included the simultaneous participation of various universities and interaction with expert practitioners, faculty, and students from across the globe in a single course.

Structure/Method/Design: Collaboratively developed by faculty at the University of Southern California (USC) and University of California Irvine (UCI), the course was offered by three additional universities -National Taiwan University (NTU), Chinese University of Hong Kong (CUHK), and University of Tokyo — constituting a global learning environment. Approximately ten graduate students participated from each university, totaling about fifty students. While four of the universities participated using a distance education classroom setup, USC participated entirely virtually as common to other courses in its Online Master of Public Health (MPH) program. Asynchronous methods including discussion boards, readings, and assignments were designed and housed in Piazza which was free and equally accessible to all universities. Once a week for ten weeks during a mutually agreeable time across all five universities, synchronous learning occurred through live videoconference sessions with expert practitioners working in various global health settings including governmental agencies, NGOs, social enterprises, etc. across the globe, using Google Hangouts. Teams composed of students representing each university worked together on group projects.

Outcome & Evaluation: In addition to increased knowledge and skills, students benefitted from cultural exchanges in an expanded network. Faculty benefitted from an expanded network including access to guest experts. Course evaluations reflected student satisfaction and their perceptions of the course as a valuable learning experience which would not have been possible in traditional courses offered by a single university alone.

Going Forward: While additional technologies may provide added value in future courses, this course presents a model to implement global health education in collaboration with university partners across various countries and regions for a robust and culturally diverse experience.

Abstract #: *1.026_TEC*

The first Myanmar-based telemedicine solution for the people of Myanmar: A pilot study at 3 diverse facilities

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Background: Myanmar ranks 190th (out of 190) in the WHO's global ranking of healthcare systems. Approximately 70% of the population is rural while physicians and nurses are concentrated in urban centers. As a result, access to health workers remains well below the global standard of 2.28 per 1,000 people. However, the recent adoption of mobile technology has grown at unprecedented rates, such that Myanmar will soon be the world's first mobile-only country. Current estimates suggest that 80% of citizens will own a cell phone (mostly smartphones) by the end of 2015. The combination of health system challenges and the expansion of the telecommunication infrastructure introduces an opportunity to expand the reach and quality of healthcare throughout the country.

Methods: A needs assessment, utilizing site visits and stakeholder discussions with general practitioners at private rural clinics, identified four critical needs that could potentially be met through a telemedicine partnership: x-ray interpretation; ECG interpretation; ultrasound technique and interpretation; and video consultation with specialists. To assess the feasibility of utilizing telemedicine in Myanmar, three pilot clinics were selected, each in a different type of community (village, township, city) with an average physician availability of 0.08 per 1,000 people. Radiologic images were transmitted to and interpreted at Parami Hospital while video teleconsultations began with a Yangon-based emergency medicine physician, who then coordinated additional specialty consultations as needed.

Findings: Between May 2014 and October 2015, three sites (Kyaihto in the state of Mon, Kin Mon Chone in the Bago region, Pathein in the Ayeyawaddy region) completed the 10-month pilot period without interruption. The clinics of Pathein and Kin Mon Chone determined that they would review their ECGs and x-rays autonomously. During the combined 30 months, 2,644 x-rays and 876 ultrasounds were interpreted via teleradiology, 871 ECGs were remotely interpreted, and there were 122 teleconsultations. In total, 4,513 services were provided.

Conclusion: Piloting the first Myanmar-based telemedicine solution in three diverse and underserved regions demonstrates that teleradiology and teleconsultation are feasible in Myanmar. Expanding the clinical and technological infrastructure for telemedicine could help Myanmar progress towards achieving universal health access.

Abstract #: *1.027_TEC*

If we build it, will they come? Deploying a medical mobile clinic in the Philippines

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Program/Project Purpose: Around the world, non-communicable diseases (NCD) account for most of mortality and morbidity. The Philippines is no different. By 2016, the number of premature deaths is projected to double from 140,000 reported in 2000. In an effort to mitigate the country's most preventable diseases, a medical mobile clinic (MMC) will drive to the heart of some of the poorest communities and provide continuous, cost-effective care with emphasis on collaboration, prevention, and health education.

Methods: The MMC will operate 20 days out of the month and offer services to a village for one day. The proposed van will have its presence in 20 villages, poised to serve about 40,000 people in Tacloban, Leyte, year-round for the life of the van, which can be anywhere from 10-15 years. Each MMC will have a coordinator from both the United States and the Philippines, as well as a team consisting of a physician, nurse, and driver. Community

members will be recruited by local government as health workers. Local community members' involvement will contribute to the sustainability of the clinic. Patient information, laboratory results, and biometrics will be collected and uploaded into the Stanford School of Medicine REDCap database. Data analysis will be conducted to determine changes in health outcome.

Outcome & Evaluation: Although there are currently no outcomes since the project's launch is in progress, there is strong evidence of successful fundraising to support the first clinic. In addition, target locations, staffing, equipment, expenses, and projections for meeting all goals have been well-established.

Going Forward: Once launched, the first mobile clinic will give us information on improvement of operations. Training programs for pre-health students ranging from undergraduates to graduate students will be offered. Health education will continue to grow with new avenues for teaching and research. Ellectronic medical records will be implemented.

Funding: Major funding is proposed to come from corporate and the ABCs for Global Health.

Abstract #: *1.029_TEC*

Changing social norms to promote positive changes in maternal, newborn and child health in upper west region, Ghana

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Program/Project Purpose: Various demand side interventions have sought to improve survival of mothers and children in Ghana. Despite these efforts, maternal newborn and child health (MNCH) indicators continue to stagnate in deprived areas of Ghana. New, innovative and stimulating approaches are needed to accelerate progress in these low resource settings. The Community Benefits Health (CBH) project seeks to better understand the role of community influencers paired with the incentivizing of social and healthy behaviors in some of most deprived regions of Ghana. This abstract describes the potential of tailored and targeted MNCH behavior change messaging delivered alongside the promise of non-financial and community level incentives.

Structure/Method/Design: CBH is being implemented in 34 communities separated into two groups in three districts (Jirapa, Lambussie, and Wa West) of Ghana's Upper West Region. In the first group of communities, the project delivers targeted and comprehensive MNCH behavior change messaging through a variety of channels including community dramas, video shows, peer educator outreaches and interactive discussions led by community volunteers and community health officers to those with the most influence within communities. In the second arm, CBH has engaged communities to identify a non-financial, community-level incentive to be provided in stages based on the achievement of mutually agreed targets along with the comprehensive behavior change messaging stated above.

Outcome & Evaluation: To date, through a rigorous monitoring plan and data from some Community Health Planning and systems (CHPS), CBH's health communication activities have contributed to communities' willingness and acceptance of desired social

behaviors to improve MNCH. There is growing support of key community influencers - mother-in laws and males - for early antenatal visits, skilled deliveries and postnatal care. Behaviors around disposing 'colostrum' (dirty milk) is changing and home deliveries have also reportedly reduced.

Going Forward: Changing social behaviors and norms around MNCH led by key community influencers along with providing an incentive that benefits an entire community has contributed to increased knowledge and is reducing resistance for some desirable MNCH behaviors. Communities have embraced the idea that investing in women and children's health is for the happiness of the entire community.

Abstract #: *1.030_TEC*

Mobile phone technology and sex work in India: Boon or curse?

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Background: Technology has brought about substantial changes to the landscape of sex work globally. Past research has underscored the connections between increasing use of mobile phones by female sex workers in India and HIV risk behaviors. However, there is little evidence on the holistic impact of cell phones on female sex workers' lives.

Methods: Sixty-seven brothel, home, and street-based FSWs and 18 staff and leaders from local non-governmental organizations (NGOs) in Maharashtra and Karnataka participated in an exploratory phenomenological study. After obtaining written and verbal informed consent, data were collected through in-depth interviews and focus group discussions. Atlas.ti was used to analyze qualitative data. Adelphi University's Institutional Review Board approved the project.

Findings: Respondents unanimously emphasized the myriad ways in which cell phone technology had changed the sex work environment in terms of client solicitation, forging and maintaining long term relationships with clients. Both FSWs and NGO personnel underscored the immense usefulness of cell phone technology in enabling increased connectedness with families and facilitating real-time help seeking. Participant narratives also highlighted the challenges posed by technology in terms of invasion of privacy, risk of blackmail and sexual coercion, and stalking by both intimate partners and clients.

Implications: Study findings point to the need to adopt a nuanced understanding of the role of technology in sex workers' lives. There is an urgent need to rethink traditional modes of working with FSWs, including ways to develop training modules to impart comprehensive techno-literacy knowledge and skills to sex workers. Finally, interventions will need to account for NGOs' own resistance to technology that poses barriers in effective engagement and advocacy.

Abstract #: *1.031_TEC*