PROCEDURES AND DEADLINE:

Deadline for final abstracts. The deadline for abstracts to be received via TEPHINET is Friday, January 22, 2016 at 5pm EST. There will be no extensions to this deadline.

• Submission of abstracts: Individuals submitting abstracts should coordinate submission with their program directors. Program Directors should encourage and assist their fellows/residents to submit abstracts to the program.

• Program Rankings: Because of limited space for presentations during International Night and a desire to maintain a broad representation of programs, **a maximum of 10 abstracts can be submitted from any single program and 1 abstract per person (first authors)**. Nonetheless, programs are encouraged to submit all viable abstracts. In the case of a program submitting multiple abstracts for consideration, program directors/resident advisors should rank them and provide those ranking to the International Night organizers. The results of the independent peer-review will take precedence in determining abstract acceptance; however, if there are ties or minimal differences in final scores within a given program’s submissions, the director’s/Resident Advisor’s input will be considered in determining the final selection. Priority for financial support will be given to the abstracts accepted for oral presentation.

• Web-based abstract collection. Abstracts will be collected from Program Directors through a web-based system. This system will be setup at the TEPHINET website.


  - Please see [www.tephinet.org](http://www.tephinet.org) (Conferences tab) for this information.

INSTRUCTIONS FOR SUBMITTING:

• Use Microsoft Word to create abstract. Save each abstract and other documents as separate files and paste them into the web-based abstract submission system.

• Abstracts may not exceed 275 words in length. The word count excludes the subheadings of the structured abstract (Background, Methods, Results, Conclusions), title, author list, address, or keywords. A word count is easily obtained by selecting the appropriate text of the abstract and then choosing the “Word Count” command in the “Tools” menu of Word.

• Go to [www.tephitract.org/conference](http://www.tephitract.org/conference) (on the TEPHINET conference website) to submit the abstract into the abstracting system (i.e. TEPHITRACT).
• Please note that for duplicate submissions the latest submission will be used only, no abstracts will be accepted past the official due date, and abstracts previously accepted for oral presentation will not be accepted for presentation at a subsequent TEPHINET conference.

• Because of production limitations, no graphics can be accepted.

ABSTRACT FORMAT (The web-based system will collect the following information. See sample abstract to indicate how abstract text should be pasted from word into the web-based system):

1. Authors and FETP identification.
   - First author (presenter). Type the full first name and middle initial, if any, before the last name (e.g., John H. Jones).
   - Co-authors. List each co-author in order of contribution by typing one initial followed by the last name (e.g., D. Smith, S. Brown).
   - Home country in which FETP is based and program director’s name
   - Presenter’s year of entrance into FETP
   - Presenter's email, complete mailing address, and complete office telephone number.

2. Title.
   - Be brief. Avoid subtitles if possible.
   - Capitalize major words only. Capitalize the second component of hyphenated terms.
   - Do NOT use abbreviations or acronyms in title.
   - Give geographic location (country, state or city) and dates of study or investigation. Do not abbreviate geographic locations; separate them from the rest of the title by an em dash, e.g., “Outbreak of Pneumonia — Texas, 1995.”

3. Abstract text.
   - Structure the abstract, using the following subheadings to identify each section: Background, Methods, Results, and Conclusions.
   - Each subheading should be typed flush left, in bold font, and followed by a colon.
   - The Background section should address both 1) the public health significance of the subject and 2) the scientific background and rationale for the study.
Since an abstract is a citable document, the Results section must contain data. It should not include such statements as "Data will be discussed." If considerable work is needed before the conference, please state in the abstract that results are preliminary.

Because of time constraints, changes cannot be made to the abstract after it is submitted. You may find, however, that the results and conclusions of the study do change, based on data analysis done after submission of the abstract. If your abstract is accepted and significant changes have been made after submission of the abstract, please highlight the changes in your presentation, whether oral or poster.

5. Key words:
- Please include 4-6 key words; use terms listed in the Medical Subject Headings (MeSH) from the Index Medicus (http://www.nlm.nih.gov/mesh/meshhome.html).

6. Word count of abstract:
- Abstracts are limited to a maximum of 275 words (see instructions above). The abstracting system will truncate any abstracts exceeding this length.

STYLE GUIDELINES:
- Avoid using jargon, such as “cases” for “patients.”

- Define all abbreviations upon first use in the abstract, e.g., oral contraceptives (OC), except for those used in standard measurements, e.g., 25 mg/L.

- Use an en dash “–” with no spaces between characters for a dash, e.g., "health-care providers in the area–i.e., physicians."

- Spell out numbers less than 10 except in the case of standard measurements such as time, dose, and temperature, e.g., "two patients," but "2 cc" and "9 p.m."

- Use metric units. Show conventional terms, if desired, in parentheses, e.g., "0 C (32 F)."

- Use standard "mL," "cm," etc. Exception: Use "L" for liter.

- Use "%" with specific measurements, e.g., "2%," but use "percentage" in stating a generality or category, e.g., "The percentages reflect . . ."

- When a percentage is given in addition to a numerator and denominator, the percentage should directly follow the numerator and be enclosed in parentheses, e.g., "18 (86%) of 21 patients developed..."
The listings under each of the 6 criteria are designed as a guide only. Apply them only as appropriate and necessary for the abstract under review. They are not fully inclusive for all possible investigations and they all are not meant to be applied for every abstract.

Each abstract will be reviewed by at least three reviewers according to the following six criteria: 1) background and rationale for study, 2) appropriateness of methods, 3) presentation of results, 4) conclusions and interpretations of results, 5) public health significance and 6) overall clarity of abstract.

Abstracts will be considered as candidates for either oral or author-attended poster sessions. Once an abstract is accepted, the Scientific Program Committee will determine whether it is more appropriate for oral or poster presentation.

1. Background and rationale for study (0-4)
   - Is the public health problem or question that the study will address and its significance apparent?
   - If necessary, are key antecedent data or issues presented to set the stage for the study?
   - Does the author explicitly state the objective(s) of the study?
   - Is the objective(s) appropriate for addressing the problem or study question?

2. Appropriateness of methods (0-4)
   - Is the overall study design adequately described?
   - Is the overall study design appropriate and efficient to address the study objectives?
   - Are critical definitions clearly stated (if not obvious)? These could include for example: case, principal exposure, vaccine failure, etc.
   - Are the epidemiological/statistical methods concisely described? Authors should avoid naming software packages instead of epidemiologic or statistical procedures.
   - Is the population involved stated or apparent?
   - Is the data source (questionnaire, registry, surveillance data set) stated?

3. Presentation of results (0-4)
   - Do the study results logically follow the described methods?
   - Are study results summarized using appropriate quantitative/qualitative measures (e.g., number of individuals in study, major time, person, and place findings)?
   - Are numerical comparisons correct and appropriate (e.g. rates for explicit or implied comparisons)
   - Are sufficient and adequate data presented to allow the reader to reach a conclusion?

4. Conclusions and interpretations of results (0-4)
   - Are the conclusion and interpretation based on the data presented?
• Does the conclusion/interpretation address the problem and objectives?
• Does the study appear sufficiently valid and reliable to serve as a basis for the conclusions and for taking public health action (i.e. are the results unlikely to be attributable to chance, confounding, or other potential biases)?
• Is the interpretation of the findings consistent with current scientific knowledge?
• Does the author synthesize results into a conclusion (Conclusions should not simply repeat data from the results or restate them with adjectives replacing numbers)?

5. Public health significance (0-4)

• Does this study, in both topic and results, have an obvious application to improving public health?
• Do the data solve an immediate problem or build on existing knowledge (and not simply repeat what is already done with little or no effective modification)?
• Are actions/recommendations/control measures practical, and derived directly from study results?
• Are public health actions recommended, reported as undertaken, completed, or shown to be effective (e.g., initiating or enhancing prevention or other public health programs; developing procedures, policies or legislation; implementing and strengthening public health surveillance systems; reducing disease incidence)?
• If the recommendations have not been implemented yet, are they likely to address the problem or health issue that led to this study?

6. Overall clarity of the abstract (0-4)

• Is the writing concise and direct, without unnecessary qualification?
• Are numerical data displayed, organized, and placed so that they enable efficient understanding and comparisons?
• Is there a logical sequence and cohesiveness among and within abstract sections?
• Is content of each section correctly placed (i.e. results in the results section only)
• Are appropriate terms/concepts consistently used throughout avoiding vague, ambiguous terms or jargon?
• Are instructions on word limit, abstract structure, and style adhered to?

Each of these 6 evaluation criteria will be assigned a score of from 0 to 4 points, using an approximate scale of: 4 = excellent, 3 = very good, 2 = good, 1 = fair, 0 = poor/absent. Thus, each abstract can receive a total score of from 0 to 24 points. Final scores will be adjusted to account for variability among reviewers.
Title:
Effectiveness of Short Message Services Reminder on Childhood Immunization Programme in Kadoma, Zimbabwe, 2013 -- A Randomized Controlled Trial.

Abstract Text:
**Background:** Globally, non-attendance for immunization appointments remains a challenge to healthcare providers. A review of the 2011 consolidated monthly return form (T5) for Kadoma City revealed that annual OPV, Pneumococcal, and Pentavalent coverage was 74% at six weeks, 84% at 10 weeks and 74% at 14 weeks against a district target of 90% for all antigens at 6, 10, and 14 weeks. We investigated the effectiveness of Short Message Service (SMS) reminders on immunization coverage in Kadoma City.

**Methods:** A randomized controlled trial was conducted. Women who delivered and were resident in Kadoma City were recruited. In the intervention group, SMS reminders were sent at 6, 10, and 14 weeks. In the non-intervention group no SMS reminders were sent. All women in both groups received routine health education on immunization schedule for their children and were issued with immunization cards post delivery. Data was analysed using Epi-Info 3.5.1

**Results:** We recruited 304 participants: 152 with the intervention and 152 without the non-intervention. After 6 weeks immunization coverage was 97% for the intervention and 82% for non-intervention group (p<0.001). After 10 weeks, it was 96% for the intervention and 80% for the non-intervention (p<0.001). After 14 weeks it was 95% for the intervention and 75% for the non-intervention (p<0.001). Those who delayed receiving OPV1 were 82% for the intervention and 18% for non-intervention group. Median delay for intervention was 0 days (Q1=0; Q3=0) and 10 days (Q1=6; Q3=17) for non-intervention group.

**Conclusion:** SMS messages were effective in improving immunization coverage. Based on this evidence we recommended using SMS reminders to increase immunization coverage throughout Kadoma City.

**Key Words:** Randomized Control Trial, Immunization, Kadoma

**Words:** 261