecy versus openness discourse describes the terms used when talking about HAS. “Other” discourse involved participants’ perception of HAS as something practiced by others unrelated to them and outside their communities. Acceptability/trendiness discourse: young women described HAS as something trendy and increasingly gaining acceptability in their communities. Materiality discourse: describes HAS as a practice that was more profitable than vaginal sex. Masculinity discourse involved discussions on men proving their manhood by engaging in HAS especially when women initiated the practice. Masculine attitudes were also reflected in how men described the practice using a language that would be considered crude. Public health discourse: describes HAS as riskier for HIV infection than vaginal sex. The reported use of condoms was low due to the perceptions that condoms were unsuitable for anal sex, but also perceptions among some participants that anal sex was safer than vaginal sex.

Conclusion
Discourses among young women and adult men across the study populations were supportive of HAS. Understanding how prevalent discourses shape patterns of sexual practices related to HAS, and using them as resources in HIV prevention, could contribute to “culturally compelling” interventions.
Poster 12: Relationship of Giardia to environmental and social and behavioural factors: public health implications

Pedro Almirall

Abstract: Giardia lamblia (synonymous G. duodenalis, G. intestinalis) is the most common intestinal pathogenic protozoan infection reported in humans, and represents a major cause of diarrhoea in children and travellers worldwide. The disease it causes, giardiasis, is nowadays included in the neglected diseases initiative. An average of 280 million people is infected each year with this parasite but this could be an underestimation considering the infection is higher in endemic countries where diagnostic facilities and reporting systems are unavailable or not functional.

Giardiasis has a wide range of spectrum, varying from asymptomatic to severe gastrointestinal disease with abdominal pain, diarrhea, vomiting, weight loss, malabsorption and vitamin A deficiency. More recently, giardiasis has been considered responsible for residual morbidity, i.e., chronic fatigue, post-infectious irritable bowel syndrome, and, in early childhood, poor cognitive function and failure to thrive.

Even when giardiasis is a mild and potential self limiting disease, some perceive it as a harmful disease. To explore the general level awareness about giardiasis, clinical features, mode of transmission, prevention and consequences, and describe the sources and channels of information of caregivers would prefer using to be informed about this disease a triangulation of quantitative and qualitative methods was carried out with caregivers of children who were taken to the Academic Paediatric Hospital “Centro Habana” (APHCH).

A case control study was carried out in in-patient children and those who had Giardia lamblia infection were compared with non Giardia-infected children, focusing only on 4 clinical manifestations: diarrhoea, abdominal pain, asthenia and vomiting. In multivariable analysis, abdominal pain (odds ratio [OR] 4.71, 95% confidence intervals [CI] 2.66–8.32) and asthenia (OR 3.30, 95% CI 1.16–9.37) had positive and independent associations with Giardia infection.

A questionnaire was administered to caregivers attending to the outpatient clinic and focus groups with caregivers of children admitted in the APHCH. Nearly 73% considered giardiasis as a modern problem, and 39% considered that it could be a fatal disease. Although 76.7% of caregivers were aware that small intestine is the organ affected, other localizations were cited. Abdominal pain and diarrhea were recognized as the commonest symptoms; however, asymptomatic forms of these infections are hardly accepted. Around one third could identify that giardiasis may spread through drinking unboiled water, unwashed vegetables and fruit intake; however, other incorrect ways were mentioned at the same time; respondents with more than 12 years of formal education were more likely to have better knowledge. Similar occurred concerning the methods of prevention. Commonly, television (59.4%) and health care workers (52.9%) were suggested as a good ways of supplying information.
Caregivers have knowledge of giardiasis, although there were myths and misconceptions regarding giardiasis. Boiling water and washing hands before eating and after defecation and washing vegetables were mentioned among the principal ways of preventing this infection.

The most commonly mentioned reasons for not adopting preventive behaviours included lack of time due to outdoor activities and limitation of combustible distribution. Treatment-seeking behaviour when giardiasis suspected mainly included visiting the nearby doctor. Misconceptions about giardiasis need to be removed through focused health education messages. Intervention strategies to control giardiasis needs to be through an integrated approach aiming at boosting caregivers’ knowledge and encouraging all healthcare workers to act as a readily available source for health information about giardiasis.

The present study also supports the potential role of G. lamblia in abdominal pain in children who attend- and are admitted- to a hospital in Havana City, and highlights the importance to keep abdominal pain and asthenia in mind in hospital admitted children in the event of an association with an evocative epidemiological context.
Poster 13
Women’s voice to improve the quality of maternal health care provision in Burundi: challenges and perspectives

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Ntahimpereye Gérard
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Georges Nsengiyumva
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Background
More than a decade of civil war in Burundi left the health system including maternal health services delivery destructed. Free care for women aimed to improve access to service delivery was decided upon. This did not achieve sustainable results unveiling the need for more innovative solutions. One option is the use of social accountability to improve maternal health services; an approach in which citizen express their needs stimulating service providers to be responsive. An exploratory study was carried out in two provinces of Burundi in 2013 to identify and discuss community perceptions on the quality of maternal health provision in order to discuss opportunities to use or strengthen social accountability mechanisms for maternal health provision in Burundi.

Methodology
Semi-structured interviews were used to collect data from community informants made of men, women, community health workers, health community members, community leaders, religious leaders, health and administrative authorities and health providers. Data analysis facilitated by MAXDA 11 software proceeded with data coding and the constant comparison was used for content analysis.

Results
Citizens especially women hold grievances against maternal health care provision: the staff bad attitude and disrespect towards women; Staff’s lack of skills, delay to be received in the health facility were mostly pointed out. The majority of women are reluctant to express directly their claims and dissatisfaction about maternal health provision to the medical staff. In case women decide to speak out, they use intermediaries mostly community health workers . Gossip is also used with the hope that it can spread out and reach health providers. Most of providers do not understand the needs for a warm welcome; dialogue with women; a good attitude towards them and are not hence responsive to their needs.

Conclusion
Social accountability for maternal health services does not yet exist in Burundi .For its implementation, women voice needs to be strengthened by the mean of a dialogue facilitated by an independent structure that will allow free expression for women and medical staff and organize a constant dialogue between women and health providers.

Key words
Community; maternal health care quality ;perceptions; social accountability
Intravaginal cleansing practices among women of reproductive age in Mwanza, Tanzania: The implication of vaginal microbiome disturbances in increasing risk for STI’s transmission.

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Background: Intra-vaginal practices (IVP) such as insertion of herbs, soaps, or cloth are widespread in some parts of the world. Motives for such IVP differ across cultures. In sub-Saharan Africa, these motives include enhancement of health, hygiene, and sexual satisfaction of male partners. Some IVP are associated with reproductive tract infections such as bacterial vaginosis, which has been shown to be a risk factor for HIV acquisition.

Objectives: The aim of this study was to identify and characterize the types of products used intra-vaginally and to identify the motivations for IVP among Tanzanian females. The study was part of a larger biomedical study exploring the composition of the vaginal microbiota among adolescent girls.

Methods: The study was conducted in Mwanza, Tanzania, and employed an ethnographic research design. Respondents were purposively selected according to age and location. We conducted 53 in-depth interviews (IDI) with 16 adolescent girls aged 16-19 years, and 37 IDIs with men and women aged 20-75 years. To complement IDIs, focus group discussions were conducted with adolescent girls (N=3) and adolescent boys (N=2).

Results: The most common reported IVP during IDIs and FGDs included inserting fingers, herbs, cloth, soaps and/or water into the vagina. Participants considered IVP to be beneficial to women’s health, hygiene, fertility and men’s sexual satisfaction. Young women are taught vaginal cleansing practices for hygiene and health purposes by their mothers or female relatives. Cleansing for sexual practices and other IVPs for tightening or warming the vagina were taught to them through peers, marriage teachers and social media. Most women were not informed about the potential risk of IVP on their sexual health. During IDIs, we also found that both male and female perceptions towards ideal state of the vagina indirectly influenced women’s IVPs.

Conclusion: This study strongly suggests that IVP are common and embedded in social and cultural norms. These findings should be taken into consideration when designing interventions to address the impact of IVP on risk on women’s reproductive health. Trials investigating candidate cervicovaginal products for the prevention of HIV in sub Saharan Africa should consider how to discuss the modification or cessation of IVP with the study community.
Poster 15
Developing a social autopsy tool for dengue mortality: a pilot study

Valerie Ridde

Abstract: Background: Dengue fever is a public health problem in the tropical and subtropical world. Dengue cases have grown dramatically in recent years as well as dengue mortality. Colombia has experienced periodic dengue outbreaks with numerous dengue related-deaths, where the Santander department has been particularly affected. Although social determinants of health (SDH) shape health outcomes, including mortality, it is not yet understood how these affect dengue mortality. The aim of this pilot study was to develop and pre-test a social autopsy (SA) tool for dengue mortality.

Methods and Findings: The tool was developed and pre-tested in three steps. First, dengue fatal cases and ‘near misses’ (those who recovered from dengue complications) definitions were elaborated. Second, a conceptual framework on determinants of dengue mortality was developed to guide the construction of the tool. At last, the tool was designed and pre-tested among three relatives of fatal cases and six near misses in 2013 in the metropolitan zone of Bucaramanga. The tool turned out to be practical in the context of dengue mortality in Colombia after some modifications. The tool aims to study the social, individual, and health systems determinants of dengue mortality. The tool is focused on studying the socioeconomic position and the intermediary SDH rather than the socioeconomic and political context.

Conclusions: The SA tool is based on the scientific literature, a validated conceptual framework, researchers’ and health professionals’ expertise, and a pilot study. It is the first time that a SA tool has been created for the dengue mortality context. Our work furthers the study on SDH and how these are applied to neglected tropical diseases, like dengue. This tool could be integrated in surveillance systems to provide complementary information on the modifiable and avoidable death-related factors and therefore, be able to formulate interventions for dengue mortality reduction.
Poster 16
The impact of the politico-culturally derived definitions of “Harmful Traditional Practices” for Health Promotion in Ethiopia.

Ken Masuda (Nagasaki University, Nagasaki, Japan)
Chiharu Kamimura (Japan Society for Promotion of Science, Nairobi, Kenya)

This presentation provides cases of how politically driven efforts to eradicate “Harmful Traditional Practices (HTPs)” impede health promotion in Ethiopia. HTPs are customary practices that have been deemed “harmful” by governmental organizations and that should consequently be eradicated. However, such campaigns for HTP eradication are not necessarily health-related, but instead target particular cultural practices. This study attempts to situate the “prohibition of traditional practices” in the Ethiopian political context and discourse.

One such case from southern Ethiopia involves the HTP prohibition of nightly dance in the bush (warsa) that is popular among Banna youth. The government has rationalized the condemnation of this practice under the premise of HIV prevention, as the nightly dances are said to provide an opportunity for Banna youths to date. Another case involves the traditional practice of extraction of milk teeth among the Amhara. This practice has gradually been abolished as a result of extensive health promotion and governmental intervention. However, milk teeth extraction continues to be conducted by traditional healers due to the culturally specific illness of “milk teeth diarrhea”.

The politically driven efforts to eradicate “Harmful Traditional Practices (HTPs)” has to be understood in relation to Ethiopia’s gradual process of modern-nation building, which has been marked by gradual ethnic Amhara domination over the Southern cultures. This assimilation to Amhara culture, or amharanization, was perceived to be synonymous to modernization since the late 19 century and includes Christianity as belief system. During the military-socialist regime (1974-1991), attempts at development were marked by interventions aiming at improving people’s life styles. Since the 1990s, the Ethiopian government has imposed social development, equivalent to amharanization, especially in the education and health sectors among people on the margins of society.

Health promotion in the Ethiopian political context is actually a cultural intervention. In the process of establishing a political center-versus-periphery structure, particular cultural elements and values were evaluated as being either ‘good’ or ‘bad’, in addition, supported and justified by the ‘universal’ value of heath and medicine.

Ken MASUDA is a social anthropologist and associate professor of the Gradate School of International Health Development, Nagasaki University. He has carried out anthropological research among the Banna in southern Ethiopia since 1993. Ms. Chiharu KAMIMURA is deputy director of Nairobi Research Station of Japan Society for Promotion of Science. She carried out research in northern Ethiopia in 2011 and 2012.
Vantage points on disease elimination strategies
(Theme 3)
Theme 3: Vantage points on disease elimination strategies

Edwin Michael

University of Notre Dame, USA

Edwin Michael is currently a Professor in disease epidemiologist at The University of Notre Dame, USA, with a research focus on the mathematical modelling and analysis of the population ecology, epidemiology, and control of neglected tropical and vector-borne diseases. His main interest lies in developing a systems dynamics approach to gaining a better understanding of the complex transmission dynamics of parasitic infections in different socio-ecological settings, in order to provide location-specific policy informatics strongly rooted in field data for guiding the design, monitoring and evaluation of large-scale sustainable intervention programmes, ranging from vector control, chemotherapy to vaccinations. His core work spans both theoretical work in developing novel data-model frameworks, and the application of these frameworks to monitoring and intervention field data using cutting edge methodologies based on Bayesian Monte-Carlo techniques, geographic information systems and spatial modelling, and Big Data applications that facilitate the assembly, curation, and use of diverse and multi-scaled data for disease modelling. Dr. Michael currently runs the inter-disciplinary Global Epidemiology and Biostatistics Group at ND, which works closely with vector biologists in the Department of Biological Sciences, computer scientists from the Center of Research Computing, and mathematicians/statisticians from the Department of Applied Mathematics, together with field partners and policy makers from a range of African, Asian and Latin American countries as well as international partners at The Carter Center, The Task Force for Global Health, Case Western University, The London School of Economics, and the University of Copenhagen, for integrating insights from modelling studies of complex transmission dynamics toward the development of novel policy and governance approaches for enhancing the local and global control of parasitic infections.

Notes
Managing Neglected Tropical Disease Control: Complexity, Uncertainty, and Governance

Sustainable management of persistent parasitic diseases requires understanding of the often indeterminate interactions between diverse, complex, and dynamic human and natural systems. A key need is also the taking of a fuller amount of the impacts of the in-context dynamics, uncertainty, and socio-ecological complexities that underlie parasite transmission in diverse endemic settings for guiding management action. Recent work in governance studies have highlighted how addressing these system issues is crucial to developing the governance structures required to affect sustainable, effective, change in persistent societal problems. Here, I will first provide examples of recent work from modelling lymphatic filariasis (LF) extinction, helminth-helminth, and LF-malaria interactions, in order to explore the importance of considering in-context socio-ecological complexity and uncertainty in designing and managing parasite elimination. The implications of these complexities for policy and approaches to managing parasite elimination or control will then be highlighted and compared with standard command and control approaches as deployed by current global control programmes. The implications of considering system complexity and knowledge uncertainty in developing successful parasite control programs, including the crucial need for inclusiveness, learning and research as well as adaptability and flexibility in management responses, will then be discussed in terms of the policy shifts and governance changes required if these programmes are to successfully meet the goal of achieving the transitions needed in reducing or eliminating the burden of neglected parasitic diseases.
Theme 3: Vantage points on disease elimination strategies

Melissa Parker

London School of Hygiene and Tropical Medicine, UK

Melissa Parker is Reader in Medical Anthropology at the London School of Hygiene and Tropical Medicine. She has undertaken multi-disciplinary and collaborative research in African and European settings. A unifying theme is the study of global health and international development. Research questions have typically emerged from extensive periods of ethnographic fieldwork, and engage with global health policies and practice. Topics investigated include HIV/AIDS in the UK, mental health in war zones, health-related quality of life in Kenya, female circumcision in Sudan, and the control of neglected tropical diseases in Sudan, Uganda and Tanzania.
The ‘Other Diseases’ of the MDGs: rhetorics and realities of mass drug administration for the treatment of lymphatic filariasis in Tanzania

Large amounts of funding are being allocated to the elimination of lymphatic filariasis. Strategies primarily rely on the mass distribution of drugs to adults and children living in endemic areas. The approach is presented as morally appropriate, technically effective and context-free. Drawing on research undertaken in Pangani and Muheza districts, Tanzania from 2004-2011, this paper shows that current strategies are ineffective. For a variety of social, economic and political reasons, the majority of people living at highly endemic locations either did not receive or actively rejected free treatment. In addition, there is a disjuncture between the low drug coverage levels being reported by adults at a village level and the higher uptake of drugs being recorded in official reports. The latter informs claims that elimination will be a possibility by 2020. This gives voice to a broader problem: there is considerable pressure for those implementing MDA to report positive results. The very real challenges of making MDA work are pushed to one side – adding to a rhetoric of success at the expense of engaging with local realities.
Steve Harvey

John Hopkins University, US

Steven A. Harvey, PhD is Assistant Professor of International Health in the Social and Behavioral Interventions program at the Johns Hopkins Bloomberg School of Public Health where he teaches qualitative research methods. His research interests include prevention and care-seeking behavior related to infectious disease and maternal health. He has carried out studies on domestic poultry-raising and Campylobacter jejuni infection, insecticide-treated bed net use, acceptability of malaria rapid diagnostic tests among health workers and patients, barriers and facilitators to intermittent preventive treatment of malaria in pregnancy, and perceptions of Chagas transmission among at-risk populations. His work also includes improving maternal care with emphasis on skilled birth attendant competency, client perspectives on quality, and the cultural competence of obstetric care. Prior to joining the Hopkins faculty in 2011, he was Senior Malaria Advisor at University Research Co., LLC where he provided technical support to President’s Malaria Initiative/USAID projects in Benin and Ghana. In collaboration with WHO and the Foundation for Innovative New Diagnostics, he developed training materials for community-based use of malaria rapid diagnostic tests that have become a de-facto international standard. His research has been published in the American Journal of Tropical Medicine and Hygiene, the International Journal of Gynecology and Obstetrics, the Journal of the Royal Society of Tropical Medicine and Hygiene, the Malaria Journal, and the WHO Bulletin. He has nearly 20 years research and program experience in Africa, Asia, Latin America, and the United States.

Notes
The social science agenda for malaria prevention, control, and maybe (?) elimination

In 2006, Bill and Melinda Gates shook up the infectious disease world by calling for global malaria eradication. Later, with Gates Foundation funding, PLoS Medicine outlined an eradication research agenda posing key questions of basic science, drugs, vaccines, vector control, diagnostics, health systems, surveillance, and modeling. [1] Curiously absent from this list was research on human behavior.

Since that 2006 announcement, the global community has invested billions of dollars in the approaches described by PLoS Medicine. We’ve distributed nearly a billion long-lasting insecticidal nets (LLINs) in sub-Saharan Africa. We’ve invested over a half billion dollars on the RTS,S vaccine alone, a product that, after 3 doses, confers temporary protection to slightly more than a third of newborns receiving it. [2]

We’ve spent the tiniest fraction of that amount exploring the human dimension: In what contexts are people willing use LLINs? When and where is net use not feasible? Why is it so difficult to achieve good coverage with intermittent preventive treatment of malaria in pregnancy? Given the proliferation of malaria rapid diagnostic tests, why do providers still prescribe antimalarials to RDT-negative patients? If we manage to develop a transmission-blocking vaccine – a vaccine that confers no individual protection, but prevents infected individuals from passing parasites to others – will individuals and communities be willing to accept it? This presentation will draw upon my recent qualitative research from several settings to explore barriers and facilitators to acceptance of interventions like these by the individuals and communities most affected by malaria.


Poster 1
How qualitative research is informing the roll-out of test-based management of malaria in Ghana

Frank Baiden

**Abstract:** Ghana is rolling out the World Health Organization-recommended strategy of Test-Treat-Track (T3) in the management of malaria. This approach is a departure from what caregivers have been used to for many years and therefore require a well-informed deployment strategy.

We conducted a study to assess the acceptability among caregivers of under-five children in a high malaria transmission region in rural Ghana. The major findings of a cross-sectional survey were used to develop an interview guide that was used in follow-up focus group discussions (FGDs) with caregivers.

A total of 3047 caregivers were surveyed. Although the overwhelming majority (98%) preferred the test-based over the presumptive (care based only on clinical judgment) approach, the follow-up FGDs revealed that acceptance was based on the expectation that: (1) A test-based approach represented improvement in quality of care; (2) It provided a more objective assessment of what was wrong with the child; (3) It will lead to favorable clinical outcomes and (4) It will afford opportunity for interaction between the health workers and caregivers.

The presentation will highlight the merit and demerits of using a mixed methods approach and how the findings of the study are being used in the roll-out of the T3 strategy in Ghana.
Working with communities: learning from the past and planning for the future
(Theme 4)
Susan Rifkin

University of Colorado, USA

Professor Susan Rifkin teaches at the Colorado School of Public Health and the London School of Economics. Her first two degrees were in Chinese studies. She was the first Coordinator of the Community Health Action Network (ACHAN), the forerunner of the Peoples’ Health Movement. She has assisted in establishing two Masters Degrees in Community Health and Management, one at the University of Heidelberg; the other in Kisumu Kenya. She has been a consultant for several international organizations including WHO and UNICEF and has developed frameworks for analyzing and evaluating community participation in health that have been used in several countries throughout the world.

Notes
People Don’t Behave the Way We Think They Should: Reflections on 40 years of Practice and Theory of Community Participation in Health

In this presentation, I will review my experiences in both the field and research on the topic of community participation and health. My experience has been mainly in low and middle income countries but many lessons are generalizable. I will focus the assumptions researchers and planners have made about the value and the implementation of health programs with a community participation component. I will argue that because in many cases these assumptions have not been evidence based, the outcomes have often not met planners’ expectations. Finally I will briefly look at the role social science plays in understanding the contribution of community participation to improved individual and population health outcomes.
Jo-An Atkinson

Australian Prevention Partnership Centre, Sax Institute, Australia

Dr. Atkinson is a postdoctoral research fellow with the Australian Prevention Partnership Centre. She has over 15 years’ experience in health service delivery and clinical research in Australia, as well as public health operational research to inform strategy for disease control and elimination in the Asia-Pacific region. This experience has included the use of quantitative, qualitative, and participatory research methodologies. Her interests include human behavioural and system-level influences on intervention effectiveness; exploring the acceptability of new and existing technologies for disease prevention; the design of strategies for community engagement in prevention initiatives; and more recently, the use of systems dynamic modelling to inform policy for complex public health problems.

Notes
Scaling-up community participation for communicable disease control and elimination.

Strategies to control and eliminate communicable diseases will likely fail if communities aren’t engaged. Dr Atkinson reviewed 60 years of literature to identify the many factors that interact to influence community participation. However, questions remain: how do we determine the relative importance of these factors in different contexts; how can we use this information to achieve community participation at scale to support national programs; and how can community participation move off the side-lines of public health policy and better integrated as an adequately resourced, essential component of programs? Based in the South-West Pacific, Dr Atkinson worked with Ministries of Health in Solomon Islands and Vanuatu using research to inform their strategies for engaging communities in national malaria elimination programs. Her experience provides insights into scaling up successful methods of community participation as well as how qualitative and integrative research methods might support this.
Johanna Gonçalves Martin
University of Cambridge, UK

Johanna Gonçalves Martín is a medical doctor from Venezuela, currently finishing her PhD in Social Anthropology at the University of Cambridge, and with an MSc in Disease Control from the Tropical Institute of Medicine in Antwerp. She worked for several years as a doctor amongst the Yanomami people in southern Venezuela, where she also conducted epidemiological research on malaria, and was extensively involved in the design and implementation of an innovative culturally specific course for Yanomami community health agents. For her PhD project, she worked on Yanomami practices and notions of reproduction, fertility and gender relations, and the tensions which arise at the intersection with biomedical practices of sexual and reproductive health. During her anthropological fieldwork on reproduction, she was a consultant for the Ministry of Health and Indigenous People’s Health Office in Venezuela, and was in charge of the evaluation and further training of Yanomami health agents. Her presentation will be grounded on this aspect of her most recent fieldwork. Apart from her focus on indigenous people’s health and reproductive care, her research interests include more broadly: gender, care as a social practice, intercultural and interdisciplinary translations, the articulation of different fieldwork methods and the role of intersubjectivity in care and in research. As a doctor and anthropologist, she is committed to bringing together theories and methodologies of the social sciences with the design and implementation of a more human health care.
Learning to walk the paths of health: Becoming a Yanomami health agent in Venezuela.

In this paper, I will speak about the Yanomami health agents in the Upper Orinoco in Venezuela. Worldwide, Alma Ata placed the community health workers onto the spotlight of public health policies; the 1980s and 1990s saw them fade away under neoliberal reforms; ‘task shifting’ and the current crisis in human resources is bringing them back. However, in Amazonas (Venezuela), the official programme which trains indigenous health agents has been running non-stop since the 1970s, and is currently expanding. How is this so? I will address our notions about ‘community’ and ‘participation’, and show how these don’t capture the complexity of the social forces at stake for the success of the Yanomami health agents’ programme. I will argue that Yanomami own cultural notions of sociality in and between their villages, and the significance of relations with outsiders as a potential source of fertility and wellbeing, are central for understanding Yanomami people’s interest in becoming health workers and their unfaltering work in spite of the all too common lack of supervision and further support. Therefore, we should see these community health workers programmes not only as external means of promoting ‘participation’ by means of ‘community embeddedness’, but as internally originating strategies of mediation with outsiders, framed within a Yanomami sociocultural logic. The Yanomami often refer to their process of becoming a health agent, as ‘learning to walk the path of health’, and by this they mean both learning what doctors do, and also the process of coming into a closer relationship with the doctors and the health system. I will present the point of view of the Yanomami through the case of the cooperative production of an innovative training course for Yanomami health agents. As a coda, I will end this paper with a comment on the difference between quantitative or qualitative research methodologies, as compared to participant observation and ethnography as a productive method for deep listening.
Maria Eugenia Toledo

Institute of Tropical Medicine “Pedro Kourí” (IPK), Havana, Cuba

Dr. Maria Eugenia Toledo Romaní. Medical Doctor. She works at Epidemiology Division of the Institute of Tropical Medicine “Pedro Kourí” (IPK), Havana, Cuba. She holds the categories of senior researcher and assistant professor. She is Master of Science in Epidemiology (IPK, 2009), Doctor of Science in Health (IPK, 2009) and Doctor of Science in Medicine (Ugent, 2011). She has more than 15 years of research experience and she is member of the Scientific Council at Pedro Kourí Institute. Her specializations areas are: social epidemiology, clinical and community trials, community empowerment and communicable disease control. She has published on topics related to community participation in dengue prevention and effectiveness, impact and cost-effectiveness evaluation of community trials.

Notes
Added value of community empowerment in dengue control: Lessons learned from implementation practices in Cuba.

I will resume a cycle of operational research combining observational studies and community trials (quasi-experimental/experimental designs) (in the two provinces in Cuba with the highest Aedes aegypti infestation levels. We examined elements that could add value to and ensure a sustainable effect of deploying technical tools for dengue vector control. We evaluated changes in community perceptions and risk behaviour and demonstrated that top-down implementation of technical control tools without community empowerment has a very temporary effect on entomological indexes and that it does not lead to the behavioural changes necessary for sustainable control.
Theme 4: Working with communities: learning from the past and planning for the future

Gorik Ooms

Institute of Tropical Medicine, Belgium

Gorik Ooms is a human rights lawyer and a public health scholar. He graduated as Lic.Jur. from the Catholic University of Leuven in 1989. During most of his professional career he worked with Médecins Sans Frontières Belgium, of which he was the executive director from August 2004 until June 2008. In March 2008, he obtained his Ph.D. in Medical Sciences from the University of Ghent, for a thesis on the subject “The right to health and the sustainability of healthcare: Why a new global health aid paradigm is needed.” In August 2008, he joined the Department of Public Health at the Institute of Tropical Medicine, Antwerp.

During the 2009-2010 academic year, with support of a Fulbright scholarship, Gorik Ooms was appointed global justice fellow with the Whitney and Betty MacMillan Center for International and Area Studies at Yale, where he remains corresponding fellow. Since 2010 he is an adjunct professor of law at Georgetown University, and since 2013 a visiting scholar at the Faculty of Law of the University of Antwerp.

Community participation as a core obligation to realize the right to health: to be included in the health SDG or not?

Go4Health (which stands for Goals and Governance for Health) is a research project funded by the European Union (EU), contributing to setting health-related development goals beyond 2015. More specifically, Go4Health is expected to help ensure that the health-related development objectives for the period after 2015 are based on the best scientific evidence available and address the main shortcomings of the current Millennium Development Goals (MDGs).

Go4Health uses the right to health as defined in international human rights law as its starting position. Our research is divided into four ‘work packages’ (WPs): two of them use normative approaches (the first established a dialogue with marginalised communities to find out their priorities, the second researches national and international law and litigation), two others are verifying the political feasibility of proposed elements of the new health goal (the first with governments, the second with international organisations).
Community participation is a priority for marginalised communities. Rather than a set of internationally defined health services, they want health systems that are responsive to their needs.

Under international human rights law (the International Covenant on Economic, Social and Cultural Rights), the right to health is defined as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, but its realisation is made contingent on available resources – this is known as the ‘progressive realisation’ of social human rights. However, the Committee on Economic, Social and Cultural Rights, created to monitor state compliance with the Covenant, has argued that states “have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant”, and that this includes, with regards to health, “[t]o adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process”.

Governments and international organisations do mention the importance of community participation in their contributions to the debate on the new health goal, but they do not seem to consider community participation as highly important.

The process of formulating Sustainable Development Goals (SDGs) has taken over the process of reformulating the MDGs. The Open Working Group on SDGs issued a proposal in July 2014, which includes health under Goal 3: “Ensure healthy lives and promote well-being for all at all ages”. This goal comes with nine targets and four ‘means of implementation’: none of them mentions community participation. Community participation is mentioned under proposal Goal 6 – “Ensure availability and sustainable management of water and sanitation for all” – as a ‘means of implementation’: “support and strengthen the participation of local communities for improving water and sanitation management”.

Should health advocates argue for the inclusion of a similar mention under the health goal? In countries where there is no meaningful community participation at all, civil society groups feel that such a mention would empower them in their demands. In countries where there is at least a beginning of meaningful community participation, civil society groups feel that such a mention could disempower them: someone in New York ‘ticking of the box’ of community participation for their country could allow their governments arguing that they are already doing what needs to be done.
Poster 1
Creating Partnership with Men Who Have Sex with Men. Towards Building Their Capacity on HIV Prevention in Osun State, Nigeria

Ademola Adelekan, Department of Research and Reproductive Health, Public Health Promotion Alliance, Osogbo, Nigeria
Elizabeth Edoni, Department of Community Health Nursing, Niger-Delta University, Wilberforce Island, Nigeria
Philomena Omoregie, Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan, Ibadan, Nigeria

Issue: Survey in Nigeria has revealed HIV prevalence of 13.5% amongst Men who have Sex with Men (MSM) and they are five times likely to be HIV-positive than the general population. Only 10.0% of MSM were consistent condom users in Nigeria. Men who have sex with men in Osun State suffer negligence, stigma and discrimination in accessing health care facilities and have little or no information that HIV can be transmitted through anal sexual intercourse. This intervention was therefore designed among MSMs in Osun State toward HIV prevention.

Description: We conducted outreaches through parties, picnic and community dialogue as a strategy for reaching MSM in the State. Needs assessments were conducted through in-depth interviews and focus group discussions to identify the plight and perceptions of MSM towards HIV/AIDS and safe sex practice. We therefore implemented an HIV prevention programme through sensitization workshop and provision of condom and lubricants for MSM at the community level. A total of 131 MSM were recruited for this project and 5 were lost to follow up. This intervention was carried out between March, 2012-February, 2013 and was evaluated at 6 month and 1 year.

Results: At baseline, 18.0% of the participants had a poor knowledge of HIV/AIDS and within 6 month, 87.9% had a good knowledge of basic information about HIV/AIDS. At baseline, 73.8% of the participants reported engaging in unprotected sex in the last 3 month and almost all (98.2%) had never used lubricant. During the evaluation of the intervention after 1 year, only 13.9% reported engaging in unprotected sex and 89.5% of the participants used lubricants during the last sexual intercourse. Availability was a major barrier to use of lubricant among the participants. Prior to the intervention, MSM in the state had a negative perception that condoms are to be used only for vaginal sex and only 3.9% had ever used condom. At 6 month evaluation, 87.9% reported regular use of condom and at 12 month, the percentage of participants using condom decreased to 60.7%.

Conclusion: Creating partnership was effective in promoting HIV/AIDS prevention among men who have sex with men. This intervention showed an increase in HIV knowledge and promotion of lubricant among the participants. Use of condom was also increased within 6 month evaluation but it was reduced before one year evaluation. Research to determine the factors responsible for this is therefore recommended.
Poster 2
Assessment of the effectiveness of community based health education messages for control of schistosomiasis in Amagunze community, Enugu State, SE Nigeria

By Obioma Nwaorgu1, Chinyere Ekwunife1, Nkechi Okeibunor2 and Nkeadi Onyegbegbu3
1. Department of Parasitology and Entomology, Nnamdi Azikiwe University, Awka, Nigeria
2. Department of Sociology and Anthropology, University of Nigeria, Nsukka, Nigeria
3. Institute of Education, University of Nigeria, Nsukka, Nigeria

Schistosomiasis is a serious public health problem with prevalence of about 70% among school children 6 to 15 years old in this community (Anigbo et al 1994; Nwaorgu et 1999 and Ozumba et al 2001). Based on these studies, a mass drug administration (MDA) programme was carried out through drug donation from WHO and State Ministry of Health in the community. However this programme did not lead to drastic reduction in the disease prevalence or its control in the community. The aim of this survey therefore is to determine the role of an integrated community based health education and drug administration programme in the control of schistosomiasis in Amagunze.

Amagunze community comprises of 6 villages. It has two distinctive seasons (dry and wet). The main occupation of the inhabitants is subsistence farming, fishing and wine tapping. Each of the 6 villages are surrounded by water bodies which are used for domestic (washing of utensils, clothes, soaking and washing of cassava and vegetables), recreational (swimming and bathing) and fishing activities. All these activities has been responsible for increase in water contact with schistosomiasis infested water bodies. A randomized cross sectional community based intervention trial with two study arms was carried out during which the 6 villages making up Amagunze community were divided into two arms comprising three villages per arm. The first arm received Health Education plus MDA (praziquantel) while the last three villages received MDA (praziquantel) only. A community knowledge, attitude and practice (KAP) survey on schistosomiasis was carried out among community members in Amagunze. The purpose being to use the result from the survey to develop community based health education messages (for behavior change and improved knowledge on schistosomiasis) in Amagunze. Following the analysis of results of the community members’ perception, attitude and practices on schistosomiasis, the results were found to be poor. Within this context, appropriate community based health education packages were developed based on how schistosomiasis is transmitted and what causes the disease, how it could be prevented, treated, and controlled. Messages developed were first pretested among community members. This is to ensure that the messages are clear and will meet the need of Amagunze community members and thereby enable them to participate. Also community members were recruited and involved in creating and carrying out the health education messages in various parts of the community namely: markets, schools, churches, village square etc. Urine samples were taken from at least 320 school children and community
members from each of three villages in each of the arms at baseline (before interventions) for parasitological study and thereafter every three months. These activities were carried out over a 12 months period. After one year, analysis of different study arms was carried among the school children and community members to determine the following: Change in intensity, change in prevalence and level of knowledge of community members including pupil and teachers on schistosomiasis especially as it related to prevention issues. The results were compared with the ones at baseline using chi-square tests.

Results revealed that health education was successful in significantly reducing intensity of schistosomiasis infection, increased knowledge about transmission and prevention and significantly reduced infection prevalence among the intervention arm villages which received both health education and MDA when compared with those in the arm that received only MDA. There was also increased community involvement in provision of prevention measures e.g. provision of makeshift bathrooms and urinary’s near water bodies.

Community based Health education packages developed through application of results from community knowledge; attitude and practices survey on schistosomiasis in combination with MDA was effective in significantly reducing both the intensity and prevalence of schistosomiasis in a schistosomiasis endemic community. Also the level of knowledge of both community members including teachers and pupil on transmission and prevention of schistosomiasis was also increased.
Research ethics: in whose interest?
(Theme 5)
Theme 5: Research ethics: in whose interest?

Raffaella Ravinetto

Institute of Tropical Medicine, Belgium

Raffaella Ravinetto holds a Pharmacy Master Degree from the University of Torino and a Postgraduate Diploma in Tropical Medical Biology from the Antwerp Institute of Tropical Medicine.

After a seven-year experience as a Clinical Research Scientist in the private pharmaceutical sector, she worked in humanitarian emergency and development programs in the Balkans and in Africa. In 2002, she joined the humanitarian organization Médecins Sans Frontières (MSF), where she followed various dossiers on access to essential medicines and on quality of medicines, while performing regular field assessments in sub-Saharan Africa and Latin America.

She currently works at the Antwerp Institute of Tropical Medicine (ITM), as head of the Clinical Trials Unit, which provide methodological and scientific support to ITM researchers and to ITM partner institutions in the South, for designing and conducting non-commercial clinical research projects in the field of malaria, tuberculosis and neglected tropical diseases. She is the coordinator of the ITM Switching the Poles Clinical Research Network, which aims at developing ethics- and GCP-compliant approaches to medical research carried out in research-limited contexts and vulnerable communities; and the co-promoter of Quamed, a North-South Network promoting evidence-based strategies for universal access to quality-ensured medicines. She was president of the Italian branch of MSF (2007-2011). She’s currently a member of MSF Ethics Review Board.

Her main areas of interest include North-South collaborative clinical research, research ethics (particularly in relation to resource-constrained settings) and access to health.
Clinical Research Challenges in the South

More and more clinical trials are carried out in low and middle income countries, often by non-commercial actors. But the major Good Clinical Practices (GCP) Guidelines, which guide and orient national legislators, were issued respectively in 1995 (WHO) and 1996 (ICH). Thus, they still reflect the situation of almost twenty years ago, when multi-centre clinical trials were mainly conducted in Western contexts by commercial sponsors, and they do not take into account the role currently played by non-commercial research groups. In particular, non-commercial research consortia in North-South collaborative clinical trials must develop innovative approaches for fully coping with appropriate ethical and methodological standards, despite their limited resources and despite the contextual constraints. This presentation will aim at giving a short overview of the challenges met by these new actors in international research and of the specific challenges linked to contextual and cultural specificities in the “new” research environments.
Angus Dawson

University of Birmingham, UK

Angus Dawson (PhD) is Professor of Public Health Ethics and Head of Medicine, Ethics, Society & History (MESH) at the University of Birmingham, UK. His background is in philosophy, but he has specialised in teaching ethics to health care professionals and medical students for the last fifteen years. His main research interests are in public health ethics (particularly vaccinations and issues related to lifestyle choices) and the use of empirical evidence in moral arguments (particularly in relation to problems in gaining informed consent in clinical trials). He is joint Editor-in-Chief of the journal Public Health Ethics and joint coordinator of the International Association of Bioethics’ Public Health Ethics Network (InterPHEN).

He has been involved in consultancy and research projects funded by the Centers for Disease Control and Prevention, World Health Organization, GAVI Alliance, European Union, Wellcome Trust and the Public Health Agency of Canada on a range of issues related to public health ethics. He has been editor or co-editor of four collections of original papers mainly on topics in public health ethics, including (with Marcel Verweij) Prevention, Ethics, & Public Health, Oxford University Press (2007) and Dawson, A. (ed.) Public Health Ethics: Key Concepts and Issues in Policy and Practice, Cambridge University Press (2011).

Notes
Research Ethics & Responsibility: Guidance not Regulations

Research ethics is often conceptualised as consisting of a series of quasi-legal rules, requiring researchers to follow guidance as though it had regulatory force. This talk points out that most research ethics actually takes the form of advisory, guidance documents. I argue that we ought to take this seriously. Neither research ethics committee nor researchers should interpret ethical requirements as if they are absolute claims (i.e. always true). There are always exceptions, and circumstances where it is not appropriate to follow a rule blindly. Indeed, doing so, can be more unethical than following a rule in some circumstances. I argue that we ought to see research ethics guidance as existing to help researchers and committees make the right kinds of decisions, and for everyone involved in research to take responsibility for their actions. On this view true research ethics is about developing the ability to articulate why you did what you did, and be able to provide reasons why it is justifiable. Research ethics is not a mere tick box exercise about making sure that you’ve back-translated an information sheet etc. The general point is illustrated with two examples. The first relates to the conduct of cluster randomised trials and argues that it is sometimes appropriate not to be individual level consent from all participants. The second related to the recently revised MSF research ethics framework, which aims to help those without much knowledge of ethical issues make ethical decisions.
Adamu Adissi

Addis Ababa University, Ethiopia

Institution and current position: My institutional affiliations include; (a) Assistant Professor, School of Public Health, Addis Ababa University, Addis Ababa (Ethiopia); and (b) PhD Fellow at Brighton and Sussex Medical School, Brighton (UK)

Academic background: a Medical Doctor (MD), Public Health Specialist (MPH) and Bioethicist (MA). Just completed PhD in ethics at BSMS (UK)

Work experience: Worked as a clinician, community-based program manager, academician and researcher in different institutions in Ethiopia for over ten years.

Publications and Presentations: Has journal publications in both local and international peer reviewed journals; has written three book chapters and one book. The areas of research focus include ethics in medical research; and epidemiology of infectious and chronic diseases. Has also given speeches and conference presentations in several local and international conferences in area of public health and ethics. In the last three years have been exploring the ‘Rapid Ethical Assessment (REA)’ tools as a doctoral project. Serves as vice chairman of IRB.

Personal: Married with two daughters.

Notes
A tool to catch contexts’ specificities: the rapid ethical assessment

The universal principles of biomedical ethics provide overall guidance which primarily evolved in the developed world and is based primarily on western values. They are designed to be applied in all settings. However, the range of ethical issues present in different communities differs subject to variations in ethno-cultural contexts, which are more visible in developing countries.

Rapid Ethical Assessment (REA) is a brief qualitative intervention designed to map the ethical terrain of the research setting prior to a research team starts recruiting participants with the purpose of connecting ethical principles to contexts and realities on the ground. REA attempts to discover, describe and respond to the ethical issues specific to a particular research setting, and as such should help researchers to address the issues that genuinely matter to proposed study participants and their community. The assessment is conducted among key stakeholders to inform the design of the particular research project. Its findings are utilised to inform and guide the research consent process; ranging from the conception and development of the consent form, to the way consent is obtained.

The REA tool has been piloted since 2007 in different settings in Africa. Based on a recent wide-scale pilot study done in a range of research contexts in Ethiopia, REA was found to be highly useful in identifying and addressing context specific ethical issues for community based medical research. It was associated with better participant comprehension and recruitment outcomes, and was found to be affordable, flexible and easy to adapt. The tool is recommended for wider applications in similar settings.
Jennifer van Nuil

University of Liverpool, UK

Jennifer Ilo Van Nuil is a medical anthropologist working at University of Liverpool’s Institute of Infection and Global Health. She is based in Kigali, Rwanda at Rinda Ubuzima, a local NGO specializing in family planning and HIV prevention. Jennifer works on the social science components of the Ring Plus Study, a study examining the safety and acceptability of a vaginal contraceptive ring in Rwanda.

Jennifer is also a doctoral candidate from the Department of Anthropology at Wayne State University in Detroit, Michigan. She is currently at the end stages of her doctoral research, which focuses on how community groups for people living with HIV shape the experiences of HIV in Rwanda and how members create a social world within the group and within their communities. In her dissertation, she also explores the influences of global health policies and Rwandan cultural practices on the formation and structure of these groups through space and time. Jennifer plans to submit and defend her dissertation by the end of 2014.

Notes
Balancing Benefits and Rumors: Informed consent and participation in clinical research in Kigali, Rwanda

There are debates regarding whether or not people in developing countries can truly exercise free choice to participate in research. The choice is often overshadowed by health services and benefits received or rumors about research can hinder participation. The decision to participate or not is often made before attending informed consent sessions.

To better understand the research participation context, we collected data (in-depth interviews, focus group discussions, quantitative data) from Ring Plus Study participants, a safety and acceptability study of contraceptive vaginal rings in Kigali, Rwanda. The informed consent process consisted of a group video with informed consent information, a literacy assessment, individual review with a counselor and an assessment of understanding.

351 women came for prescreening, 4 were excluded because they were not able to complete the assessment of understanding. The remaining participants’ ages ranged from 17 to 38 (mean 28.27) and 79% had primary level of education or below. 120 were enrolled. The primary motivations, obtained from participants at the end of study, for wishing to be enrolled included cervical cancer screening, Sexually Transmitted Infections’ testing/treatment, and travel reimbursement (information provided by the clinic at education sessions in the community) as well as the expectation for lack of negative side effects from the ring and increase in vaginal lubrication, both communicated informally in the community. There were also negative rumors circulating in the more research naïve communities (e.g. the speculum causes cancer, the uterus is stolen at the exam) and some participants came from these sites to verify if the rumors were true before enrolment. The informed consent process, as well as the research center’s positive atmosphere, helped participants to dismiss the rumors and/or verify the decision to participate.

Social science research about local communities can inform effective ways for collaboration and help participants understand the research risks and benefits.
Theme 5: Research ethics: in whose interest?

Patricia Kingori

ETHOX Centre, Oxford University, UK

Patricia Kingori, PhD is a Wellcome Trust Biomedical Society and Ethics Fellow at the Ethox Centre, University of Oxford. Her disciplinary background is in Medical Sociology and her current research interests intersect a sociology of science and medicine, and a critical examination of ethics. Patricia is particularly interest in the frontline practitioners of medical research, the politics of health and the meaning of research and guidelines in practice. Her work has focused on the views, values and experiences of fieldworkers and similar frontline research staff involved in collecting data and interacting with research participants. This has taken place in East Africa but has recently extended its focus to South East Asian and West African countries.

Patricia has recently co-edited a special issue of Social Science and Medicine entitled Bioethics in the Field (2013) which explored some bioethics guidelines in practice. She is working on another special issue in the Journal of Anthropology of Medicine entitled “The Museum of ‘Failed’ Research: HIV and AIDS research and the analysis of failure” (2015) which examines what constitutes failure in HIV research.

Notes
Research realities and the everyday experiences of clinical trial fieldworkers in western Kenya

If data is the oxygen of science, medicine and public health - supporting the quality and efficacy of health interventions, policy and services, then it is important to understand the everyday conditions and practices involved in data collection. Drawing on a qualitative exploration undertaken over two years, in western Kenya, this paper will focus specifically on the views and experiences of fieldworkers tasked with data collection. The fieldworkers were examined while collecting data in five different clinical investigations of diseases including HIV/AIDS and malaria.

This paper will present some of the practical and ethical challenges faced by fieldworkers during their daily duties and how these influenced the quality of the data they collected. Fieldworkers’ practical problems included attempts to meet recruitment targets in a location with a weak transport infrastructure but also a context with a range of physical, geographical and structural challenges. They also faced a range of ethical challenges which were often generated by scarce access to healthcare, transport, food and financial resources among the local population. When faced with these dilemmas, fieldworkers were compelled to devise solutions and these were often independent of the knowledge of senior researchers operating at the field stations of research institutions. The solutions fieldworkers devised were important because they had the biggest impact on the quality of data produced.

This paper will explore the process of data collection, the emotional and physical labour demanded of this role and the ethical challenges faced by fieldworkers. Most importantly it has highlighted the importance of understanding fieldworkers’ roles and positions in the production of data.
Theme 5: Research ethics: in whose interest?

Béatrice Godard

Université de Montréal, Canada

Professor Béatrice Godard, University of Montreal, Department of Social and Preventive Medicine, teaches in the Bioethics Programs and has designed and launched courses in research ethics, research methods, and global health ethics. She directs the Quebec Population Health Research Network. Her research expertise focuses on the study of ethical and social issues raised by biomedical research. Aiming to lay an empirical foundation that can both discern and anticipate the socio-ethical issues associated with technologies in the pursuit of health interventions, she integratively employs a wide range of qualitative and quantitative research methodologies. Basically, her research work concentrates on emerging ethical responsibilities in biomedical research at the juncture between research and the clinic and it is oriented on the development of frameworks for ethical decision-making.

Notes
Ethical issues in international clinical research: understanding, respecting and addressing local cultural patterns

International clinical research is mainly initiated by sponsors and investigators in the United States, Western Europe and Japan. However, more and more human subjects are enrolled in Africa, Latin America and Asia. Cost benefits, a larger pool of ready volunteer subjects, and greater efficiency in clinical testing are some of the reasons for conducting clinical trials overseas. Despite these advantages, the involvement of individuals in new geographical settings raises questions about scientific and ethical integrity, especially when experience with those settings is lacking at the level of trial management. A lack of proper community involvement may have serious implications regarding the integrity of clinical research and the ethical treatment of individuals, whether they are human subjects or not.

Community involvement is well-understood in developed countries, with several effort taken to enhance and maintain the autonomy of communities and their right to participate or not. This is not always the case in low- and middle-income country settings. The information given to communities before a clinical research might not be properly developed and presented, an issue that can result in serious threat to the decision-making process. There has been little empirical investigation as to whether and how sponsors and researchers’ obligations of responsiveness, ancillary care, post-trial benefits and research capacity strengthening are upheld. Yet, bioethicists have long debated the content of sponsors and researchers’ obligations of justice in international clinical research.

We aim to address the issue of how respectfully and ethically clinical research can be better done with communities and what we can do to enhance the practice in an ethical context. Practical guidance on how to fulfil these obligations is needed if sponsors, researchers and other actors are to successfully translate them into practice because doing so is often a complicated, context-specific process. Based on different case studies, we aim to show how information can be gathered from not only international clinical researchers but also human subjects, research ethics boards, and community advisory board members in order to fulfil these obligations and to identify the contextual factors and roles and responsibilities that were instrumental in the fulfilment of these ethical obligations. As shown in case studies, such empirical work is necessary to inform the articulation of obligations of justice in international clinical research and to develop guidance on how to fulfil them in order to facilitate better adherence to guidelines’ requirements.
Lesong Conteh

Imperial College, London, UK

Lesong Conteh is a Senior Lecturer in Health Economics in the School of Public Health, Imperial College London, she is also the Director of the Global Health Stream of the MPH. Her research focuses on health economics and health systems mostly in sub Saharan Africa, and includes coordinating multi-country economic evaluations; understanding the behaviour of community health workers and; comparing and contrasting consumer and provider interpretations of quality in health care delivery.

Notes
Beyond the clinical trial: a health economics perspective

‘How ethical is health economics?’ At one end of the spectrum some believe that health economists work in an ethical void and heartlessly deny individuals’ much needed access to treatments. At the other end of the spectrum the case is made that it is unethical not to explicitly measure and justify the costs and benefits of providing care to some, thus denying it to others. In this talk I discuss the interaction of ethics and health economics at both a conceptual and programmatic level. Specific attention will be paid to how health economists interpret the wide reaching impacts of clinical trials on the communities in which they are conducted.
Soori Nnko

Mwanza Intervention Trials Unit/NIMR, Tanzania

Soori Nnko is principal research scientist at the National Institute for Medical Research (NIMR). For more than twenty years he has worked in various fields of health research predominantly on sexual and reproductive health. He has also participated in designing and implementation of research that address community responses to various medical technologies e.g. malaria control interventions (including ITN and IRS) and rapid screening of syphilis.

Nnko has also participated in research on ethics, and particularly research on ethical challenges such as comprehension of informed consent processes. He participated in research to explore community acceptability of participation of adolescent girls in biomedical research.

Notes
Community perceptions and acceptability of adolescent girls’ participation in biomedical research: experience from Mwanza, Tanzania

Adolescent girls in sub Saharan Africa are at high risk of acquiring sexually transmitted infections (STI); however more research is needed on adolescent sexuality and reproductive health before intervention can be deployed. At the same time there is a need to better understand the informed consent process for research on adolescents as well as the public’s attitude toward adolescent girls’ participation in biomedical research. Objectives The aim of this study was to understand community acceptability of enrolling adolescent girls in research on reproductive health and on the acceptability of biomedical procedures including the collection of vaginal swabs. Method We conducted 53 in-depth interviews (IDI) with adolescent girls, parents and community gatekeepers (e.g. teachers and health workers). Information from IDI was complemented by seven focus group discussions (FGDs) conducted with adolescent girls and parents. The study was part of a larger biomedical study exploring the composition of the vaginal microbiota in young girls. Results Study participants equated biomedical research with health service and expected girls to receive free medications during their participation in research. Since parents were asked to provide permission for their daughters to participate in research, they expected to be given the STI and pregnancy test results of their daughters. All parents were told that study staff would not disclose test results to them, but daughters would be encouraged to discuss the results with their parent. Although the test results were not disclosed to the parents, they agreed for their daughters to participate in the biomedical study. Adolescent girls were concerned that disclosure of test results to their parents would have a negative impact on the parent-child relationship, especially if they are found to be infected with an STI and feared expulsion from schools if found to be pregnant. Conclusion Study participant information should dispel the misconception that biomedical research is a form of service. It is important for researchers to explore parents’ major concerns for participation of their children into biomedical research and clarify those concerns prior to enrolment of the children.
Theme 5: Research ethics: in whose interest?

Poster 1 - The ring or not the ring that is the question; Acceptability and adherence of the Nuvaring® in Kigali, Rwanda.

E. Kestelyn | J. Van Nuil | S. Agaba | J.C. Ndagiyimana | M. Uwineza | I. De Baetselier
T. Delvaux | T. Crucitti | J. Van de Wijgert

Background
A multidisciplinary research project was conducted to assess the acceptability and adherence of vaginal ring use in Rwandan women, including attitudes towards a future multi-purpose vaginal ring for prevention of both pregnancy and sexually transmitted infections.

Method
Quantitative data collected in an open label, randomized controlled trial in Kigali was triangulated with qualitative findings from various sources including In Depth Interviews, Focus Group Discussions, Individual structured face-to-face interviews, Comparison Inquiry forms and Ballot box questionnaires.

Results
Overall the participants’ acceptance was really high due to the lack of perceived side effects, increased lubrication as well as sexual desire. Being a new method, the ring lead to discussions about sex instigated by the male partners. At the final visit, all 120 participants answered that they did not mind wearing the vaginal ring every day. Participants rarely thought about the ring; 75.8% at the regular visits and 82.5% at the last visit. Concerns about the ring were limited with 118 (98.3%) of the participants reporting that they didn’t think the ring might come out accidently or might get lost inside their body. 92.5% of participants reported that they would use the ring if it was readily available on the market in Rwanda.

Various sources reported overall good adherence to the ring with over 111 (92.5%) participants scoring 8 to 10 on a self-rated adherence scale. 36 participants reported a total of 42 expulsions (10% of all insertions) and 11 participants removed the ring themselves (17 times in total or 4%). Only one participant stated that she could not imagine wearing a ring that was proven to prevent pregnancy and HIV infection. If this multi-purpose ring was similar to the ring they used in the study but not exactly the same, 39.2% of the participants would very likely keep it inserted in their vagina every day and 55% likely.

Conclusions
Preliminary high self-reported acceptability and adherence was documented although a more accurate representation of this self-reporting will be presented after further triangulation and analysis of the data.
The social lives of medicines
(Theme 6)
Erika Vlieghe

Institute of Tropical Medicine, Belgium

Dr. Erika Vlieghe is an internal medicine and infectious diseases specialist who studied at and was awarded a PhD by the KU Leuven and the Institute of Tropical Medicine (ITM). She gained extensive experience in Belgium as well as in the tropics.

She currently works as a senior clinical staff member and researcher at ITM. Dr. Vlieghe is head of the Unit of Tropical and Infectious Diseases at the University Hospital in Antwerp (UZA), which works closely with ITM.

The unit treats patients with AIDS, malaria, tuberculosis and other tropical diseases and advises other hospital departments about (hospital) infections.

Dr. Vlieghe teaches tropical medicine and infectious diseases at ITM and Antwerp University. The past few years she carried out pioneering research on antibiotic resistance in South East Asia.

Since the emergence of the Ebola epidemic in West Africa, she was closely involved in the design and implementation of precautionary measures in Belgium, Antwerp University Hospital and at ITM.

In October 2014, she took up the position of national Ebola coördinator, assigned by the federal Minister of Health.
Social dimensions of antibiotic prescribing: a physicians’ perspective

Antibiotic resistance is a fastly growing problem worldwide. The use of antibiotics, leading to selective pressure and survival of the most adapted (resistant) bacteria, has been identified as one of the most important drivers of this ‘silent epidemic’. Low hygienic standards in communities and healthcare settings can subsequently facilitate the further spread of the out-selected resistant bacteria. Although the emergence of resistant bacteria after each antibiotic market introduction has been observed over the past 70 years, this phenomenon has spread in an exponential manner over the past two decades. The increased access of affordable antibiotics worldwide, and the ‘social status’ of certain antibiotics play an important role, in particular in emerging economies.

The motivations which drive clinicians worldwide to prescribe antibiotics are numerous, and are often not evidence based. Irrational antibiotic prescribing and use may be driven -among others- by limited medical training using outdated sources and guidelines, lack of (technical) knowledge on the correct choice and use of antibiotics, lack of diagnostic means, peer pressure or lack of supervision, financial incentives and pressure of pharmaceutical companies,... In addition, irrational use of antibiotics occurs also widely outside the medical context, e.g. in agriculture.

Data on antibiotic use worldwide are very limited; more evidence and insight are urgently needed from quantitative and qualitative research alike. These insights may feed interventions at all societal levels to contain the further development and spread of antibiotic resistance.
Adelaide Compaore

Clinical Research Unit of Nanoro (CRUN), Burkina Faso

After obtaining a Bachelor degree in Sociology at the West African Catholic University of Bobo-Dioulasso, Burkina Faso. I joined the Clinical Research Unit of Nanoro (CRUN) in 2012 as research assistant. At the CRUN, I have been actively involved in implementing research project assessing the risk of malaria prior to and during early pregnancy in nulliparous women receiving long-term weekly iron and folic acid supplementation. During the course of this trial, I registered for a Master degree in sociology for which I conducted some research on the factors influencing adolescent girls’ adherence to weekly iron supplementation in a randomized controlled trial in the rural population of Nanoro. The next step of my career development is to undertake a PhD program after the defense of my Master thesis planned in December 2014.
“There is Iron and Iron...” Burkinabe Women’s Perceptions of Iron Supplementation: A Qualitative Study

Compaore A, Clinical Research Unit, Nanoro, Burkina Faso
Gies S, Clinical Research Unit, Nanoro, Burkina Faso; Unit of Malariology, Department of Biomedical Sciences, Institute of Tropical Medicine, Antwerp, Belgium
Brabin BJ, Child and Reproductive Health Group, Liverpool School of Tropical Medicine, Liverpool, UK
Tinto H Clinical Research Unit, Nanoro, Burkina Faso a; Institut de Recherche en Sciences de la Santé (IRSS), Bobo-Dioulasso, Burkina Faso
Brabin L. Academic Unit of Obstetrics & Gynaecology, University of Manchester, Manchester, UK

Most pregnant women in Burkina Faso are iron deficient and many are anemic. This study assessed women’s understanding of anemia and the role of iron in preventing and treating this condition. A qualitative study was conducted within a randomized controlled trial of weekly iron supplementation in a rural malaria endemic area. Focus groups with women of similar age, parity, and marital status took place in 12 of 24 study villages. Two additional focus groups were conducted with female field workers. Tape recorded transcripts were translated into French and analyzed using Framework analysis. Anemia, for which no “Moore” term or traditional treatment for anemia was evident, was described in terms of blood volume. Moderate blood loss (diminished blood) could be easily replaced by eating well and was not considered serious. Massive blood loss (finished blood) was a rare, life-threatening illness. Iron tablets could increase blood volume and help women withstand massive blood loss at delivery, but for the latter, transfusion was indicated. Women had no knowledge of iron’s role and did not readily concede that iron supplements contained elemental iron. Neither adolescents nor field workers were convinced of the benefits of supplementing non-pregnant adolescents, who were incorrectly considered to be at low risk of anemia. Young women’s knowledge of anemia did not provide an adequate explanatory framework to motivate anemia prevention. Improving information on the role of iron is especially important for adolescent girls who may be incorrectly considered at low risk of anemia as they have not yet experienced pregnancy.

Keywords: Adolescents; Perceptions; Burkina Faso; Anemia; Malaria; Iron; Iron supplementation
Clare Chandler

London School of Hygiene and Tropical Medicine, UK

Clare Chandler is a Senior Lecturer in Medical Anthropology in the Department of Global Health and Development at the London School of Hygiene and Tropical Medicine. She is currently on a fellowship through the LSHTM’s Institutional Strategic Support Fund with the Wellcome Trust. Her research interests lie at the interface of anthropology and global health, studying social aspects of malaria, health care delivery, public, private and community health care access, diagnostics, use of medicines and pharmacovigilance in low-resource settings. The focus of her work has been in Tanzania and Uganda, as well as in other areas of Africa and Asia. She is experienced in interdisciplinary research, and is concerned with re-shaping questions around global health intervention and impact and she is committed to strengthening the quality of social science in global health research.
When artemisinin combination therapies (ACTs) were scaled-up rapidly for the treatment of malaria there were concerns about the safety of these drugs and how this could be monitored. Post-marketing pharmacovigilance relies on passive and active adverse event reporting by clinicians, but systems for doing this in malaria endemic countries are weak. Furthermore, a large proportion of treatments are provided by non-clinicians. Most commonly used forms are challenging for lower-level health workers and non-clinicians to complete, and do not encourage participation in the reporting system. Through participatory research, we sought to develop user-friendly adverse event report forms designed to capture information on events associated with ACTs.

Following a situation analysis, we undertook workshops with community medicine distributors and health workers in Jinja, Uganda, to develop a reporting form based on experiences and needs of users as well as communication and visual perception principles. Participants practiced with the forms and gave feedback for revisions of subsequent versions. We then conducted a series of 8 pretesting sessions with 77 potential end users using scenarios to test and refine passive and active versions of the form.

The development process resulted in a form that included a pictorial storyboard to communicate the rationale for the information needed, and a diary format to record the drug administration and event details in chronological relation to each other. Successive rounds of pretesting used qualitative and quantitative feedback to refine the form, with the final round showing over 80% of the form completed correctly by potential end users.

We developed novel adverse event report forms that can be used by non-clinicians to capture pharmacovigilance data for anti-malarial drugs. The participatory approach was effective for developing forms that are intuitive for reporters, and motivating for respondents. The forms or their key components could be adapted for use in other low-literacy settings to improve quality and quantity of drug safety reports as new medicines are scaled-up.
Theme 6: The social lives of medicines

Ian Harper

University of Edinburgh, UK

Ian Harper is a trained medical practitioner who has worked in hospital medicine and general practice in the UK. For three and a half years he managed a tuberculosis control project in Nepal, and for two years worked with NGOs throughout India in supporting community health programmes. His experiences of practicing medicine and public health in such diverse cultural and political situations led him to study medical anthropology. He served on the ASA committee as the ethics officer (2005-7) and is a co-founder of Anthropology Matters http://www.anthropologymatters.com, the ASA’s national web-based postgraduate network. He is the current secretary of the Britain Nepal Academic Council http://www.digitalhimalaya.com/bnac, and is an associate editor of the International Journal of Tuberculosis and Lung Disease http://www.ingentaconnect.com/content/iuatld/ijtld.

From August 1998 to March 2000 he researched into the social relations around, and the effects of, a series of public health programmes in Palpa district, Nepal. Briefly researching into the privatisation of technical training in the health sector in Nepal, between 2007-9 he researched as part of a multidisciplinary team on a DfID / ESRC funded research project “tracing pharmaceuticals in South Asia” http://www.csas.ed.ac.uk/scaffolding/new_page_root/research_projects/tracing_pharmaceuticals. Between August and December 2008, at the invitation of the Director, he worked in the Nepal National Tuberculosis Programme (NTP) assisting with the implementation of Global Fund funded programmes. He is currently a CI on a grant from Phase 2 of the ESRC/DfID Joint Programme of Research on international development issues, entitled “Biomedical and Health Experimentation in South Asia: Critical Perspectives on Collaboration, Governance and Competition http://www.bhesa.org” which started in September 2010.

From 2012 he is the recipient of a Wellcome Trust Senior Investigator Grant for the project: Understanding TB Control: Technologies, Ethics and Programmes http://www.wellcome.ac.uk/News/Media-office/Press-releases/2012/WTM054458.htm
The availability of, and access to TB drugs, is literally a matter of life and death. We look at issues around access to treatment, and the relationship between supply and regulation of antituberculous drugs in Nepal. Drawing on fieldwork into pharmaceutical distribution and regulation (with a focus on the off patent TB drug rifampicin) and time working in the Nepal TB control programme, we explore the interplay between changing production and supply patterns of TB drugs, the impact of the Global Fund and WHO procurement mechanisms on this, and the consequent availability of drugs, both through the public DOTS programme and in the private sector. The increasing availability of combination therapy (both strips and combined into one tablet), from Indian pharmaceutical companies, and the general success of the DOTS programme has resulted in a change in the private market place for TB drugs, the demise of local TB drug production, and a situation where it is more difficult to access the wrong combinations. Yet this public health gain needs to be balanced against the slow rise of MDRTB in Nepal, and further questions over the availability, procurement and distribution of these far more expensive and complex second line drugs.
Patrick Cloos

University of Montréal, Canada

Patrick Cloos is currently Assistant Professor at the Faculty of arts and sciences, Université de Montréal, Québec, Canada. He holds a medical doctor degree, a master in public health and a Ph.D. in social sciences. He practiced emergency medicine in the 1990s in Brussels and for Médecins sans Frontières in several countries in Africa and Asia where he coordinated health programmes in various contexts of war and urban environments. He was also Chief Medical Officer in the Commonwealth of Dominica. He has conducted research on perceptions of condom use by Canadian native youths in order to prevent HIV transmission; perceptions of older Caribbean people on health care and social services, economic situation(s) and living conditions; and on the racialisation of U.S. public health. He is currently conducting qualitative research on the relationships between social and cultural dynamics, and health among Haitians immigrants in Quebec; representations of memory loss among older Haitians immigrants in Quebec; and he is collaborating in a research on representations of cancer among immigrants living in Montreal. Patrick Cloos’ particular interest is in the relationships between power, representations, practices and knowledge. He is the author of « Pvoir, Différence et Stéotypes : Regard socio-antropologique sur la santé publique américaine, Presses de l’Université Laval (in press). He has also published a number of articles in peer-reviewed journals on racism and racialisation in Public Health, and on ageing in the Caribbean.

Notes
The contribution of critical medical anthropology in global health: the case of antimicrobial resistance.

Antimicrobial resistance is recognized as a major international public health issue. It has been suggested that antimicrobial resistance is correlated with drug use. According to the World Health Organization, the respect for international policies and standard guidelines should increase appropriate use of medicines (not only by health care providers but also by patients), and therefore contain antimicrobial resistance. However, as for any other health problem, the making of resistance to drugs has strong political, economic and sociocultural aspects. This presentation will discuss what is known as ‘critical medical anthropology’ and the way this theoretical standpoint can contribute to global health research in this context. What does ‘critical’ mean and with which objectives? Is this perspective relevant to public health or should it be seen as an academic exercise without any pragmatic contribution? Usually anthropologists pay attention to local cultural worlds and lived experiences of an illness that are shaped by social changes, political and economic transformations. Anthropologists are sometimes seen as researchers who will try to adapt public health messages and interventions to local contexts in order to increase the likelihood of their success. However, any ‘critical’ standpoint has to include reflexivity, question institutional interests and propose social transformation or, in other words, emancipation possibilities in order to reverse or at least reduce health inequalities. Are these principals realistic and what are their limitations in global health research?
Poster 1
Factors influencing prescription of higher generation broad spectrum antibiotics among general practitioners in Bangalore and Tumkur, India

Annelies Post
Praveen Ailvalli
Vijayashree HY
Christina Quevedo-Gomez
Erika Vlieghe
Prashanth NS
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Introduction: Antibiotic resistance is a threat to global health. Overuse of antibiotics is a major contributing factor, fuelled by inappropriate prescription by medical doctors. The present study assessed factors influencing prescription of higher-generation broad-spectrum antibiotics (including fluoroquinolones, aminoglycosides, macrolides, third-generation cephalosporins, carbapenems) among general practitioners (GPs) in southern India.

Method: Between May – June 2014 a total of nineteen semi-structured interviews were conducted with GPs working in either the public (n=3) or private sector (n=16) in Tumkur, a semi-rural area, and the metropolitan area of Bangalore. All interviews were voice recorded and transcribed verbatim. The data was analyzed using the framework approach as described by Ritchie and Lewis (2003).

Results: GPs declared a multitude of factors influencing their prescription behavior, such as patients’ demand and pressure for a quick cure enforced by increasing competition between practitioners, the perceived high level of multidrug resistance within the population and incentives provided by the pharmaceutical industry such as gadgets, holidays, medical equipment and shares of up to 40% of profit. According to the interviewed GPs a lack of regulation of the health sector and widespread corruption practices throughout the healthcare system further stimulate inappropriate prescription practices. While self-regulation by the medical professional community was perceived as having so far had a limited effect, (inter)national peer pressure through for instance social media was believed to have a positive influence, especially on the younger generation GPs.

Conclusion: Inappropriate prescription of antibiotics by GPs is an issue of concern in India. The pharmaceutical industry has an enforcing influence on these practices. Social media could be used as a tool to stimulate appropriate prescribing practices.
Theme 6: The social lives of medicines

Poster 2
Community perceptions on adherence to anti-malarial treatment during pregnancy in a rural area of The Gambia

Fatou Jaiteh

Abstract: Non-adherence to antimalarial treatment has been identified as a major barrier to malaria control efforts especially during pregnancy. Current studies on adherence focus on establishing causal links with broad quantitative outcomes, however lacking attention on the cultural and contextual factors which have led to the failure of past malaria control efforts. This study aims to understand these factors by exploring community perceptions on pregnant women’s adherence to their antimalarial treatment in a rural area of The Gambia.

Method: A qualitative study based on focused ethnography was conducted from June to July 2014 in the Upper River Region of The Gambia. In depth interviews in addition to participant observation were conducted in 3 cluster villages. Semi-structured interviews were conducted with 30 participants, which included women of reproductive age (n=15), mother in laws (n=5), husbands (n=4) and health workers (n=6). Data was analysed using NVivo (QSR International Pty Ltd. Version 10)

Findings: Late debut of pregnancy was found to influence women’s (especially young adolescents and multigravida) knowledge of the importance of treatment adherence. For pregnant adolescents, late debut was linked to feelings of awkwardness and social shyness as they transition into motherhood. For mothers with additional late age pregnancies (multigravida) their behaviour was associated with their social role and position. In general, women indicated having insufficient information on treatment efficacy and possible side effects of anti-malarial medication and their mother in laws played influential roles in their treatment taking behaviour.

Conclusion: The findings from this study indicate that increased focus should be placed on pregnant women, (adolescents and multigravida) who are at risk of being isolated from health education and promotion regarding malaria in pregnancy. Additionally, mother in laws should be included in facility and community based health promotion programs targeted at pregnant women.
This paper focuses on one particular biosocial space for reconfiguration of epidemic potential, that of the spread of multi-drug resistant Tuberculosis (MDR-TB) caused by the interaction of anti-TB medicines and Mycobacterium tuberculosis in the human body. The paper explores how the regime of Directly Observed Treatment – Short-course (DOTS) – promoted by the World Health Organization as a strategy to treat Tuberculosis (TB) and prevent drug resistance – in the case of India has contributed significantly to successful treatment but failed to prevent drug resistance, both in its own domain of public healthcare services and in a context dominated by commercial healthcare. The spread of TB is linked to a range of other conditions and deeply embedded in the social fabric and can be understood through the syndemic approach proposed by Singer. However, the paper suggests that important dimensions of spread of TB and multidrug resistant TB (MDRTB) can be understood as a cultural epidemic. The epidemic potential of chemically-biologically modified strains of MDRTB calls for explorations of processes of contamination to address questions such as ‘how is the social life of drug resistance created and maintained over time’; as well as investigations of the politics of configuration to understand how the epidemic of MDRTB is driven and distributed within populations.
Poster 4
A better understanding of the root causes of refusals to vaccination in the Katanga Province, DR Congo

Vololomanitra Belalahy

Abstract: Background. The independent monitoring conducted during polio campaigns reported refusals as one of the main reasons of unvaccinated children. The study is aimed to identify the underlying causes of vaccine refusals in the Katanga province, DR Congo.

Methods. A qualitative study was conducted during 6 months in 4 health zones in the Katanga province through 16 focus group discussions, 80 household in-depth interviews and 101 interviews of key informants. The focus group discussions were conducted in health areas where the vaccination coverage is low and which include one or more communities considered reluctant to vaccination. The in-depth interviews were conducted within households known as refusing (60%) or compliant (40%). Only households having children under-five years old were selected.

Results: The study found that refusals to vaccination are due to the prohibition within some religious groups according to their interpretation of the Bible. Vaccination is also considered as a mean for white people to perpetuate their domination upon black people. Anemia is sometimes attributed to vaccination. Some religious leaders are also trusted for their ability to treat illnesses so there is a symbolic and economic competition between biomedicine and these religions. Moreover, there is the consideration that illnesses are due to behaviours of individuals who violate traditional rules or that polio is due to witchcraft so the solution would be a “counter-witchcraft” and not vaccination. Also some people don’t know what vaccine is and how it works. Furthermore, resistance is a way for some individuals to contest against the health system deemed hard for accessing and unfair. Finally, vaccination by force increases resistance as punished individuals are considered as heroes against the health system.

Conclusions. Root causes of refusals have to be well understood in order to tailor a communication strategy that should be based on dialogue for a better understanding of the foundation of the vaccination by the community but also for identifying a way to put traditional/religious healing practices and biomedicine together. Improvements in access of the population to health services may also have a huge impact on the decrease of refusals to vaccination.
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Practicalities

Conference Dinner
The official colloquium dinner will take place on Wednesday 26 November 2014 from 7 p.m. until 10.30 p.m. in the Glass Room of the BNP Fortis Bank in the touristic centre of Antwerp (see city map on page 147). The evening consists of a reception, followed by a walking dinner that caters to vegetarians and various food preferences.

Poster presentations
All posters will be on display for the participants during the 3 days of the colloquium. In addition, the programme includes 2 dedicated 2-hours poster sessions (after lunch on Tuesday 25 November and Wednesday 26 November).

On Day 1 posters linked to colloquium themes 1, 3, 4, 5, and 6 will be highlighted.
On Day 2 posters linked to theme 2 will be put in the spotlight.

A prize will be awarded for the most ground-breaking and best presented poster at the end of the colloquium. If you have submitted a poster, we kindly ask you to be present during the dedicated poster session.

Registering your poster
If you are presenting a poster, please indicate so during registration.

Hand over your poster at the registration desk on Monday 24 November at the latest.

Your poster may not be larger than 120 cm (h) x 90 cm (b) in portrait orientation. We do not accept posters exceeding the size limit.

Flyers
Tables will be placed at the entrance of the Forum where you can deposit flyers, handouts of your presentation or other documents presenting your (net)work.
Liability
The colloquium organisers are not responsible for any loss, accident or injury that may occur during the meeting.

Insurance and medical assistance
Obtain appropriate travel insurance and a proper health and accidents insurance as well as a civil liability insurance to ensure your entry into Belgium. If you have an acute health problem, you can rely on the dispensary of ITM for medical assistance.

Internet
The ITM offers free internet access. Some hotels do the same, but most of them will ask a fee.

Weather
In November, the average temperature in Belgium can be as low as or even below 0°C and it may be rainy or snowy.

Tourist information
The congress venue is located near to Antwerp’s main shopping area and historical centre. For more information, visit the website www.visitantwerpen.be.
City guidelines
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