

study participant characteristics and the key variables referred to above. Chi-square tests will be used to assess the relationships between participant characteristics and perception and knowledge indicators measured quantitatively using scales.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Universidad Mayor de San Andres

Universidad Mayor de San Francisco Xavier

Universidad Mayor de San Simón

Summary/Conclusion: Challenges identified include insufficient knowledge, academic support, expertise, regulation, and funding. Study findings describe the current research ethics needs and practices in Bolivia and facilitate the development of a sustainable research ethics education program.

CSIH MentorNet: Impact of an innovative national global health mentorship program on students and young professionals

S.L.K. Sunley¹, S. Dhawan², K. Wong¹, C. Jackson¹, A. Frain¹, C. Macphail³, L. Padyachee⁴; ¹Canadian Society for International Health, MentorNet Program, Ottawa, ON/CA, ²University of Alberta, School of Public Health, Edmonton, AB/CA, ³McMaster University, Global Health Office, Faculty of Health Sciences, Hamilton, ON/CA, ⁴University of Saskatchewan, Edwards School of Business, Saskatoon, SK/CA

Background: In 2011, the Canadian Society for International Health (CSIH) created MentorNet, a national global health mentorship program that connects students and young professionals (SYPs) with experts in fields relevant to global health. MentorNet recognizes that global health encompasses a diverse array of disciplines, and seeks to bring together mentors and SYPs from a wide range of health-related professions, including nursing, nutrition, epidemiology, and the social sciences. The program aims to expand SYPs' awareness of the global health field, increase SYPs' confidence in pursuing a global health career, encourage knowledge transfer between new and experienced professionals, and improve SYPs' understanding of global health issues.

Structure/Method/Design: MentorNet is run by a volunteer steering committee (SC) of young global health students and professionals living across Canada, many of whom have previously participated in the program. SC members are responsible for program coordination and the recruitment, selection, and matching of SYPs and mentors. SYP admission is competitive, and successful applicants are matched with mentors based on their interests and geographic location. Over a 9-month period, mentor-SYP pairs receive monthly global health modules from SC members, which prompt them to critically engage with global health issues, reflect on their career goals, and discuss challenges and opportunities in global health practice in Canada and internationally.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Not applicable

Summary/Conclusion: Following a successful pilot year (2011-12), during which MentorNet developed a module-based global health curriculum and matched 30 SYPs, a second cohort of 35 SYPs completed the program in 2012-13. Pre- and post-evaluation results from years 1 and 2 indicate that the program has consistently improved SYPs' awareness of opportunities in the global health field, enhanced their understanding of global health issues, increased their interest in pursuing a career in global health, and expanded their contacts and networks in global health. Ongoing challenges identified by participants include geographic/time differences and time constraints/competing

commitments. The SC is addressing these challenges by factoring geographical location into the matching process, and working with pairs to tailor the scheduling of modules. After 2 years, MentorNet has proven to be a valuable initiative for supporting Canadians SYPs to become leaders in global health, and provides a low-cost, youth-led program model to build global health capacity.

Health education for sickle cell disease: Strategies to support families and health care workers in Tanzania

G.P. Venner¹, D. Zakus², D. Soka³, J. Makani³; ¹University of Alberta, Edmonton, AB/CA, ²University of Alberta, Faculty of Medicine and Dentistry, Medicine: Community and Occupational Medicine, Edmonton, AB/CA, ³Muhimbili University of Health and Allied Sciences, Haematology and Blood Transfusions, Dar es Salaam/TZ

Background: Sickle cell disease (SCD) is a major public health concern in Tanzania, with an estimated birth prevalence of 7/1000. There is limited awareness among health care workers and the community. This study aimed to identify the needs of children living with SCD and their families, health care workers, and teachers to better understand the importance of awareness, education, treatment access, and proactive lifestyle modifications.

Structure/Method/Design: Method: This community-based study included two areas in Tanzania: a rural community in the Coast region and a tertiary-level health facility in an urban setting in Dar es Salaam. We aimed to enroll 30 participants: 10 children (0-18 years) with SCD, 10 parents/caregivers of a child with SCD, and 10 health care providers and teachers overseeing individuals with SCD. Purposeful sampling was used to identify children with SCD and their families through local health services. Associated allied health care providers and teachers were identified using snowball sampling. Each participant was interviewed using one of four predefined questionnaires specific to their group. Open-ended questions beyond the structured interview were used to expand on key themes.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Muhimbili University of Health and Allied Sciences

University of Alberta

Students' International Health Association

Community partners in villages who participated

Summary/Conclusion: Results: A target number of participants was not reached due to short time frame in the targeted communities and limited access to participants. Two children, one parent, and seven health care providers participated (n = 10). Children indicated they had limited knowledge about SCD, particularly when describing pain severity. Parents highlighted the deficit in support from the local health care facility. Participants identified a need for better SCD management protocols and nutritional education. Rural health care providers had limited knowledge of the importance of a high index of suspicion to improve diagnosis of SCD and on the severe complications of disease particularly infection, severe anemia, and malnutrition. Urban health care providers prioritized increasing understanding and efforts to develop awareness at the national level, particularly improving diagnostic facilities throughout the country, as well as encouraging patients' adherence to clinics for follow-up and advice. They also identified multiple challenges in the management of SCD, including underdiagnosis of SCD, misdiagnosis as malaria, and significant lack of knowledge about SCD.

Conclusion: Gaps in knowledge about SCD were identified among patients, families, and health care providers in rural Tanzania. Knowledge of disease severity is low, which increases the risk for other

conditions such as infection, malnutrition, and severe anemia that can lead to complications and death. It is recommended that strategies are developed to improve health education for SCD.

Social accountability in global medical education: The REVOLUTIONS framework

W. Ventres¹, S. Dharamsi²; ¹University of El Salvador, Institute for Studies in History, Anthropology, and Archeology, San Salvador/SV, ²The University of British Columbia, Family Medicine, Vancouver, BC/CA

Background: Socially accountable medical education prepares future physicians around the world to address the priority health concerns of society, with particular attention to marginalized populations, using educational, research, and service models that engage interdisciplinary professionals, public and private organizations, and civil society. Schools of medicine interested in advancing their socially accountable roles need structural frameworks on which to build such programs in the communities they serve.

Structure/Method/Design: This presentation builds on available literature and theory regarding socially accountable medical education, a review of exemplary medical education programs from around the world that focus on social accountability, and our personal experience, both domestically and internationally, in developing socially accountable systems of medical education.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): We present the REVOLUTIONS framework for socially accountable medical education in a global context. This framework is based on the following theses: 1) medical schools have a duty to train socially accountable physicians; 2) training such physicians means building socially accountable systems of medical education; 3) building such systems means movement (from traditional to socially accountable educational models or practices) along 11 teaching, learning, and service dimensions. Each of the 11 REVOLUTIONS dimensions highlights: 1) one area of medical education, including characteristics of that area that correspond to traditional and socially accountable educational systems; 2) changes needed in each area to make medical education more socially accountable; and, 3) reference to exemplary programs demonstrating progress in social accountability.

Summary/Conclusion: Medical schools interested in becoming more socially accountable need a blueprint for developing their curricula. The REVOLUTIONS framework for socially accountable medical education provides this blueprint. In this presentation we review the reasons for moving toward a social accountability in medical education, present a framework for considering and structuring these changes, and provide an up-to-date review of global best practices in socially accountable medical education.

Global health education locally: A community service-learning program to support refugees, engage medical students, and fill a gap in the community

R. Warmington¹, M. Sickand¹, L. Saliba¹, E. Snyder¹, N. Martel¹, L. Farren-Dai¹, D. Gruner¹, K. Pottie²; ¹University of Ottawa, Medicine, Ottawa, ON/CA, ²University of Ottawa, Ottawa, ON/CA

Background: Over the past 2 years, the Refugee Health Initiative (RHI), a medical student-led interest group at the University of Ottawa in partnership with the Catholic Centre for Immigration (CCI), has successfully piloted an original collaborative program with the intention of fulfilling the following three objectives:

- i) To support newly arrived refugees in their first year of resettlement and to help families navigate the barriers that prevent integration into the Ottawa community
- ii) To provide relevant cultural competency training to medical students interested in learning how to practice medicine within a global context
- iii) To work collaboratively with community partners to fill needs that are not currently being addressed by other program mandates

Structure/Method/Design: The program was implemented via a new curricular initiative that required all first-year medical students to complete 30 hours of community service. RHI facilitated this program by working closely with various community partners including the CCI, physicians, and interpreters.

In October, students are matched with a newly arrived family and have the initial encounter as a medical intake interview. In the following months, the students and families complete various activities such as accompaniment to additional medical appointments, grocery store visits, and tutorials on how to access resources in the community. Under the guidance of community case managers, we ensure that activities are tailored to the needs of each family, making each match unique. The year culminates in a Community Health Fair. The first Health Fair brought together over 150 refugees, physicians, nurses, dietitians, community partners, and students in an effort to provide relevant information regarding access to Ottawa community resources, health, and well-being.

Throughout the year, students attend various training sessions run by medical professionals with expertise in global health. These sessions provide immediate benefit to the refugee families and at the same time, equip future physicians with the tools to ensure equitable and accessible health care for diverse populations.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): - 21 families matched

- 150+ refugee families attended Community Health Fair
- 46 students trained as “health brokers” for refugee population; over 1500 hours of total community service-learning experiences
- Effectively filled a need identified by community partners
- Refugee families empowered by the added support, opportunities to interact with students and access to community resources
- Students acknowledged improved cultural competency and knowledge about refugee and migrant populations alongside increased comfort when working with vulnerable populations
- Community partners recognized value of the program in alleviating workload and filling unmet needs

Summary/Conclusion: A student-led community initiative can successfully address refugee well-being, cultural competency training, and unmet needs in the community with minimal resources. RHI’s pilot program therefore holds tremendous potential for growth in various domains.

IVUmed: A nonprofit model for surgical training in low-resource countries

J. Wood¹, A. Steele¹, M. Fredley¹, C.R. Devries²; ¹IVUmed, Salt Lake City, UT/US, ²The University of Utah Center for Global Surgery, Salt Lake City, UT/US

Background: Low-resource countries (LICs) face both training and infrastructural challenges for surgical care, particularly for specialty care, such as for urology. Practitioners charged with caring for these patients have few options for basic or advanced study. Travel abroad for hands-on training is virtually impossible due to certification