

**HAI**

**HEIDELBERG ALUMNI  
INTERNATIONAL**



**UNIVERSITÄT  
HEIDELBERG  
ZUKUNFT  
SEIT 1386**

## **Alumni Summer School 2014**

# **Health Promotion for Populations in the Periphery**

**September 14<sup>th</sup> – 19<sup>th</sup>, 2014**





**Welcome to the  
Alumni Summer School 2014**

**Heidelberg Alumni International**  
**in cooperation with**  
**the Institute of Public Health,**  
**Faculty of Medicine, Heidelberg University and**  
**kindly supported by the Community of Bammental**

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# Welcome

Dear alumni,



In the name of Heidelberg University, Heidelberg Alumni International and the Institute of Public Health we are very happy to welcome all of you today to our Alumni Summer School 2014 in Bammental/Heidelberg. We are overwhelmed and touched that so many of you took on the effort to come back to Germany despite tight working schedules, often difficult situations in your home countries and hard travel conditions. This proves that our topic “Health Promotion for Populations in the Periphery” is of utmost importance and the discussion on the responsibility for matters of health of underprivileged populations very important. Thus we are very happy to be able to hold this 9<sup>th</sup> Alumni Summer School and are very glad to have the seminar funded by the German Academic Exchange Service.

This year’s summer school is tailored for you to be acting as both, participants and speakers. You are experts in your fields and highly dedicated to promote the health of populations in the periphery. We can profit from each other’s knowledge and experiences. Thus we hope that this mix of teaching and learning will be especially interesting and worthwhile for you.

We wish you a successful seminar which strengthens your well-established ties and fosters new valuable contacts, which holds promising projects and collaborations for you – and not to forget which brushes up memories of Heidelberg!

*Silke Rodenberg, Director, Heidelberg Alumni International*



Dear cooperation partners and colleagues, dear friends,

with great pleasure we welcome you to our summer school on topics, which have been at our professional hearts over the past years, if not decades. We shared our efforts in various research projects, postgraduate teaching events and network symposia, first in the field of schistosomiasis research and control, later in public health. Many of you know each other from these events, but a bridge between our fields of expertise only became possible through this unique occasion to meet as alumni. We bridge some 40 years of age difference: I am extremely grateful to have friends among you since times when our youngest participants were just babies, and when I was offered the chance by my former Director of Institute, esteemed mentor and scientific father, Prof. Hans-Jochen Diesfeld, to become a post-doc under his guidance. It is because of him that we can meet today. We have the privilege to share a week as a group, where neither age nor professional discipline counts, but rather the joint reflection on our personal possibilities and responsibilities to make the world a better place to live for those who are greatly disadvantaged. I dare to claim that there is a >99 : 1 gap, and today all of us here are on the 1%-place, even though some of you perfectly know the 99%-place from your earlier personal life situations.

Thanks to all for dedicating a week of your precious time: a week of free and confidential exchange, a week of mutual support to develop visions by learning from each other, and a week of the shared pleasure to be (back) in Heidelberg and also in Bammental.

*Dr. Andreas Ruppel, retired professor and director of teaching, Institute of Public Health*

# Introduction

## “Health Promotion for Populations in the Periphery”

Health promotion implies that it is needed. Agreement for such need is universal when thinking of those who have no or limited access to medical care, as in remote rural areas in many countries, including recently also Germany. In an affluent context like Heidelberg, however, this need may be debatable. It may equally be debatable in medical centers around the world, where even medical tourism flourishes in low- or middle-income countries. Centers of high quality medical services exist in the form of specialized hospitals, even in low-income countries. The divergence of ‘developing’ versus ‘developed’ countries has by now become a myth: between-countries and within-countries health-wealth distributions show the same patterns.<sup>1</sup> In all societies, there is a privileged minority which can afford paying top medical services.

‘Periphery’ in the context of this workshop relates to those populations, who, for whichever reason, cannot access adequate medical services. For a remote rural village, the meaning of distance (in kilometers, in walking hours, or obstacles to cross barriers like gorges or rivers) to the medical center easily illustrates ‘periphery’. However, next to distance there may be different ways to determine a situation in the periphery, like lack of cash money, obligations to care for family, possibility to leave home. For a critically ill patient, the periphery may start in front of the door of the hospital to which access is denied because treatment cannot be paid. The rich part of the populations in any country has access to medical care (with the frequent attribute of ‘excellent’), whereas poverty in any country predisposes for a life in the ‘periphery’ of quality medical services.

Poverty predisposes also to a diseased life. This is a trivial statement, but places disease in the larger context of determining factors, which include good governance, economic development, intact civil society, traffic infra-structure, political responsibility. Among these competing factors health care does not necessarily rank highest on a government’s agenda.<sup>2</sup> Also, individual health professionals may not necessarily place responsibility for quality care at the top of their individual agenda.<sup>3</sup> Economic development is undoubtedly a key factor to promote health services, and there is probably no country not aiming at this. However, ‘what people desire and what goals are possible to achieve in a sustainable society’ poses the challenge to balance between efforts to eliminate poverty and to avoid global collapse.<sup>4</sup>

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<sup>1</sup> Google: Hans Rosling’s 200 countries 200 years.

<sup>2</sup> Paul Collier, 2008. The bottom billion. Oxford University Press.

<sup>3</sup> Google TED Talks: Patrick Awuah: how to educate leaders.

<sup>4</sup> Google: Ehrlich (2010) The MAHB, the Culture Gap, and Some Really Inconvenient Truths. PLoS Biology.

All participants of this workshop have dedicated their professional life (which is maybe synonymous with private life) to aspects of health promotion, be it as researchers in the laboratory or in the health system, as managers in health services with a ministry of health or with a hospital, as medical doctors in unusually challenging situations or else. Many participants have committed their professional work to health services under conditions, which are – to say the least – shaky. I have highest esteem for those who chose ‘to serve, not to be served.’<sup>5</sup>

Everyone in this workshop decided to promote the health of populations in the periphery; some had this aim already for several decades. We can profit from sharing a wealth of experience and ideas how to be the change, which we would like to happen. The individual goals and achievements are extremely varied by field of expertise: they may concern small or large numbers of people, but someone will always benefit. Examples of success may encourage others. Failures are indispensable elements of expertise and to disclose failures may help others to avoid at least those. We have the chance to learn a lot from each other.

The German Academic Exchange Service (DAAD) and Heidelberg University have generously sponsored this workshop. It is organized in cooperation with Heidelberg Alumni International, the university’s alumni department directed by Silke Rodenberg. All participants have professional links with Heidelberg University or have been part of a DAAD program or both. DAAD and Heidelberg University hope that this workshop will foster, strengthen and intensify ties and commitment amongst the participants as well as with the university. I wish to thank everyone for taking the time and efforts to travel here and for contributing to the success and pleasure of this week.

*Andreas Ruppel*

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<sup>5</sup> Motto of the Wesley Clinic, Tahan, Myanmar.

# Schedule

	Sun. 14.09.14	Mon. 15.09.14	Tue. 16.09.14	Wed. 17.09.14	Thu. 18.09.14	Fri. 19.09.14
09:00	Arrival and hotel check-in	Scientific session	Scientific session	Scientific session	Scientific session	Scientific session
10:00						
11:00	Arrival and hotel check-in	Scientific session	Lunch	Lunch	Lunch	Lunch
12:00						
13:00	Arrival and hotel check-in	Lunch	Transfer to field trip location	Transfer to field trip location	Transfer to field trip location	Lunch
14:00		Transfer to Heidelberg	Field trip: Nuclear Power Plant, Phillipsburg	Field trip: Waste Recycling and Disposal Factory, Sinsheim		
15:00	Administrative check-in with the alumni office at Hotel Eisenztal	Introduction to HAI	Return to Bammantal	Return to Bammantal	Filed trip: Mosquito Control Center, Speyer	Free time or Visit of health-related institutions
16:00						
17:00		Guided tour				
18:00	Opening		Dinner	Dinner	Dinner	Symposium for the public
19:00		Dinner in Heidelberg				
20:00	Dinner				Return to Bammantal	

- Check-In
- Scientific sessions
- Field trips
- Lunch / Dinner
- Special events

Schedule may be subject to change.



## Sunday, September 14<sup>th</sup>, 2014

- Until 17:00      **Arrival and check-in at the hotels**
- 15:00 – 17:30    **Administrative check-in**  
Meet Christine Domnik of the alumni office at Hotel Elsenztal.  
Submission of documents for refund.
- 18:00 – 20:00    **Opening**  
Town Hall Bammental, 3<sup>rd</sup> floor
- Music: Johann Pachelbel – Canon  
Flute (Christine Weller), Violin (Andreas Ruppel),  
Guitar (Salvador Camacho), Theorbo (Rainer Luckhart),  
Cello (Angelika Bohsung)
- Welcoming addresses of:
- Prof. Dr. Dieter W. Heermann, Vice-Rector for International Affairs Heidelberg University
  - Silke Rodenberg, Head of Heidelberg Alumni International
  - Holger Karl, Mayor of Bammental
- Introduction to the Summer School and of the participants,  
Andreas Ruppel
- Music: Andrea Falconieri – Folia
- 20:00            **Dinner at Ristorante Pavarotti**  
Hauptstraße 8, Bammental

## Monday, September 15<sup>th</sup>, 2014

- 09:00 – 10:30     **Scientific session: National control programs**  
Sitzungssaal, Town Hall Bammental
- Hermann Sorgho (Burkina-Faso):     Abstract  
*Recent evolution of schistosomiasis in Burkina Faso*     Page 41  
*following the implementation of the SCI control program*
  - Reda Ramzy (Egypt):     Abstract  
*Lymphatic filariasis in the Eastern Mediterranean Region:*     Page 36  
*current status and prospects for elimination*
  - Mohamed Ahmed Mohamed Idris (Sudan):     Abstract  
*The Great Neglected Tropical Diseases with Special*     Page 32  
*Reference to Sudan*
- 11:00 – 12:30     **Scientific session: Access**  
Sitzungssaal, Town Hall Bammental
- Maureen Dar lang (Nepal):     Abstract  
*Situational analysis and strategies to address reaching*     Page 19  
*un-reached populations in remote areas of Nepal*
  - Shafiu Mohamed (Nigeria):     Abstract  
*Absence of health information and obstacles in accessing*     Page 33  
*health care services among rural dwellers in Nigeria: the*  
*under-privileged experience*
  - Mahmoud Shaban (Oman):     Abstract  
*Oman's Experience in Provision of Health Services to the*     Page 38  
*Remote Rural Population*
- 13:00 – 14:00     **Lunch**  
Multifunktionsgebäude Bammental
- 14:00     **Transfer to Heidelberg**  
Pick-up in Heidelberg at train stop "Heidelberg Altstadt"
- 15:00 – 16:30     **Heidelberg Alumni International**  
Introduction to the world-wide alumni network
- 16:30     **Guided tour**  
Visit of the old university library, the Aula Magna, and sunset-walk to the  
castle with Christine Domnik
- 19:00     **Dinner at Restaurant "Goldener Hecht"**  
Steingasse 2, Heidelberg

## Tuesday, September 16<sup>th</sup>, 2014

- 09:00 – 11:30    **Scientific sessions: Quality of services**  
Sitzungssaal, Town Hall Bammental
- Than Bil Luai (Myanmar): Abstract  
Page 28  
*Being a brick and a grain of sand in healthcare services provision at the periphery of Myanmar*
  - Nasir Umar (Nigeria): Abstract  
Page 42  
*Using performance-based incentives to improve referrals and institutional delivery in a resource-constrained setting*
  - Josephine N. A. Agyeman-Duah (Ghana): Abstract  
Page 17  
*Quality improvement approaches to reduce under-five mortality in resource challenged settings – the example of Project Fives Alive, Ghana*
  - Zahra Moudi (Iran): Abstract  
Page 34  
*Safe delivery posts: an intervention to provide equitable childbirth care services to vulnerable groups in Zhedan City, Iran*
- 11:30 – 12:30    **Lunch**  
Multifunktionsgebäude Bammental
- 12:30 – 14:00    **Travel to field trip location**  
Bus in front of meeting place
- 14:00 – 17:00    **Field trip: Nuclear Power Plant, Phillipsburg**  
Guided tour including seminar and discussion
- 17:00            **Return to Bammental**
- 19:00            **Dinner in Bammental or free time**

## Wednesday, September 17<sup>th</sup>, 2014

- 09:00 – 12:30    **Scientific session: Policies of health provision**  
Sitzungssaal, Town Hall Bammental
- Ayesha Kamal (Georgia): Abstract  
Page 23  
*Health in Transition: Personal experiences in post-soviet countries*
  - Jamila Nabieva (Tajikistan/Heidelberg): Abstract  
Page 35  
*WhateverSTAN: health services in post-soviet Central Asia*
  - Angela Horvath (USA): Abstract  
Page 22  
*Public health services on a different border: How a local health department negotiates Native American sovereignty.*
  - Yonglong Li (China): Abstract  
Page 27  
*“Rural cooperative medical scheme” and “village doctor” – strategies of health promotion for populations in the periphery of China*
  - Yan Ding (China/Heidelberg): Abstract  
Page 20  
*A syndromic surveillance system for early warning of epidemics in rural China – a need assessment and a survey for infrastructures needed*
- 12:30 – 13:15    **Lunch**  
Multifunktionsgebäude Bammental
- 13:15 – 14:00    **Travel to field trip location**  
Bus in front of meeting place
- 14:00 – 17:30    **Field trip: Waste Recycling and Disposal Factory, Sinsheim**  
Guided tour through all steps in waste management, recycling and deposition
- 17:30            **Return to Bammental**
- 19:00            **Dinner in Bammental or free time**

## Thursday, September 18<sup>th</sup>, 2014

- 09:00 – 10:30    **Scientific session: The role of money**  
Sitzungssaal, Town Hall Bammental
- Zelalem Geletu (Ethiopia): *Foreign aid: my decade's observation and healthcare for the poor*    Abstract Page 21
  - Juliet Kiguli (Uganda): *Cutting of development aid to Uganda: effects on the health sector*    Abstract Page 24
  - Matomora Matomora (Tanzania): *Twenty years KIUMA development support of poor and remote people of Southern Tanzania*    Abstract Page 31
- 11:00 – 12:30    **Scientific session: Education**  
Sitzungssaal, Town Hall Bammental
- Juan A. Leonardia (Philippines): *Health promotion through the education sector: lessons from the GIZ Fit for School Program*    Abstract Page 26
  - John Krugu (Ghana): *Carnal knowledge: The sex education debate and what it means for people in the periphery – the case of Northern Ghana*    Abstract Page 25
  - Ahmad Zia Shams (Afghanistan): *Public Health in Afghanistan: A Decade of Achievements, Challenges and the Poor in Periphery*    Abstract Page 39
- 12:30 – 13:30    **Lunch**  
Multifunktionsgebäude Bammental
- 13:30 – 15:00    **Travel to field trip location**  
Bus in front of meeting place
- 15:00 – 18:30    **Field trip: Mosquito Control Agency, Speyer**  
Visit of "KABS" and "ICYBAC", guided by Dr. Norbert Becker, Director of KABS
- 18:30 – 20:00    **Dinner at Restaurant Domhof**  
Große Himmelsgasse 6, Speyer
- 20:00    **Return to Bammental**

## Friday, September 19<sup>th</sup>, 2014

- 09:00 – 10:30     **Scientific session: Implementation**  
Sitzungssaal, Town Hall Bammental
- Nina Martin (USA): *What factors affect sustained adoption of clean water, sanitation, and hygiene technologies? Findings from a systematic review of the literature*     Abstract Page 30
  - Theresa Madubuko (Nigeria): *Strengthening the human resources for health through strengthening Pre-Service Training*     Abstract Page 29
- 11:00 – 12:30     **Scientific session: Access**  
Sitzungssaal, Town Hall Bammental
- Jilong Shen (China): *Down-regulation of the host immune response to helminth infections and its significance*     Abstract Page 40
  - Mahmoud Bahgat (Egypt/Germany): *Role of basic research in narrowing the gap between populations in the periphery and access to adequate diagnostics and preventive health care*     Abstract Page 18
  - Andreas Ruppel (Germany): *Diagnosis of schistosomiasis and soil-transmitted helminthes: for whom is it available, affordable and desirable?*     Abstract Page 37
- 12:30     **Lunch**  
Multifunktionsgebäude Bammental
- Afternoon     **Free time or optional visit of health-related institutions**  
The Water Cleaning Plant, Bammental (20-minute walk)  
and /or  
the House for Residence and Care of the Elderly, Bammental (5-minute walk)

19:00

## „Eine Welt – ein Abend der Begegnungen“

*Symposium for the public –  
Multifunktionsgebäude Bammental*

Alumni Summer School 2014 workshop participants, colleagues, interested citizens and friends exchange information and experiences.

*Welcome* by the Mayor of Bammental (Holger Karl)

*Introduction* and moderation (Andreas Ruppel)

*Presentations* (15 minutes) of personal experiences and development projects in remote locations:

- Zelalem Geletu (Ethiopia):  
*International Aid and its effects*
- John Krugu (Ghana):  
*YHFG: Education of the youth for a future in dignity*
- Matomora Matomora (Tanzania):  
*KIUMMA: a faith-based medical and professional center*
- Angela Horvath (USA):  
*Public Health services for Indians in the Native American Nations of the USA*
- Than Bil Luai (Myanmar):  
*The faith-based Wesley Clinic: to serve – not to be served*

Round Table Talks:

At various “Ländertische” the experts are available for discussion and will answer questions related to the scientific topics as well as to general aspects regarding the respective country.

This evening is meant to broaden horizons for everyone, to eliminate potential prejudices, and to summarize and end the Alumni Summer School 2014.

## Saturday, September 20<sup>th</sup>, 2014

All day

**Departure**

## Participants

Last name	First name	Country	E-mail
Agyeman-Duah	Josephine	Ghana	
Bahgat	Mahmoud	Egypt	
Dar lang	Maureen	Nepal	
Ding *	Yan	China/Heidelberg	
Geletu	Zelalem	Ethiopia	
Horvath	Angela	USA	
Kamal	Ayesha	Georgia	
Kiguli	Juliet	Uganda	
Krugu	John	Ghana	
Leonardia	Juan Alfonso	Philippines	
Li	Yonglong	China	
Luai	Than Bil	Myanmar	
Madubuko	Theresa	Nigeria	
Martin	Nina	USA	
Matomora	Matomora	Tanzania	
Mohamed Idris	Mohamed Ahmed	Sudan	
Mohammed	Shafiu	Nigeria	
Moudi	Zahra	Iran	
Nabieva *	Jamila	Tajikistan/Heidelberg	
Ramzy	Reda	Egypt	
Ruppel	Andreas	Germany	
Shaban	Mahmoud	Oman	
Shams *	Ahmad Zia	Afghanistan/Heidelberg	
Shen	Jilong	China	
Sorgho	Hermann	Burkina-Faso	
Umar	Nasir	Nigeria	

\* External speakers



# Presentations

**Agyeman-Duah, Josephine N. A.**

Ghana

E-mail:

## Presentation

**Title:** Quality improvement approaches to reduce Under 5-Mortality in resource challenged settings – the example of Project Fives Alive, Ghana

**Abstract:** Ghana like many other low and lower middle income economies are faced with high under 5 mortalities, currently recording U5M of 80/1000 live births. The Project Fives Alive! (PFA) where I work is a partnership between the National Catholic Health Service, the Ghana Health Service and the Institute of Healthcare Improvement in USA. The PFA is accelerating Ghana's effort towards attaining MDG4 (to reduce under 5 mortality) through the application of quality improvement methodology, an approach of rapid cycle testing of scientifically tested yet less capital intensive change ideas. The PFA tackles U5M through three main drivers- delay in seeking care by the care giver, delay in providing care by health workers at the facility and incorrect adherence to protocol. Quarterly, stakeholders come together in an improvement collaborative network to share, plan and review change ideas to test, adopt or adapt in their setting based on their facility data of U5 care and outcomes. Project officers do monthly site visits and follow up phone calls to support the QI teams with the changes being tested.

Today, the PFA which was piloted in three regions in Ghana in 2008 has been scaled up to all ten regions with full local ownership from the regional and district directors of health and facility management teams. The PFA has directly contributed to reduce the institutional U5M in the facilities, with results of up to 70% reduction in U5M in some of these institutions.

Sustainability of the massive results achieved through the PFA platform in U5M is ensured through strong leadership, local ownership, community and care giver involvement in U5 care, capacity building in QI methodology among front line staff and more importantly, health workers paying attention to their data to advise on changes to test, adopt, adapt or abandon.

**Date:** Tuesday, September 16<sup>th</sup>, 2014

## **Bahgat, Mahmoud**

Egypt

E-mail:

### **Presentation**

**Title:** Role of basic research in narrowing the gap between populations in the periphery and access to adequate diagnostics and preventive health care

**Abstract:** Populations in the periphery, especially in low income and less developed countries, are less privileged in terms of access to both diagnostics and therapeutics. Development of adequate economic diagnostic and therapeutic means for the periphery needs to gather efforts between funding organizations and industry. Ideally, more funding schemes are needed which support collaborations between scientists from poor settings and counterparts from developed countries. The ultimate goal of such collaborations would be to develop point-of-care diagnostics and therapeutics that can properly function in remote areas in the absence of sophisticated technologies and poor access to both electricity supplies and cooling means. The speaker will review the research programs and funding schemes which supported such research activities over the last decade and the output of such projects. He will also highlight what are the still missing point-of-care diagnostics and therapeutics to control the challenges of the numerous infectious diseases endangering our world and how basic researchers can utilize the nowadays available technologies to fill these gaps.

**Date:** Friday, September 19<sup>th</sup>, 2014

## Dar lang, Maureen

Nepal  
E-mail:

### Presentation

**Title:** Situational analysis and strategies to address reaching un-reached populations in remote areas of Nepal

**Abstract:** The Ministry of Health and Population (MoHP) is implementing the second phase of the Nepal Health Sector Programme (NHSP-2) with the goal of improving the health status of the people of Nepal, especially women, poor and excluded people. Significant improvements have been achieved against most health indicators making Nepal on-track for achieving MDG 4 and 5 targets. However, disparities persist along economic, socio-cultural and geographic lines in terms of both health service use and health outcomes. Large equity gaps in MNCH indicators are seen between different geographical locations – urban/rural and remote/ non-remote. The mid-term review of NHSP-2 and joint annual reviews (JARs) of 2012 and 2013, the Government of Nepal (GoN) acknowledged that equity related gaps were limiting progress towards reaching NHSP-2 targets and recommended the implementation of targeted interventions for unreached populations including those in geographically remote locations.

A study on access to Maternal, New-born and Child Health (MNCH) services in remote areas conducted in 2013 found that while Nepal had been successful in providing MNCH services to most of its citizens, programming had tended to overlook high need areas where access to services has historically been poor. Population-based targets have dominated at the expense of disadvantaged groups facing greater geographical, social and economic barriers to accessing care. The study has also found the degree of remoteness to be a strong determinant of access both within and between districts. It also reported that high financial costs linked to long distances and travel times were the main barrier to reaching MNH services especially in the case of obstetric complications. The study concluded that both demand and supply-side barriers must be addressed through context-specific approaches if access to health services in remote areas is to improve. It further recommended a number of strategies including scaling up interventions proven or promising in reaching un-reach populations and strengthening the district health systems to enable remote health service managers to respond quickly to local problems.

This presentation will share the study findings and currently piloted as well as scaled up strategies for reaching un-reached women and children in MNCH in Nepal.

**Date:** Monday, September 15<sup>th</sup>, 2014

**Ding, Yan\***

Nepal/Heidelberg

E-mail:

**Presentation**

Title: A syndromic surveillance system for early warning of epidemics in rural China – a need assessment and a survey for infrastructures needed

Abstract: The existing infectious disease surveillance system, called the China Information System for Disease Control and Prevention (CISDCP), relies on clinically or experimentally confirmed cases. Health facilities at the township level and above are the major components of the disease reporting system, whereas village clinics are involved via telephone or reporting by paper cards. Infectious diseases are more likely to be diagnosed and reported when patients seek care at hospitals above the level of village clinics, whereas in reality villagers tend to first visit village doctors. Village clinics or even township health centers, however, only have simple equipment. Laboratory tests for confirmation are for most cases not available. A syndrome surveillance system (SSS), as an added function to CISDCP, might improve early detection of epidemics. An SSS is “an investigational approach, where health department staff, assisted by automated data acquisition and generation of statistical signals, monitor disease indicators continually (real-time) or at least daily (near real-time) to detect outbreaks of diseases earlier and more completely than might otherwise be possible with traditional public health methods”. It targets resource-poor areas, where people are more likely to have infectious diseases, but capacities of health facilities to diagnose and notify communicable diseases are limited. Experience with an SSS during its recent implementation phase will be discussed under the aspect of whether it might be able to support better health for the poor rural population in China

Date: Friday, September 19<sup>th</sup>, 2014

\*External speaker

## Geletu, Zelalem

Ethiopia  
E-mail:

### Presentation

Title: Foreign aid: my decade's observation and healthcare for the poor.

Abstract: The modern era of aid giving was said to have begun in the 1940s. Today, after 50 years, we are left with 'many questions'. Altruism and 'gift' have been viewed by many cultures with skepticism. Ancient Greeks won the famous war against the Trojans who accepted the gift of a large horse. In German, the phrase 'ein Danaer-Geschenk' means 'a fatal gift', one that brings misfortune or causes problems. Is modern aid a 'fatal gift'? My intention is not to answer this question. However, after 50 years of billions of dollars and Euros aid, I observe a world where 'a minority of riches' has access to world-class health services (including through medial tourism) and 'the majority of the poor' lacks basic health care. This is creating 'health inequity' and unsustainable global development. I have spent more than a decade working on programs that intended to improve health outcomes for the poor. In my logical judgment, I have observed successful and at the same time deeply depressing situations. I learned so many things among which the top is 'know thyself' (quest for self-knowledge). Self-knowledge does not simply come by itself. It comes with asking the 'right question'. In my search for the right question and knowledge, education is the most (may be the only powerful) tool. Heidelberg University has helped me to think and to ask the right questions. I learned that support should be unconditional. I learned that misguided aid supports bad governance and unaccountability.

Date: Thursday, September 18<sup>th</sup>, 2014

## Horvath, Angela

USA

E-mail:

### Presentation

**Title:** Public health services on a different border: How a local health department negotiates Native American sovereignty

**Abstract:** The challenges of providing public health services such as nutrition education or access to care along the US-Mexico border have long been documented, but working along the “border” of Native American Nations (NAN) can be just as challenging. Eleven Native Nations share territory with Coconino County, a highly rural jurisdictional unit of the US state of Arizona. While NANs are sovereign nations recognized by the US government, their territory also is considered part of the County and States in which they are situated. Centralized US government organizations such as the Bureau of Indian Affairs and the Indian Health Services provide health and emergency services to NANs, but local State and County governments receive taxes from the NANs and therefore are tasked with providing some services to the Nations. The varied way service delivery occurs and how individuals seek those services are the topic of this presentation. Case studies from Coconino County’s Public Health Services District will be used to highlight unofficial agreements up to laws that mark jurisdictional responsibilities, notably the Indian Health Care Improvement Act (2010) and the Alaska Native and American Indian Direct Reimbursement Act (2000). The discussion then progresses to how local health departments can better serve NANs while acknowledging and respecting their sovereignty.

**Date:** Wednesday, September 17<sup>th</sup>, 2014

## Kamal, Ayesha

Georgia  
E-mail:

### Presentation

Title: Health in Transition: Personal experiences in post-soviet countries

Abstract: Free and comprehensive health services, both preventative and curative, have been amongst the most worthy achievements of the Union of Soviet Socialist Republics (USSR). At its peak, citizens of the USSR perceived their health service to be of the highest quality and reliability. Citizens enjoyed the comfort of having a responsible state who secured good health for its people. With the collapse of the Soviet Union, this security vanished overnight. As Newly Independent States (NIS) emerged, public health services crumbled. Amongst other factors, civil wars and conflicts, faltering economies and food shortages aggravated the deterioration of public health services. Very quickly this extremely comprehensive health care ceased to exist or at best became unreliable; accessible only at a price. Citizens resorted to various coping mechanisms to address this but overall the NIS showed declining health of their population. Meanwhile, governments struggled to formulate policies that would reinstate free, comprehensive health services to their people. Though well intended, the various ideologies underlying health reforms proposed by aid agencies created more confusion than meaningful assistance. Only the Millennium Development Goals, along with overall economic recovery, appears to have aided Governments in NIS to focus health reforms towards clearer targets and allocate resources to implement the reforms. Nonetheless, the health care available to citizens in NIS today is a far semblance of what it used to be during Soviet times. Accessibility, comprehensiveness and cost - all areas in health care have seen substantial changes. The above account is being presented through anecdotal evidence of a person who lived and worked in 5 of the former Soviet Republics since 1999.

Date: Wednesday, September 17<sup>th</sup>, 2014

## Kiguli, Juliet

Uganda  
E-mail:

### Presentation

Title: Cutting of development aid to Uganda: effects on the health sector

Abstract: According to Stierman, Sengooba and Bennett (2013), over the past decade, development Aid has increased dramatically to Uganda to meet government expenditure to health. Uganda is a developing country with growing poverty due to a fast growing population totaling to 35 million people in 2014. So health sector funding is necessary to meet the needs of a healthy population. This paper aims at showing how funding has been flowing from European countries, especially Germany, with a strong economy and when Development AID was cut due to political rules and statutory laws in early 2014, thus leading to impact on the health sector and followed by the economic crisis of the 21st century. Further, the paper explains the economic challenges at national and local household levels affecting especially women and children and also patients suffering from infectious diseases. What can Uganda do?

Date: Thursday, September 18<sup>th</sup>, 2014



## Krugu, John

Ghana

E-mail:

### Presentation

**Title:** Carnal knowledge: The sex education debate and what it means for people in the periphery – the case of Northern Ghana

**Abstract:** Increasing rates of high unintended teen pregnancies and sexually transmitted diseases among adolescents are adding urgency to the debate over sex education in schools. Moralists claim the alarming statistics illustrate why abstinence should be the single mantra when it comes to sex education in schools. Liberals on the other side counter that the increase in disease is the strongest case for more comprehensive sexuality education in schools. Caught in the middle are Ghanaian adolescents, who are more vulnerable than ever to potentially deadly diseases and unintended teen pregnancies, accompanied by various undesirable consequences.

In the debate over sex education, one thing is undisputed: The average adolescent today, including those living in the periphery of the rural world, is immersed in sexual imagery. A generation growing up in the open market of high mobile technology and social media penetration to the rural areas is familiar with the facts of life. Yet, many young people in the periphery face a barrage of confusing messages. Along with titillating images from the media, some young people are simply told to “just say no” to sex. Transcending the cacophony of mixed messages is a host of alarming facts.

For the past decade, the YHFG has been working in northern Ghana to support young people deal with the challenges of their sexual and reproductive health in the midst of the various debates. We take the opportunity to share our experiences and solicit more ideas on how to contribute to the sex education debate towards advocacy for the inclusion of comprehensive sexuality education in the school curriculum in Ghana.

**Date:** Thursday, September 18<sup>th</sup>, 2014

## Leonardia, Juan Alfonso

Philippines

E-mail:

### Presentation

Title: Health promotion through the education sector: lessons from the GIZ Fit for School Program

Abstract: Much of public health happens outside the health sector. Health behaviors are shaped by settings wherein people spend most of their lives. For school-age children, this setting is the school. With strategic inputs from the health sector, schools provide an efficient platform for health promotion and service delivery, while multiplying the efforts of health personnel through teachers, parents, and students.

The GIZ Regional Fit for School (FIT) Program aims to institutionalize evidence-based preventive measures like hand washing with soap and tooth brushing as part of daily routines in public elementary schools in Cambodia, Indonesia, Lao PDR, and the Philippines, including the improvement of water and sanitation facilities and maintenance of thereof. The presentation enumerates six key features of the FIT approach that addresses the challenges of health promotion through the education sector:

1. Work with what they have: The FIT program merely provides an action framework for national policies on school health, and is implemented through existing structures within the education system. Financial, technical, and managerial resources needed for running and scaling up the program are kept within what partners in every level can realistically afford.
2. Start small, simple, and streamlined: FIT starts with the most relevant, cost-effective entry-level interventions to catalyze stepwise change. The success of a health program outside the health sector depends on clear roles and the ease by which it is implemented.
3. Stick to what is scalable: Scale is necessary to mainstream a concept and achieve relevant impact. FIT interventions are limited to what partners can scale up by themselves. The program supports the government with modular, uniform, and user-friendly implementation templates developed from the experience of model schools.
4. Sustain through institutionalization: Securing governance, financing, and regulatory structures to support FIT implementation firmly embeds the program within the government institution, thereby ensuring its sustainability.
5. Involve the community: Involving the community as active contributors than just passive benefactors builds ownership, rallies support around the program, and increases government accountability for results.
6. Provide evidence for advocacy: Demonstrating the impact of program performance to health and educational goals serves to ultimately justify the why the education sector should invest in health.

Date: Thursday, September 18<sup>th</sup>, 2014

## Li, Yonglong

China  
E-mail:

### Presentation

Title: “Rural cooperative medical scheme” and “village doctor”– strategies of health promotion for populations in the periphery of China

Abstract: It is a common and serious social problem that the populations in the periphery hardly obtain health service. The major reasons are lack of money in the population and of doctors in the periphery. To solve the problem, China established two systems, the “rural cooperative medical scheme” and “village doctor”. After years of practice, it has been proven that the strategies are useful to improve the situation of health services in the periphery.

The cooperative medical scheme in the countryside including the periphery of China has been established since 2003. Its duties are to raise and administrate funds for the population of the countryside. Generally the fund comes from 3 parts : 20% paid by the inhabitants, 40% paid by the local government and rest of 40% paid by the central government. To ensure that enough funds were raised, the system was established based on the unit of county and the fund is administrated by a committee. 86% of the countryside population in of China had been covered by the system until 2007 and the pressure from medical burden to the people in countryside has been alleviated to different degrees.

The “village doctor” system was established in 1969. At the beginning, it was called “barefoot doctor”; the name means that the doctors are amateurs, in fact, they are farmers. Most barefoot doctors were young people with a middle education level and lived in the villages. The government gave them some basic and simple medical training and then let them provide primary health care to their neighbors. Since 1985, “barefoot doctors” were renamed as “village doctors” This means that the doctor is a professional not amateur. A barefoot doctor can become a village doctor after passing examinations and getting a license, and then the doctor is certified to practice medicine in a village. In addition, the village doctors must receive further education twice every year if they intend to practice medicine continually. Nowadays there are more than a million village doctors in China and they link with 8 hundred million peasants. The village doctors never leave their hometown and they fill the lack of doctors in in countryside including the periphery.

Date: Monday, September 15<sup>th</sup>, 2014

## Luai, Than Bil

Myanmar  
E-mail:

### Presentation

**Title:** Being a brick and a grain of sand in healthcare services provision at the periphery of Myanmar

**Abstract:** A comprehensive Healthcare Services Provision is vital to individuals for attaining perfect health so as to be more productive for his/her family as well as country. However this is really a challenge to many countries, and especially true to low-income countries. Myanmar has been under military and socialist dictatorship rule for more than 48 long-years, since 1962. During all these years, until 2010, Myanmar has been infamous that she is the never-never land where history is under house arrest and all the clocks were stopped. This situation resulted in that even a primary healthcare services provision to individuals not only in the rural areas but also in town and cities has become a real shortage. Almost all consumables, including medicines, hospital and healthcare utilities were illegally imported through border gates. Individuals and families were facing real challenges to meet their healthcare expenditure for which in one point they had to pay up to 95-99% of the price. Wesley Hospital has been born on 15th January 1987 and standing a alongside the poor ever since. The hospital's mission is to provide a comprehensive but affordable primary healthcare service, both in the hospital and the outreach setting, to individuals especially the poor through a patient-centered approach. Wesley Hospital has demonstrated that it is possible to provide a fairly comprehensive primary healthcare service to the poor and marginalized people through affordable fees for service. Wesley Hospital is now one of the bricks and grains of sand in healthcare services delivery in the periphery of Myanmar. This paper is to highlight some of the achievements and challenges encountered by the hospital and to make future planning to meet those challenges.

**Date:** Monday, September 15<sup>th</sup>, 2014

## Madubuko, Theresa

Nigeria

E-mail:

### Presentation

Title: Strengthening the human resources for health through strengthening Pre-Service Training

Abstract: Strengthening the human resources for health (HRH) is essential in the provision of quality health care services and key in strengthening the area of HIV medicine. The Center for Clinical Care and Clinical Research Nigeria (CCCRN) with funding from a President's Emergency Plan for AIDS Relief (PEPFAR) grant through a program called Partnership for Medical Education and Training (PMET) has been collaborating with Nigerian training institutions in both urban and rural areas to revise/ develop curricula and train pre-service professionals in comprehensive HIV prevention, care, treatment and support. PMET's goal is to create a network of health training institutions that will assist state and federal government in Nigeria to develop their health care systems through enhancing training capacity in prevention, care and treatment of HIV disease, opportunistic infections, the appropriate use of antiretroviral therapy, and the implementation of community-based care; and strengthening the human and organizational capacity of their health systems to sustainably address emerging new HIV challenges or for any related diseases of poverty. For sustainability a three prong approach is prescribed: improving the individual capacity of health trainees, strengthening the training institutions/systems and by promoting policy action. Established partnerships have been successfully formed with 12 institutions, the pre service HIV curricula has been developed or reviewed for nurses, midwives, community health practitioners and postgraduate medical doctors with the respective regulatory bodies and stakeholders. The new revised curriculum is currently being implemented in CCCRN supported institutions and is well received by both students and faculty. Looking forward to sharing the progress made so far and lessons learnt along the way.

Date: Friday, September 19<sup>th</sup>, 2014

**Martin, Nina**

USA

E-mail:

**Presentation**

**Title:** What factors affect sustained adoption of clean water, sanitation, and hygiene technologies? Findings from a systematic review of the literature

**Abstract:** Background:

According to 2012 estimates, approximately 89% of the global population had access to an improved water source, while only 66% of the world's population has access to improved sanitation. Progress against sanitation targets has been particularly slow in Sub-Saharan Africa and South Asia. Water, sanitation, and hygiene (WASH) interventions, such as water treatment or hand washing with soap, play a key role in controlling disease spread and reducing diarrhea disease mortality, but continue to be underutilized. To further our understanding of the barriers and facilitators to sustained adoption and use of water and sanitation technologies, we conducted a systematic review of studies concerning both initial adoption and sustained adoption of water, sanitation, and hygiene interventions at the individual, household, and community-levels in low- and middle-income countries.

**Methods:**

We searched commercial databases, hand-screened journals and web resources, and conducted a library search to access a range of peer-reviewed and grey literature to identify eligible documents. We extracted descriptive data that provided general information about the available literature documenting sustained adoption of water, sanitation and/or hygiene interventions. We identified 44 articles specifically reporting on long-term use or sustained adoption, and use the IBM WASH framework as a guiding model for our syntheses.

**Results:**

The literature was well distributed between interventions or programs that addressed hygiene (n=60 studies), safe water (n=63) and sanitation (n=64). 46% of studies explicitly mentioned sustained adoption. Various factors across psychosocial, contextual, and technological domains are crucial to long-term use of WASH technologies. Program design and outcome definitions are also important to achieving sustained intervention uptake.

**Implications:**

The findings of this review imply a need for direction and leadership in guiding the research agenda on sustained adoption of WASH technologies. Sustained adoption can be enhanced by setting intentions to support long-term WASH programming, identifying knowledge gaps, planning and funding assessments of long-term behaviour change; executing robust interventions that clearly define intervention activities and metrics for assessment; and interpreting and disseminating important findings.

**Date:** Friday, September 19<sup>th</sup>, 2014

## Matomora, Matomora

Tanzania

E-mail:

### Presentation

Title: Twenty years KIUMA development support of poor and remote people of Southern Tanzania

Abstract: Tanzania, like other African countries, is struggling hard to keep its development wheel moving. However, the country's vast southern region, of the size of the old FRG, has in all history lagged very much behind. It is an extremely remote and hardly accessible, cut off region, dominated by extreme poverty, poorest educational facilities and pitiful health status. It is an area which needs special attention and great effort to keep it on the development track of the rest of the country. Despite inherited interreligious enmity KIUMA, a Church development support center, has received great backing of the broader local population. Supported by the WORTUNDTAT Mission KIUMA has, since twenty years, embarked on intensively backing the region.

At the Centre KIUMA is involved in vocational training of the youth, running a community hospital and a nurse training school as well as running a large secondary school. It is currently also struggling to start a teacher training college. Within the communities KIUMA runs Village Hope Centers and supports water projects. Over the years KIUMA has also organized various conferences involving traditional leaders to assist the local population to contemplate and articulate their problems and present them to higher, even national level authorities. The results of the KIUMA work is a gradual opening up of this hitherto closed up and neglected region.

The lesson we learn from the KIUMA approach is the need for strongly convinced and seriously committed organizations to augment government and other efforts in reanimating nearly dying regions.

Date: Thursday, September 18<sup>th</sup>, 2014

## Mohamed Ahmed, Mohamed Idris

Sudan  
E-mail:

### Presentation

Title: The Great Neglected Tropical Diseases with Special Reference to Sudan

Abstract: Neglected tropical diseases (NTDs) affect more than one billion people globally, primarily poor populations living in tropical and subtropical countries. They impair physical and cognitive development, contribute to mother and child illness, limit productivity and enhance poverty. Over a dozen NTDs such as schistosomiasis, leishmaniasis, onchocerciasis, lymphatic filariasis (LF), trachoma, leprosy, soil-transmitted helminthiasis, human African trypanosomiasis, buruli ulcer and mycetoma (madura) in addition to malaria, HIV/AIDS and tuberculosis, are endemic in The Sudan (Sudan and South Sudan). Some of these diseases are a major cause of death in endemic areas. Others cause chronic disability, deformity, stigmatization and morbidity affecting mostly the poor and marginalized populations in rural areas with limited or even no access to health care in the war-torn Sudan. Fragmented situation analyses in The Sudan highlight the enormous NTDs burden in the country. Integrated mass drug administrations (of albendazole / mebendazole, ivermectin, praziquantel and azithromycin) in addition to other interventions are recommended for control of seven NTDs (ascariasis, trichuriasis, hookworm infection, schistosomiasis, lymphatic filariasis, onchocerciasis and trachoma). Regrettably, there are few detailed data on the prevalence and geographic distribution of most NTDs in The Sudan to establish which communities require mass drug administration (MDA). Nonetheless WHO and other agencies have been supporting The Sudan in its efforts to control schistosomiasis, leishmaniasis, onchocerciasis, trachoma, dracunculiasis, LF and mycetoma.

Date: Monday, September 15<sup>th</sup>, 2014



## Mohammed, Shafiu

Nigeria  
E-mail:

### Presentation

Title: Absence of health information and obstacles in accessing health care services among rural dwellers in Nigeria: the under-privileged experiences

Abstract: Health information is essential in access and utilization of appropriate health care services. However, in Nigeria with over 70% of the population living in rural areas, people are faced with challenges in obtaining the appropriate health information. These causes immense obstacle for poor people to access and utilize appropriate health care in their communities. This paper aimed at describing what causes absence of health information and further examines the health system's factors leading to impediments among rural dwellers of access to care services in Nigeria. Under-privileged people especially those living in rural and hard-to-reach areas are mostly uneducated about how to obtain health information regarding health care services. Again, health care providers are over-burdened with workload of responsibilities due to limited manpower in health facilities and large number of patients for consultations. These providers have less time to provide the required information to their patients during consultations and other medical examinations. Pregnant women, children and old-aged people are the most affected people when accessing the needed health care. The reasons may not be unrelated to socio-economic status or the format in which such information is packaged. Availability of appropriate health information with improved access to health care services will enable under-privileged people to acquire more knowledge, plan, control and manage actions that could enables them to identify alternative solutions to reduce uncertainties, which further enhance their health and utilization of health services. Health systems constraints including inadequate human resource, low level education of clients, diverse geography and weak infrastructures were the major problems leading to lack of access to health care services. It appears that health policies must go beyond the health sector alone but also incorporate other government sectors including education, telecommunication and transportation during implementation which could adequately address the health care services and needs of the under-privileged people and their communities. Developing and strengthening the political commitment of local health committees in rural areas might provide supportive ways of making information related to access to health care services available among rural dwellers.

Date: Monday, September 15<sup>th</sup>, 2014

## Moudi, Zahra

Iran

E-mail:

### Presentation

**Title:** Safe delivery posts: an intervention to provide equitable childbirth care services to vulnerable groups in Zhedan City, Iran

**Abstract:** In recent years views have been shifted toward approaches that facilitate alternative child birth options to increase access to skilled care during childbirth.

The aims of study were:

- 1) to assess the experience of the 10 years of the first Safe Delivery Posts established in Zahedan, Iran.
- 2) to describe the reasons why women choose to give birth in a Safe Delivery Post and not in one of the four big hospitals existing in Zahedan.

A Mixed Methods research was undertaken. Nineteen mothers who had given birth in the Safe Delivery Posts, in the city of Zahedan, Southeast Iran, were interviewed. In the quantitative phase, the analysis was performed on the existing metric data that were routinely collected by the health-care sector. In the qualitative phase, a grounded theory approach was used for in-depth interviews with women who had given birth to their children at the Safe Delivery Posts. During the 10- year period, 22753 low-risk women were recorded as having given birth in the safe Delivery Posts. Of all women who were admitted to the Safe Delivery Posts, only 2.1% were transferred to hospital during labor or the postpartum period. Three key categories emerged from the analysis: barriers to the hospital use, opposition to homebirth and finally, reasons for choosing the Safe Delivery Posts care.

Key conclusion and implications for practice are: implementing a model of midwifery care that both benefits from modern medical care, and meets the needs of local population is feasible and sustainable. Benefiting from this model of care secures equitable access to care among vulnerable groups by reducing the birth costs.

**Date:** Tuesday, September 16<sup>th</sup>, 2014

## Nabieva, Jamila\*

Tajikistan/  
Heidelberg  
E-mail:

### Presentation

Title: WhateverSTAN: Health services in post-soviet Central Asia

Abstract: **Abstract to follow**

Date: Wednesday, September 17<sup>th</sup>, 2014

\*External speaker

## Ramzy, Reda

Egypt  
E-mail:

### Presentation

**Title:** Lymphatic filariasis in the Eastern Mediterranean Region: current status and prospects for elimination.

**Abstract:** Lymphatic filariasis (LF) is a neglected tropical disease, targeted for global elimination by 2020. Advances in diagnosis and therapy led the World Health Assembly to pass a resolution in 1997 calling for "the elimination of lymphatic filariasis as a public health problem." The elimination strategy, endorsed by the World Health organization (WHO), is based on rounds of mass drug administration (MDA) of an annual single-dose of combined drug regimens for 5-6 consecutive years. In the Eastern Mediterranean Region, the disease is endemic in three countries (Egypt, Sudan and Yemen). Egypt and Yemen followed the WHO strategy and completed necessary MDA rounds. Transmission assessment surveys (TAS) indicated interruption of LF transmission in treated localities. Currently, TAS is based on testing humans by immunological assays. Development of user-friendly non-invasive techniques (testing wild caught mosquitoes by molecular assays) is being encouraged by WHO. Sudan is still in the process of mapping LF endemic localities. LF is suspected in three other countries in the Region (Oman, Pakistan and Saudi Arabia). Oman has been proved as non-endemic country. Others are on their way to verifying the situation and if LF is proved to be endemic, will initiate national elimination programs and start mapping endemic localities. This contribution sheds light on the status of LF elimination activities in the Region and highlights some of the major accomplishments to benefit "the poor" in the periphery.

**Date:** Monday, September 15<sup>th</sup>, 2014

## Ruppel, Andreas

Germany  
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### Presentation

Title: Diagnosis of schistosomiasis and soil-transmitted helminthes: for whom is it available, affordable and desirable?

Abstract: I will summarize options for diagnosis of schistosomiasis and soil-transmitted helminthes. Then the audience will be asked to respond to the following personal questionnaire which aims to explore a realistic appreciation for diagnostic possibilities and needs. This questionnaire refers to the setting of a remote population for which you or your close colleagues are directly responsible.

Is testing for schistosomes or intestinal worms already established and done? If Yes: please give details about what, how, time, costs, personal etc. If No: please answer the following questions:

1. What would be realistically available in your setting:
  - A functional microscope with 40 x magnification to screen for parasite eggs?
  - A functional ELISA reader?
  - A functional PCR-machine?
  - A reliable refrigeration possibility for reagents at +4 and -20 oC
  - A reliable supply of test reagents and other consumables twice a year
  - Access to a company, which would provide reagents?
2. Could you:
  - Order and buy reagents in your setting of administration?
  - Take blood samples?
  - Send them to a competent laboratory?
  - Process stool and urine samples?
  - Perform such tasks as routine, i.e. multiple tests per day?
3. Would you
  - Use a card test, which costs one € or one \$ per person?
  - Be professionally able and allowed to set up a small laboratory equipped with a microscope?
  - Obtain the necessary funds by your health managers?
  - Have trained personal available?
  - Have qualified candidates to be trained as simple laboratory workers?
4. On a scale from 0 (not at all) to 10 (very urgent) respond to the 2 question related to your professional setting or the one of your direct colleagues in your Institution:
  - How do you rate the necessity for a practical and working diagnostic test for schistosomes and/or soil-transmitted helminthes?
  - Among all other health concerns in your professional context, where would you place such a diagnostic facility?

Date: Friday, September 19<sup>th</sup>, 2014

## Shaban, Mahmoud

Oman  
E-mail:

### Presentation

Title: Oman's Experience in Provision of Health Services to the Remote Rural Population

Abstract: In 1970, Oman passed to a new era of change from a country with only one hospital serving only residents of Muscat the capital, leaving the rest of the country with very limited focal health services, and rural populations mostly without any health services to a developing country with a vision to achieve the goal of health for all of its citizens.

This presentation will describe the experience of Oman in providing health services to the remote rural population of Dhofar Governorate south of Oman, it will highlight the importance of following comprehensive strategies in providing health services to the remote rural population with respect to the health planning, development of national health programs , development of human resources, Strengthening Primary Health Care, implementation of a proper referral system and decentralization of health management, etc.

MOH endeavors to provide the highest possible level and quality of health services for all its community members including the nomads and citizens in remote areas. A network of PHC centers easily accessible to each and every household and supported by Wilayat, Local, & Regional Referral hospitals in every region of Sultanate of Oman is a living evidence of successful completion of this humongous task.

Strengthening Primary Health Care (PHC) was a crucial strategy in Improving the efficiency of health system.

The main and most important elements of success of PHC were the Expanded Program of Immunization (EPI) for under 5 years with coverage of over 99%, and the other national health care programs e.g. antenatal care, control of communicable diseases, school health, community participation, environmental health, and health education reaching the very remote rural areas also had a great impact on the achievements of the health system in Oman. The paper will comment on the opportunities, the obstacles, achievements, and developments related to the provision of health services to the remote areas.

Date: Monday, September 15<sup>th</sup> , 2014

## Shams, Ahmad Zia\*

Afghanistan/  
Heidelberg  
E-mail:

### Presentation

Title: Public Health in Afghanistan: A Decade of Achievements, Challenges and the Poor in Periphery

Abstract: Years of invasion, internal conflicts and political instability has badly affected many sectors of life especially health in Afghanistan. Since 2001, the public health system begun to restructure after a decade of collapse during Mujahidin and Taliban regimes. The financial and technical support of the international community has helped to establish the cornerstones of a system that is pro-poor and focused on public health rather than fully medical approach. As a result, coverage and quality of basic health services relatively improved and many health indicators have shown steady improvements in recent years. Yet, many challenges remain to be addressed by the health system to assure continuity and highly-needed expansion of existing services. Provision of health services to the population especially rural poor is not that good as reflected in papers and reports. Insecurity, corruption, increasing burden of chronic diseases, high health staff turn-over, high donor-dependency and a very disorganized health private sector are major challenges leading to increasingly low coverage and quality of health services to all population and especially in the peripheries. Public health teaching is another area that needs improvements. Expansion of public health teaching from only one semester to six semesters in medical faculties across Afghanistan and establishment of a public health faculty in Kabul Medical University (capital city) that trains students as bachelors of public health are good achievements of recent years, however, shortage of qualified lecturers, the clear need of revision of teaching curriculums and teaching materials (e.g. lecture notes) hinders achieving the ultimate aim that students have a real understanding of the subject, understand the components and dynamics of the health system and place themselves better in the system to provide better and effective health services to the population and especially the poor in the periphery.

Date: Friday, September 19<sup>th</sup>, 2014

\*External speaker

## Shen, Jilong

China  
E-mail:

### Presentation

Title: Down-regulation of the host immune response to helminth infections and its significance

Abstract: The competent immunity of the human body is based on precise immuno-regulation networks. The moderate immune response to pathogen invasion facilitates elimination of the “aliens” and stabilization of the internal environment of the body. A plethora of evidences showed that helminth infections may induce a Th2/M2 (alternatively activated macrophages) bias or “polarization”, which may help the parasites escape from the immune reaction and may explain the low effectivity of some anti- helminth vaccines. So far limited knowledge has been presented on down-regulation induced by worm infections. A Deep insight of this biased immune response elicited by helminthes may contribute to clarify the mechanisms of concomitant immunity and, potentially, to optimize parasite vaccine candidates and to develop therapeutic peptides with ability to an immune down-regulation for autoimmune diseases.

It has been noted that the prevalence of allergic disorders is higher in the developed countries than in the economically underdeveloped settings. In China existing evidence indicates that a high incidence of allergic and autoimmune diseases is seen in the regions with well controlled intestinal helminthiasis, and schistosomiasis as well. Possible explanations to this “hygiene hypothesis” may include: 1. direct down-regulation of host immunity by helminth excretory/secretory products such as lacto-N-fucopentaose III and ES-62; 2. helminth infection-induced predominance of a Th2 response; 3. down-regulated immunity of Treg-cells and increased IgE levels that are closely associated with allergic diseases. Previous studies indicated that helminth-derived molecules might apparently down-regulate the immune response of host and have a therapeutic effect on type 1 diabetes, IBD, psoriasis, rheumatic arthritis, multiple sclerosis via promoting Treg-cells and activating M2.

As said by Ancient Chinese philosophy, The Tao (principle) of Heaven resembles the bending of a bow, pressing the down high, lifting up the low, reducing the excess, and compensating the deficient. And “all things connote the Ying and Yang, both keep acting upon each other, conflicting with each other, and unifying themselves each other”. “That is why a thing is added to when being reduced, or is reduced when being added to”. The Dao of Heaven acts in this way, so does the immune system against parasites.

Date: Friday, September 19<sup>th</sup>, 2014



## Sorgho, Hermann

Burkina-Faso

E-mail:

### Presentation

Title: Recent evolution of schistosomiasis in Burkina Faso following the implementation of SCI control program

Abstract: Burkina Faso has joined the SCI program in 2003 and by 2008 the national schistosomiasis control program reported 100 % coverage of treatment of all adult and school age children with praziquantel. We conducted a survey to evaluate the impact of the treatment of the magnitude across the country following 8 years control campaigns. A total of 3514 children aged from 7 to 11 years old inhabitants of sentinel sites were screened for *Schistosoma haematobium* and *S. mansoni* infection. The results show a general decrease of the schistosomiasis prevalence. In 2013 the prevalence varied from 0 % to 34.4 % but no interruption of the transmission could be shown. Few sites showed a substantial increase of the prevalence following an initial decrease. The present survey confirms the opinion that mass drug administration although valuable in reducing the prevalence of schistosomiasis infection is not capable of taking the control toward elimination.

Date: Monday, September 15<sup>th</sup>, 2014

## Umar, Nasir

Nigeria  
E-mail:

### Presentation

**Title:** Using performance-based incentives to improve referrals and institutional delivery in a resource-constrained setting

**Abstract:** Over the past decade, many countries, often with the financial and technical support from international donors, have introduced Performance-Based Incentives (PBI) in the health sector. PBI involves provision of money or other material rewards contingent on improved performance or a behavior change. Some incentives have been designed to directly affect provider behavior example, promoting delivery of quality services. Others have focused on stimulating changes at the households or patient levels to increase the use of health services. With funding from the Bill and Melinda Gates Foundation, the Society for Family Health is pilot testing a PBI scheme in Gombe state, Nigeria. We investigated the PBI schemes' potential to increase the number of women accessing basic obstetric services in Gombe state, Nigeria. We collected four months records of basic obstetric services from registers and records in the 23 pilot health facilities. Data on the number of referrals made by each Traditional Birth Attendant (TBA) were retrieved from the referral boxes, verified for validity and analyzed. Results from our analysis showed that with the introduction of PBI, the number of women that attended antenatal care during the 4-months pilot period increased from baseline by about 28%. There was a considerable increase by about 19% in the total number of pregnant women, mothers and new-borns accessing services in the health facilities for indicators measured including antenatal care, delivery/labor, postnatal care, new-born care, pregnancy complications and family planning compared to pre-PBI phase. 36% of all deliveries in the referral facilities were clients referred by the TBAs and 43% of all clients that had new-born complications were also referred by the TBAs. In conclusion, incentivizing TBAs to appropriately refer pregnant women and mothers to health facilities has helped to increase not only the volume of pregnant women, mothers and new-borns utilizing healthcare services, but has also promoted their access to skilled care in health facilities.

**Date:** Tuesday, September 16<sup>th</sup>, 2014

# Addresses / Contact information

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# Train Schedules

## Reilsheim → Heidelberg, Altstadt

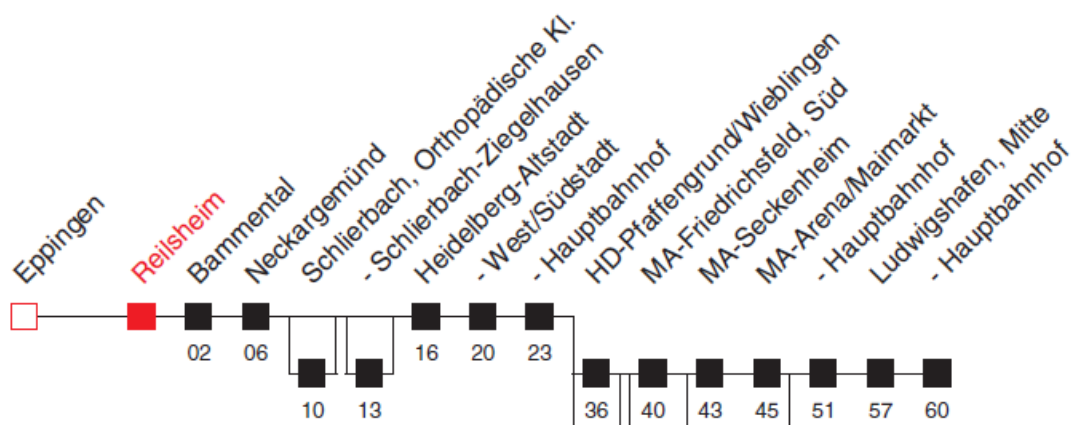
Please note:

There are two train stops in the community of Bammental, namely:

- **Bammental**
- **Reilsheim**

The one closest to all Alumni Summer School locations is **Reilsheim** (not **Bammental**).

Please refer to the city map on page 46.



# S5/51

Uhr	Montag - Freitag		
5	03 <sub>B</sub> <sup>C</sup>	26 <sub>B</sub> <sup>C</sup>	
6	04 <sub>B</sub> <sup>C</sup>	47 <sub>B</sub> <sup>C</sup>	34 <sup>C</sup>
7	05 <sub>F</sub> <sup>A,C</sup>	34 <sup>C</sup>	
8	05	05	34 <sub>B</sub> <sup>C</sup>
9	04	34	34
10	04	36	36
11	04	34	
12	04	34	
13	04	34	
14	04	36	36
15	04	36	36
16	04	36 <sub>E</sub> <sup>B</sup>	36
17	04	36	36
18	04	34	
19	04		
20	04		
21	04 <sub>B</sub> <sup>C</sup>		
22	04 <sub>B</sub> <sup>C</sup>		
23	04 <sub>B</sub> <sup>C</sup>		

Uhr	Samstag		
5			
6	04 <sub>B</sub> <sup>C</sup>	04 <sub>B</sub> <sup>C</sup>	
7	04 <sub>B</sub> <sup>C</sup>		
8	04 <sup>C</sup>		
9	04		
10	04		
11	04		
12	04		
13	04	34	
14	04		
15	04	34	
16	04		
17	04	34	
18	04		
19	04		
20	04		
21	04 <sub>B</sub> <sup>C</sup>		
22	04 <sub>B</sub> <sup>C</sup>		
23	04 <sub>B</sub> <sup>C</sup>		

Uhr	Sonn- und Feiertag		
5			
6	04 <sub>B</sub> <sup>C</sup>		
7	04 <sub>B</sub> <sup>C</sup>		
8	04 <sub>B</sub> <sup>C</sup>		
9	04 <sub>B</sub> <sup>C</sup>		
10	04 <sub>B</sub> <sup>C</sup>		
11	04 <sub>B</sub> <sup>C</sup>		
12	04 <sub>B</sub> <sup>C</sup>		
13	04 <sub>B</sub> <sup>C</sup>		
14	04 <sub>B</sub> <sup>C</sup>		
15	04 <sub>B</sub> <sup>C</sup>		
16	04 <sub>B</sub> <sup>C</sup>		
17	04 <sub>B</sub> <sup>C</sup>		
18	04 <sub>B</sub> <sup>C</sup>		
19	04 <sub>B</sub> <sup>C</sup>		
20	04 <sub>B</sub> <sup>C</sup>		
21	04 <sub>B</sub> <sup>C</sup>		
22	04 <sub>B</sub> <sup>C</sup>		
23	04 <sub>B</sub> <sup>C</sup>		

# Heidelberg, Altstadt → Reilsheim

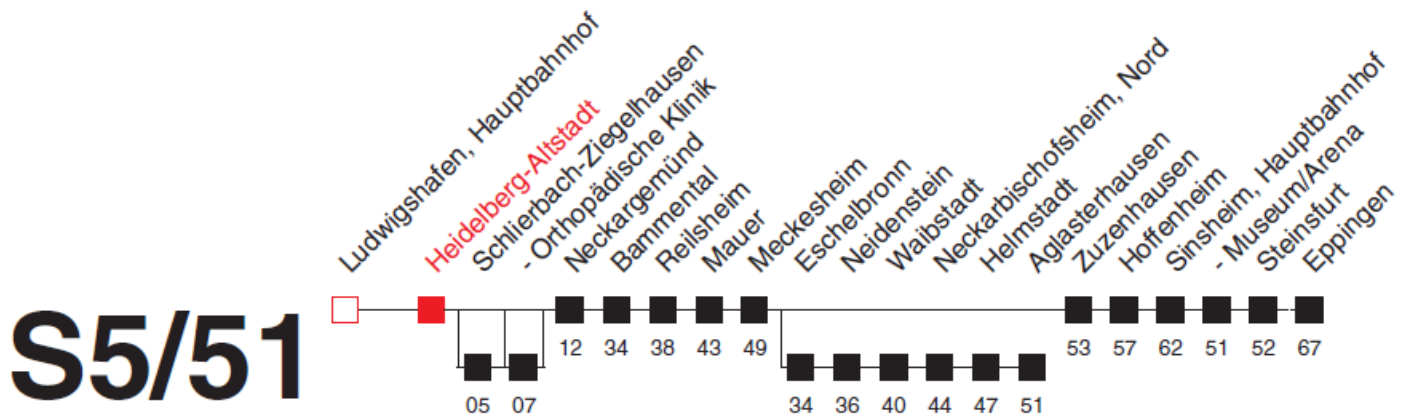
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Please refer to the city map on page 46.



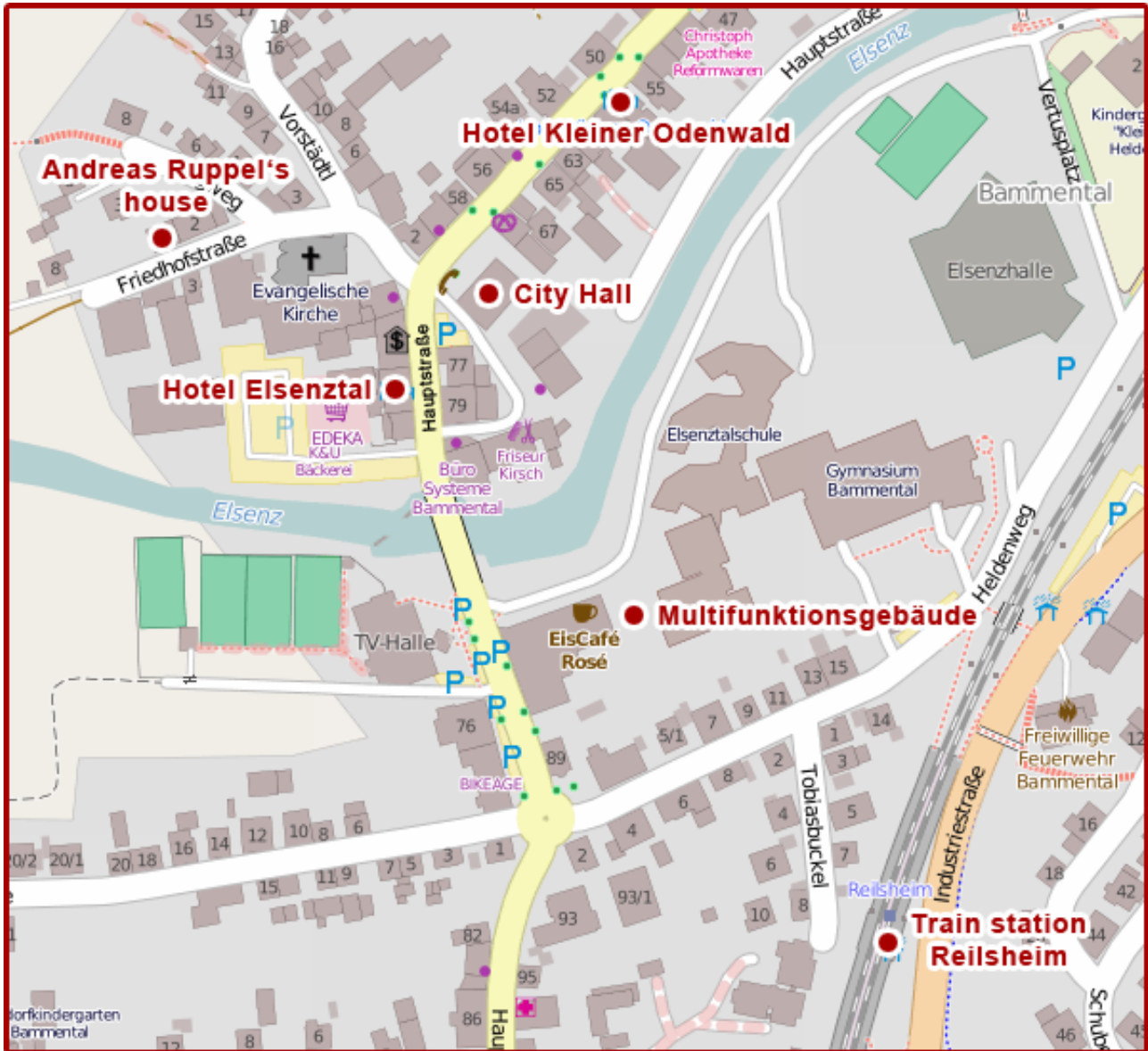
Uhr	Montag - Freitag		
5	32 <sup>A</sup>		
6	17 <sup>D</sup>		
7	19	36 <sup>C</sup>	36 <sup>A</sup>
8	08 <sup>B</sup>	08 <sup>A</sup>	39
9	09 <sup>A</sup>	39	
10	09 <sup>C</sup>	39	
11	09 <sup>C</sup>	39	
12	09 <sup>C</sup>	39	39 <sup>A</sup>
13	09 <sup>C</sup>	39	
14	09 <sup>C</sup>	39	
15	09 <sup>C</sup>	09 <sup>A</sup>	39 39 <sup>A</sup>
16	08 <sup>C</sup>	08 <sup>A</sup>	39
17	08 <sup>E</sup>	08 <sup>A</sup>	39
18	09 <sup>C</sup>	39	
19	09 <sup>C</sup>	39	
20	05 <sup>C</sup>	36 <sup>D</sup>	
21	36 <sup>D</sup>		
22	36 <sup>D</sup>		
23			
0	36 <sup>B</sup>		
1	57 <sup>B,F,G</sup>		
2	46 <sup>B,D</sup>		

Uhr	Samstag	
5		
6	36 <sup>D</sup>	
7	39	
8	39	
9	39	
10	39	
11	39	
12	39	
13	39	
14	09 <sup>B</sup>	39
15	39	
16	09 <sup>B</sup>	39
17	39	
18	09 <sup>B</sup>	39
19	39	
20	36 <sup>D</sup>	
21	36 <sup>D</sup>	
22	36 <sup>D</sup>	
23		
0	36 <sup>B</sup>	
1	57 <sup>B,D</sup>	
2	46 <sup>B</sup>	

Uhr	Sonn- und Feiertag	
5		
6	36 <sup>D</sup>	
7	36 <sup>D</sup>	
8	36 <sup>D</sup>	
9	36 <sup>D</sup>	
10	36 <sup>D</sup>	
11	36 <sup>D</sup>	
12	36 <sup>D</sup>	
13	36 <sup>D</sup>	
14	36 <sup>D</sup>	
15	36 <sup>D</sup>	
16	36 <sup>D</sup>	
17	36 <sup>D</sup>	
18	36 <sup>D</sup>	
19	36 <sup>D</sup>	
20	36 <sup>D</sup>	
21	36 <sup>D</sup>	
22	36 <sup>D</sup>	
23		
0	36 <sup>B</sup>	
1		
2		

# Map

## Bammental



Source: OpenStreetMap // [www.openstreetmap.org](http://www.openstreetmap.org)

**Thank you very much for your participation at the  
Alumni Summer School 2014!**

**We wish you a safe and pleasant trip home!**

**The Alumni Summer School 2014 is funded by  
the German Academic Exchange Service**

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