The need is equally great to fortify international professional connections and support low-resource medical systems in a non-intrusive, sustainable, and culturally appropriate manner. Global Health Chief Residents (GHCRs) at the University of Minnesota (UMN) serve as clinical educators and advocates in the field of GH for all internal medicine (IM) and medicine-pediatrics (MP) residents as well as collaborators with Tanzanian providers in Arusha, Tanzania.

Structure: Two GHCRs are chosen annually from the IM and MP residency classes to rotate for 6 months between the UMN IM Residency Program in Minneapolis and in 2 hospitals in Arusha. At UMN, they incorporate GH concepts into weekly residency conferences, are a resource for residents caring for international patients, coordinate and support residents on international rotations (co-teaching pre-departure orientation and tracking completion of safety requirements), and guide residents on the GH Pathway toward mentors and educational opportunities. They help to facilitate the Live GH Course and monthly Travel and Tropical Medicine Seminars. In Arusha, they orient and support visiting international residents and students. They are a resource for Tanzanian medical providers, giving lectures, teaching bedside ultrasound, rounding as consultants, and implementing quality improvement projects.

Outcome & Evaluation: GHCRs have integrated GH into residency-wide morning reports and morbidity and mortality conferences. They have conducted a resident survey to gauge awareness of opportunities and baseline GH knowledge. They have supported integration of visiting medical students and residents into the Tanzanian medical system, which has decreased the burden on the local system while increasing the value of this international rotation. GHCRs have forged relationships in Tanzania, supporting the education of local medical trainees and facilitating Tanzanian provider visits to UMN.

Going Forward: While the role of the GHCRs in Arusha remains flexible, the ultimate goal is to create a reliable presence for US providers traveling abroad and Tanzanian medical providers. This will decrease the burden on the Tanzanian medical system as well as strengthen consultation connections abroad, paving the way for sustainable bilateral exchange.

Funding: GHCRs work hospitalist shifts at UMN Hospital to fund this position.

Abstract #: *2.050_HRW*

Transitioning from the Ebola emergency response to health system strengthening in rural Sierra Leone using a community health worker strategy

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Program/Project Purpose: Community health workers (CHWs) are pillars in their communities and have been employed worldwide to improve health outcomes. As members of the communities they serve, CHWs are outreach agents, educators and accompagnateurs who link and retain patients to care. The 2014-2015 Ebola Virus Disease (EVD) epidemic in Sierra Leone required these skills for intense social mobilization, communication and referral to care.

Structure/Method/Design: In January 2015, Partners in Health/Wellbody Alliance, working with local authorities, recruited, trained and hired 300 CHWs in Kono District, Sierra Leone - a "hotspot" in Sierra Leone - to respond to EVD through contact tracing, social mobilization and screening. In coordination with District authorities, these CHWs helped reduce the outbreak through rapid "mop-up" campaigns in affected villages, screening over 650,000 individuals, sharing key health messages to reduce transmission and improving communication between facilities and affected households.

Outcomes & Evaluation: All CHWs were supervised by CHW supervisors and Chiefdom coordinators from January to September 2015 and reported activities on a weekly basis to supervisors. With the help of CHWs, there have been zero Ebola cases in Kono since February 23, 2015. As the epidemic waned, other health concerns emerged; CHWs led the effort to identify and respond to these burgeoning diseases — measles and malaria — forming effective surveillance and implementation teams. Messaging transitioned to broader health concerns, mobilization centered on Ministry of Health initiatives, and referrals became more inclusive.

Going Forward: With the health system weaker now than before the epidemic, it's imperative to use existing momentum to pivot from emergency response to health system strengthening. In order to maintain and respect existing community relationships and recognize the troubled history of health sector aid in the region, this transition is not without challenges. However, by building on the relationships formed during the emergency response and maintaining a continual community presence, we will rely on these CHWs to guide our long-term programs to address the most burdensome diseases.

Funding: Funded by the operational budget of Wellbody Alliance, with support from International Organization of Migration.

Abstract #: *2.051_HRW*

Ethics, Ebola and global public health: U.S. governmental and military responses

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Program/Project Purpose: In 2014 a global emergency arose with the onset of the Ebola virus disease. The outbreak ignited tremendous fears and it was reminiscent of the onset of HIV/AIDS where the medical community, governments, as well as the public were challenged to confront a global health concern. The United States was challenged as the world looked up to see how it would protect and promote health, wellbeing and to do so with a sense of moral responsibility.

Structure/Method/Design: In an effort to contribute to the global Ebola response, an advisory board to the President of the United States, the Bioethics Commission for the Study of Bioethical Issues, was charged to report on lessons learned from experiences at home and abroad, and to more specifically report on the

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ethics preparedness for future public health emergencies, while making recommendations that support policies and practices that reflect public values.

Outcome & Evaluation: This session will address each of the seven (7) recommendations the commission makes, a framework for addressing key ethical issues and guide public health planning and responses for Ebola or other acute public health crises.

Going Forward: In addition, this session will review other governmental and military ethical responses to this global public health issue.

Funding: None.

Abstract #: *2.052_HRW*

Expanding the global health workforce through resident education in Obstetrics & Gynecology: The Medical College of Georgia experience

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Program Purpose: The Department of Obstetrics & Gynecology at the Medical College of Georgia (MCG) sought to improve the quality of resident education and increase interest in global women's health by integrating global health into the core curriculum. The department developed a global women's health program, including a dedicated international rotation.

Structure: In 2012, the department established a global health program outline, identifying stakeholders, establishing educational goals and objectives, and recognizing available resources for development of an educational program. We resolved barriers related to finance, educational structure, and personal/professional liability prior to international travel. ACGME requirements were reviewed, including 1) supervision, 2) establishment of competency-based goals and objectives, and 3) evaluation. A program letter of agreement was signed with CerviCusco, MCG's global health center in Cusco, Peru. The intern (PGY-1) year was chosen (based on resident availability and flexibility within the academic program) to establish a foundation for global health and allow for future global health experiences.

Outcome & Evaluation: Since program inception, 85% of eligible residents (11 of 13) have completed the required educational modules and international rotation, averaging four weeks in Cusco, Peru. The rotation includes both ambulatory and inpatient clinical care. Curricular goals and objectives are based on epidemiology related to global health (Peru) and disease-specific education (pre-invasive disease of the female genital tract). Residents complete online didactic modules while abroad and participate in weekly departmental conferences via videoconference. Each resident keeps an electronic record of rotation procedural data and is debriefed after returning for the quality of the experience. The average cost per resident for travel, insurance, and housing is $2,416, paid by the department. The supervising physician is compensated by the department. MCG pays resident salary and benefits while abroad.

Going Forward: We have developed a sustainable global health program thanks to support from the department, the parent institution, and philanthropy from generous benefactors. Next, the program will critically assess resident attitudes and impact on future career directions in global women's health. Our program can serve as a guide for others in education to increase interest in global health.

Funding: None.

Abstract #: *2.053_HRW*

Perceptions of Malawi midwives regarding unsafe abortion

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Background: Every year, 675 out 100,000 pregnant women die in Malawi from pregnancy related deaths. (Malawi Demographic and Health Survey, 2010). Unsafe abortion in contributes to 20% of these maternal deaths (Levandowski, et al, 2013).

Methods: A survey was developed by the research team that was designed to determine midwives' perceptions regarding reasons Malawian girls and women seek abortion, methods they utilize most to terminate pregnancy, safety and effectiveness of pregnancy termination methods, abortion rights, and barriers from provision of safe abortion services. One hundred and thirty (n = 130) midwife members of the Association of Malawi Midwives (AMAMI) were contacted via email and requested to complete a 28 item survey. The survey was open for a 3 week period. Fifty-four (n = 54) surveys were returned (41.5% response rate) and used in this analysis.

Findings: Eighty-seven percent of respondents (87%, n = 47) thought unsafe abortion was one of the main causes of maternal deaths. Sixty-four percent (64%, n = 35) believed that a woman has a right to decide whether or not to terminate her pregnancy and 98% (n = 53) of the midwives surveyed indicated that they would like to see AMAMI playing an active role in reducing deaths that arise from unsafe abortion. The barriers that prevent midwives from providing safe abortion services include restrictive abortion laws (78%, n = 42), religious and cultural beliefs (78%, n = 42), not a part of the scope of practice (70%, n = 38), and concerns about what people would think (18%, n = 10), In terms of beliefs and attitudes towards abortion services 50% (n = 27) agreed that midwives have an obligation to advocate for safe abortion care. Even though the majority of midwives are concerned with maternal deaths that arise from unsafe abortion, very few of them (9%, n = 5) are actually ready to provide safe abortion to women.

Interpretation: Malawian midwives are concerned with the high maternal mortality ratio in the country and the damage caused by unsafe abortions. Currently, the Malawi abortion law is going through review with a special law commission on abortion in place. It is imperative that midwives get fully involved in the law reform process. Development of advocacy materials is a first step.

Funding: None.

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Addressing shortages in human resources for mental health: Developing an undergraduate psychiatry training program in Botswana

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