Structure/Method/Design: We implemented a prospective, ongoing trauma registry at Mbingo Baptist Hospital (MBH), a tertiary referral hospital located in the North-West region of rural Cameroon. In collaboration with Cameroonian surgeons, we developed a 56-item trauma form (Figure 1) that was then piloted and revised. Study personnel included one supervisor and twelve data collectors. They were English-speaking, paid a nominal fee, and trained before data collection and again one year into the study. Beginning in May 2013, information from trauma patients admitted to the surgical or orthopedic wards were recorded on paper trauma forms and later transferred to a secure electronic database. The previously validated Kampala Trauma Score II (KTSII) was calculated. Ethical approval was obtained from both home and local institutions.

Outcome & Evaluation: We successfully implemented a trauma registry and have collected important epidemiological data for >1,600 patients to date. Although analysis is ongoing, some key findings include: 1) motor vehicle collisions (primarily motorcycle accidents) account for the majority of traumas, 2) helmet and seatbelt use are extremely low, 3) there are significant pre-hospital delays, and 4) there are alarmingly high mortality rates among patients with mild or moderate KTSII scores. The on-site supervisor troubleshoots as needed, and the protocol director double-checks electronic records at random to ensure accurate data collection.

Going Forward: Moving forward, we plan to strengthen collaborations with the Cameroonian Ministry of Health to share our results and ensure sustainability of this registry. Given the overall success of this registry, a similar model of implementation can be adopted in other rural hospitals of low-resource countries after modifying for the specific circumstances of each facility.

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“They say once you get diabetes, that’s the end of your life”: a qualitative study with diabetes patients in Kolkata, India

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Background: In India, over 65 million people, 8.6% of the total population, live with diabetes.[1] In addition to robust quantitative public health and biomedical research, strong qualitative studies are needed to better understand the personal and cultural impact of diabetes in India. As a means of learning how healthcare systems might improve their response to the needs of diabetes patients, this qualitative study explores the question: “What is it like to be diabetic in West Bengal, India?”

Methods: The study took place in an outpatient clinic of a private hospital in Kolkata. Semi-structured key informant interviews were conducted with adult Type 2 Diabetes patients (n=17). Consenting patients were interviewed by a member of the research team in the language of their choice (Bengali, Hindi, or English). Recorded interviews were translated and transcribed into English, twice verified for accuracy, and thematically coded.

Findings: Patients spoke broadly about two themes, 1) the impact of diabetes on their lives and 2) barriers to care.

On impact, patients frequently discussed the mental impact of diabetes, recurrently using the word *tension* to describe both the cause *and* effect of the disease. They also discussed the reverberating effects of diabetes on familial and social lives, the disruption of food rituals, and their fear of other chronic conditions.

Regarding barriers to care, patients conveyed a blended sense of loyalty to their doctors and disappointment with their care, particularly the scarcity of clear communication and personalized guidance. Many patients expressed a lack of confidence in their ability to manage the disease, avoid complications, or access support services. Patients spoke often about financial strain related to medication, tests, and “healthy” food.

Interpretation: This study identifies multiple challenges experienced by diabetic patients in West Bengal, many of which can be addressed by healthcare organizations. Recommendations include: utilization of diabetes nurse educators, training medical providers to convey clear and evidence based guidance for diabetic care, creating support groups for vulnerable diabetic patients, developing a series of free classes for the newly diagnosed, and utilizing nursing students to conduct home visits.

Funding: Resources for the study provided by the hospital.

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Early supplementary feeding in rural Malawi: Constraints and motivations

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Background: Malawi has high rates of infant mortality at 53 deaths per 1,000 live births. Breastfeeding has been found to alleviate the risks of health issues leading to mortality, and both the World Health Organization and the Malawi Ministry of Health recommend exclusive breastfeeding for newborns for at least 6 months. While most mothers believe in the health benefits of exclusive breastfeeding, early supplementary feeding in Malawi starts when the infant is around 3.7 months. Our study aimed to understand the motivations for early supplementary feeding in a cluster of villages in Ntcheu district, Malawi.

Methods: The research was conducted in a rural community of central Malawi. A 6-page survey was developed to assess women’s breastfeeding practices. Study participants were selected based on convenience sampling in the study area, and basic demographic data were collected. De-identified data was compiled and analyzed through anthropological methods including coding and cross-coding to identify significant themes. Descriptive statistics were conducted to supplement emergent themes relating to infant nutrition, cultural norms around motherhood, and breastfeeding practices.

Findings: The study included 28 interviews from 21 households. The mean age of the sample was 43 years (SD 17.5). Women on average had 6 pregnancies (SD 2.7) and 4 children (SD 2.3); they fed their children an average of 4 supplementary food types (SD 3.5) from a list provided. The most common foods introduced include gripe water, medicinal herbs, formula, phala (rice porridge),