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FROM THE EDITORS

We are delighted to welcome our readers to the twelfth issue of the Innovia Newsletter. We start, as always, with the latest news from Innovia's Director, Stuart Blume. Besides sharing with us good news about the addition of a new member to the Board of Innovia, new publications, upcoming events and important updates, he presents a reflection on one of our fundamental concerns: the collaboration between researchers, patients, and advocacy groups in order to create research programmes and health policies according to local social, cultural, and political contexts, and the need to develop national research capacities.

We continue with an excellent piece written by Goedele De Clerck, an affiliate both of the University of Ghent and of the University of Buea in Cameroon. Her thoughtful narrative about her motivations and experiences in her

current research with the Deaf community of Cameroon is not only informative regarding the situation and lack of resources there, but also provides us with a self-reflexive example of the challenges and creativity involved in research with disadvantaged communities, in particular when it is combined with a commitment to empowerment. Goedele's article invites us to reflect on the expectations that the presence of a researcher may arise in the community, concluding with a question addressed to the reader.

Following this, we are pleased to introduce to the Newsletter's readers Kyra Landzelius, an inquisitive American medical anthropologist who gives us a quick tour of 20 years of work in a rich variety of contexts, cultures, and topics, combining both practical hands-on research and academic work. Kyra shares Innovia's interest in building bridges between cultures, trying to balance "values and organizing structures", and spreading knowledge in the global context. She describes how a rich diversity of subjects have converged in some thematic threads woven through her work on topics such as healing practices, health activism, notions of personhood, the category of patient, good life, life worth, and the new categories and understandings of life created by technology.

We finish with three announcements that may be interesting for the readership, one of which relates to a post in a project focused

EDITORS

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on Deaf human rights and capacity building in Western and Central Africa – a topic which links up nicely with the article by Goedele De Clerck in this issue. Where appropriate, please help to spread these announcements further.

Finally, we'd like to introduce Karina Romo, who has gladly accepted to work together with Zoe Goldstein as Co-Editor of the Innovia Newsletter, replacing Dale Rose. Karina is a Mexican physician and medical anthropologist, whose main interests are related to the interface between medical anthropology and Science and Technology Studies in understanding contemporary medicine, focusing in particular on

reproductive technologies and pregnancy, more specifically cases of pregnancy loss. She is currently working at the National Autonomous University of Mexico.

And remember, if you have research projects, stories, or experiences which you feel would be of interest to Innovia's diverse readership, please do not hesitate to contact us, the Editors. We would be pleased to help you spread the word. Best regards from the new Newsletter team to all our readers around the world.

Karina and Zoe

NEWS FROM INNOVIA

Stuart Blume

The conviction that research with patient experiences of illness and treatments at its core can make an important contribution to debates on the future of healthcare is fundamental to Innovia. But does it matter where this research is carried out? There is now a good deal of anthropological and sociological research showing that the experience of living with a chronic illness varies from one society to another, as do the uses made of medical technologies (genetic tests, for example) and the consequences of their use. It follows that studies carried out in different social, cultural, and political contexts will differ significantly in their findings: a conclusion somewhat at odds with the vogue for meta-analysis that we now find in medicine.

A paper that recently appeared in the journal *Social Science & Medicine* throws interesting light on the implications of this difference. Based on interviews with policymakers, clinicians, public health experts and health system administrators in three African countries (Burkina Faso, Ghana, and Malawi) and two Asian countries (Bangladesh

and Nepal), the paper deals with the relations between research and policymaking in the field of maternal and neonatal morbidity and mortality [1]. Two developments provide the background to the study. One is the importance that donor institutions (on which these countries are dependent) attach to globally agreed goals and objectives, such as the Millennium Development Goals. The other is the now widely-held view that health policy, like medical practice, should be based on rigorous scientific evidence. A consequence, according to many of the people interviewed, is the imposition of "globally applicable" policies, generally based on research conducted elsewhere, but held to be valid everywhere.

Research conducted in the country concerned, that takes account of the specific cultural and social context, may imply more nuanced or different policies. However, given countries' dependence on international donors, opportunities for actually implementing such alternative policies are limited in the extreme. This has consequences for local researchers. "As some explained, importing evidence-based policies derived in settings outside their own country undermines national experts' experiential knowledge and the credibility of local solutions." Respondents did not agree as

to why policymakers did not at least try to act on the basis of context-specific research. Some thought that senior health officials had little choice, since they were “disempowered by a lack of national research capacity”. Others saw the problem more as unwillingness on the part of policymakers rather than powerlessness. If research from a patient perspective is to make a significant contribution, especially on the basis of collaborations between researchers and patient/health advocacy groups, then a well developed national research capacity, particularly in the socio-medical and health social science fields, is surely a precondition.

This is not to deny the value of an international perspective or internationally focused research. Respondents in the Behague study recognised that international research and donor pressure could have positive effects. For example, it can keep health issues on the national political agenda. It can also lead to new approaches to old problems. Making use of insights from sociological theory, Beatriz Miranda’s report on stigma, commissioned by the Dutch Leprosy Foundation, develops an approach to combating stigma potentially quite different from what has been done up till now. We hope that this report will be discussed at a meeting of the Expert Group on Stigma of the International Federation of Anti-leprosy Organisations later in the year. Beatriz’ report can be downloaded from the Innovia website.

Other news from Innovia: I am pleased to say that Godelieve van Heteren has agreed to join Innovia’s Board of Management. Given her experience of research, politics, and international development, Godelieve will be a very valuable addition. There will be more about her in a later Newsletter. Further, after a

long delay, we are following up on an earlier plan to apply to the Rockefeller Foundation for a second Bellagio conference. As agreed earlier, it will be on the theme of Prevention. Aigli Chatjouli, a medical anthropologist from Greece, is helping me with the proposal. If our application is successful the conference will take place sometime in 2011 at Lake Como in Italy. There will be a very limited number of places. Apologies to those who expressed an interest when the proposal came up before, but anyone interested in presenting something is invited to contact Aigli, with a brief indication of what they would like to present. Her email address is achatjouli@yahoo.com.

Two recent publications by Innovia Fellows might be of interest. Margaret Sleeboom-Faulkner has edited *Frameworks of Choice: Predictive and Genetic Testing in Asia*. This is published by Amsterdam University Press (ISBN 978 90 8964 1656) and costs €42. My own *The Artificial Ear: Cochlear Implants and the Culture of Deafness* (ISBN 978 0 8135 4660 5) is published by Rutgers University Press and costs \$25.95 from Amazon.

Finally, a development many of us will be following with interest. Inspired by the Innovia model, a colleague of mine here in Amsterdam is looking into the possibility of establishing something similar in a different field of research and practice. More on this later!

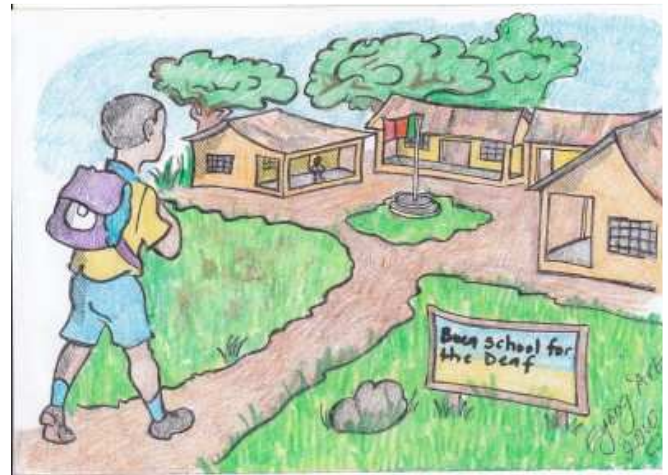
[1] Behague, Dominique et al. (2009) Evidence-based policy-making: The implications of globally-applicable research for context-specific problem-solving in developing countries. *Social Science & Medicine* 69:1539-1546.

**“WHERE CAN I LEARN THAT?”
THE CAMEROON DEAF COMMUNITY –
BETWEEN HOPE AND HOPELESSNESS**
Goedele A.M. De Clerck

As a young deaf woman, I have been fascinated by the theme of the emancipation of deaf people. How can deaf people flourish? I have been working on this question since I started my research with the Flemish deaf community in 2003. The origins of the question are in my own quest for personal development, as well as in the stories of Flemish deaf friends. Later, at Gallaudet University in Washington DC, the world’s only liberal arts university for deaf people, I interviewed many international deaf students.

The lived experiences of deaf people in different parts of the world, their commonalities and differences, advocacy, community development – these were favourite topics for long discussions at Gallaudet. It is there that I met Aloysius N’jok Bibum, a deaf Gallaudet alumnus from Cameroon. He visited the university to work on fundraising for the Buea School for the Deaf, which he had established in 2003 with his wife, Margaret Bibum. When he became deaf during his childhood, there were no deaf schools in Cameroon. Missionary support provided Aloysius Bibum with the opportunity to obtain his high school degree from a deaf school in the United Kingdom, where he met Margaret. Many years later, after study and work in the United States, the couple was motivated to pass on their knowledge and contribute to deaf education in Cameroon. Intrigued by this story and curious about life in Cameroon, I was happy to accept Aloysius’ invitation to visit the school in 2007.

I was impressed by the educational goals and ambitions at the Buea School. It was the second deaf school in Cameroon to start a programme for secondary education, and this had definitely increased future opportunities for young deaf students. All deaf schools in Cameroon are private, and consequently many



Going to the Deaf School
(for those whose parents can afford it)

parents cannot afford the school fees. Other deaf schools only offer primary education, after which deaf students are mainstreamed. There are no programmes for interpreting training, or interpreting services in Cameroon. Some deaf schools offer some form of tutoring after school, but often students give up. The limited educational opportunities made me wonder about the lives of deaf adults.

I was introduced to a gathering of deaf people in Douala one Sunday afternoon. What followed was a more or less formal meeting in which deaf leaders and deaf community members expressed their anger, frustration, and concerns about their lives. The recent history of deaf education in Cameroon – with the first deaf school only established in 1973 – has influenced the development of the Cameroon deaf community. A vicious circle of no or limited education, illiteracy, unemployment, and not being able to pay a dowry and/or gain family consent to marry a deaf spouse, has left these young deaf people without any prospects for the future. They have seen few changes in Cameroon society over the last years and they feel left alone by the government and by the Cameroon National Association of the Deaf. Their stories and their raw and energetic anger impacted me and inspired me to work on this topic as part of a cross-cultural comparative research study of emancipation processes in deaf communities in Flanders (the North of Belgium), Sweden, and Cameroon.

Two years later, in October 2009, I obtained the funding for my study and was excited to embark on a first exploratory stay in Cameroon of one month, to introduce my study to the Cameroon deaf community and prepare for in-depth research by participant observation and informal interviews. In March of this year I arrived again in Cameroon, this time for a 3 month period. Recruitment of research participants is happening through meetings organised by local deaf leaders. At the time of writing I have had meetings in 3 places in two Anglophone regions, and conducted 15 interviews. Local deaf leaders have been very generous in accompanying me and introducing me to many deaf community members. Cameroon

sign language (with regional variants, some also influenced by French Sign Language) is heavily influenced by American Sign Language, which I acquired at Gallaudet University. This basis has enabled me to pick up Cameroon signs and gain some fluency in a relatively short period of time.

During my first stay, I noticed that the Cameroon deaf community was unfamiliar with the concepts of ethnographic research and interviews. Research on the emancipation topic was associated with the work of NGOs. Therefore, I have tried to find creative ways to communicate my research concept, based on information which I have gathered during my research so far. Eyonga Beltus, a Cameroonian deaf artist, made drawings of key moments and experiences in deaf people's lives, such as becoming deaf, communication within the family, going to a deaf school and learning sign language (instead of the gestural communication and/or home signs that are used in villages and with families), helping

parents at the farm, marriage etc. (see illustrations, all by Eyonga Beltus). Deaf community members could identify with the drawings and recognise the topics, and it helped to "break the ice" and make people more comfortable and less shy when meeting a white deaf scholar.

Another tool I have used in these meetings is Ruth Morgan's book on life stories

of deaf people in South Africa [1]. The deaf participants whose life trajectories have enabled through the book have been very enthusiastic. For most of them it is the first time that they have seen a book about deaf people. Some information, such as the existence of deaf families, is received with surprise and wonder. The idea



Learning sign language at the deaf school.
The signs shown in the drawing are: Who? Father.

of a book about the Cameroon deaf community has been received as a signal of hope: it can inform the Cameroon government ("you are white, you can do that"), and, even more important for most people, the outside world can learn about deaf people in Cameroon. Even if they themselves may not be able to go out of the country, then at least their stories can...

"No, there are no successful deaf people in Cameroon," insisted one woman during a community meeting, and the entire group agreed. There seemed to be no sense of contradiction, however, when they followed this up by explaining that all people present at the meeting, apart from one, worked: "You see that we do not beg." I myself think that at least they could be proud of finding employment in a country where a large portion of the general population is unemployed. However, having a job is not the same as being able to cope. It was hard for the group to imagine change. At the end of the meeting, one woman explained that after the deaf school was closed in the area,



Working on the farm (often as a child to help parents, and later as an adult to grow vegetables for food)

education for many deaf children ended. The woman emphasised that this also meant an end of communication: they don't know sign language well and they can't read and write. We should have a project by an NGO to work on this and to help deaf people to set up a business, she stated.

"In Cameroon, parents sometimes abandon their children. They think that deaf people are like animals." In one group meeting, everyone actively wanted to discuss alternatives and solutions for problems in Cameroon. These included the wish for a national deaf football competition (and preferably also international); addressing the needs of the many deaf children and "chickens" (Cameroon deaf people who use gestural forms of communication instead of the sign language used by deaf people who attended deaf schools) who have no access to formal education; deaf people whose parents cannot afford education, who drop out of school and who turn to begging.

In another community meeting, deaf leaders asked questions about the lives of deaf people in Europe and the United States. I tried to explain the long road of advocacy and change. I explained about bilingual education, about training programmes for teachers of deaf schools, about interpreting training programmes, subtitling and captioning on TV, etc. I also explained that, in Belgium for

example, there is still progress to be made before equality is achieved. So far the deaf community in Cameroon hasn't participated in any form of collective action. But among each other, they have talked about it: "We can go to Yaounde and march." I explained about other possible forms of collective action (at least the ones I know in Western communities).

Deaf adults in Cameroon who have not had the opportunities to acquire adequate education are confronted with hard life experiences, such as unwanted pregnancies, unemployment, poverty, and HIV/AIDS. They want to learn, but there are still many questions yet to be answered:

"The teacher doesn't sign well. He/she doesn't know how to teach. I need to pass the FSLC [national exam after primary education]. But how do I learn English?"

"If I go America and study and learn how to be active, then I can do all things that hearing people can do. Then I can write more and meet the government."

"I wish to set up an organisation to help deaf [people] develop, but how...?"

As a visitor with an emancipatory project, I am placed in a history. In the interviews, deaf people ended their examples of the corruption of government and local leadership, the broken promises of white people, deaf Cameroonians who moved to Europe and the United States and didn't come back, with the challenging statement: "And now you are here." I swallow and nod: "Yes, I am here". I am here for fundamental research, which, though sincerely necessary and probably helpful in some way, doesn't provide the support for community development that would perhaps answer deaf people's concerns more adequately (and which ideally should be connected to the project). "And then white people come, and they say that it is not easy to

find funding, but they have a computer, a photo camera, all those things..." I have been thinking this over and over since starting the study. We should be able to get some funding to make this happen, but how?

[1] Morgan, R. (Ed.) (2008) "DEAF ME NORMAL" *Deaf South Africans tell their life stories*. Pretoria: Unisa Press.

Goedele De Clerck is a Postdoctoral Fellow of the Research Foundation-Flanders, affiliated with Ghent University, Department of Comparative Science of Culture, and a visiting scholar at the University of Buea, Department of Special Education, in Cameroon. She can be contacted for further information and/or correspondence at: goededeclerck@gmail.com.

GETTING TO KNOW...

Kyra Landzelius

I am a medical anthropologist, and in that capacity, have worked for nearly 2 decades as both an applied fieldworker in the public health arena and as an educator/researcher in the landscape of academia. Considered in a broad sweep, my work has predominantly been concerned with healing practices and cosmologies, as these take form and make meaning in traditional (indigenous) societies as well as in Western(ized) societies. In fact, a great deal of my mediational work in applied anthropology (mainly as a consultant for international and American philanthropic foundations) has been dedicated to bridge-building across different medical cultures, and seeking balance in the alignment of contrasting values and organizing structures.

Schooled and trained in the USA (PhD University of Pennsylvania; BA Tulane University), I enjoyed a teaching-intensive post as Assistant Professor in anthropology at Centre College before moving abroad at the *fin de siècle*. In Europe, I am honored to have been appointed a Corpus Christi Visiting Scholar at Cambridge University, a Wenner-Gren Visiting Scholar at Lund University, and a Lise Meitner Postdoctoral Fellow at the Institute for Advanced Studies in Science, Technology, and Society in Graz (under the auspices of the Austrian Science Foundation). I have been



Principal Investigator for a number of projects commissioned by the Swedish Research Council, including: a multi-sited exploration of the use of information-communications technologies on the part of indigenous and diasporic peoples (resulting in the publication *Native on the Net* [1]); a study of citizenship, techno-scientific engineering, and health activism (Patient Organization Movements, theme issue of *Social Science and Medicine*, co-edited with Joseph Dumit, 2006 [2]); and at present, an analysis of the cultural diagnostics of fibromyalgia in Sweden, which maps the rise of a once-contested disorder to the highest *per capita* diagnoses in the world.

I continue to be an active teacher, notably with courses in Bioethics, Science Theory, and Cultural and Psychological Anthropology, and in this capacity serve also as Adjunct Lecturer at Chalmers Technical University. With the aspiration to acquire more formal training in

Medical Ethics, I recently bid adieu to my Docent position at the Gothenburg Center for Public Learning and Understanding of Science, an outreach pedagogical and research institution devoted to sustainability. At gcPLUS I was engaged in launching an international network to define the metrics of “sustainable health” and design models to achieve this globally, an agenda I will continue to pursue.

Like many of my fellow anthropologists who – it is often joked – naturally find ourselves in a profession of misfits, strangers in our own home culture, I fell backwards into anthropology after a multidisciplinary course on the Mayan Indians of Yucatan (culminating in 8 weeks of fieldwork), which convinced me to switch my undergraduate major from physics and dance to anthropology. Prior to a specialized internship in medical anthropology, I did graduate training in the four-fields anthropological tradition, which incorporates socio-cultural anthropology, linguistics, archaeology, and human evolution, and is in keeping with the holistic configuration of anthropology in US universities (as distinct from its disciplinary division in Europe). Likewise, I feel fortunate to have had, by necessity, “bread and butter” jobs as an urban medical anthropologist during my graduate years. Looking back, I undoubtedly learned the most in these multi-team task-forces to tackle such issues as homelessness, to better understand schizophrenia, to improve maternal-infant and reproductive health, to design innovative programs to deliver primary care to migrant populations, and to chart the growth and development of cocaine-exposed infants in a pediatric intensive care unit. Personally, I am daily thankful for the breadth of perspective my training and research facilitated. Pragmatically, it optimally equipped me to work in health diplomacy. Theoretically it has been a constant background advisor and a reminder to “think beyond” and consider the larger gestalt, the pan-human and pan-historical implications of even the mundane, as we seek knowledge in the human sciences.

While it may seem “madness without method” from a distance, I’d like to think that a number of thematic threads ultimately weave together my work and interests across the diversity of subjects that my research has embraced. Primary among these, I here confess a fascination with personhood in relation to the existential and societal crises precipitated by illness and its interception. From this perspective, one of my earliest applied projects to improve nutrition among Pueblo Indians eventually landed at the intersection of religion, medicine, and foodways, and there – highlighting women’s central, if subtle, roles in healing rituals – it also became a lesson for me in the cultural power of ambiguity. My interest in health solidarity movements predominantly focused on the transnational and cosmopolitan, yet exquisitely personal, forms of human association emerging in the name of illness identity. In this, online performance videos authored and circulated by (for example) fibromyalgia patients provide poignant instances of the making of art out of affliction and the making of community out of suffering; but equally the forging of markets for pain management. Research questions generated herein have carried me into a semiotic study of pain in a cross-cultural framework, and vis-à-vis notions of the Good Life, life quality, and life worth.

My genealogical project to map the preterm baby as an exquisitely modernist *persona* has spilled out from the clinical domain to analyze politico-legal quandaries, as well as ultra-public debates regarding the healthcare mission and our moral obligations to the new *forms of life* that technoscience invents and brings into our midst. As we know, in the blogosphere everyone has an opinion; and accordingly, to juxtapose vernacular ethics with classic or formal ethics is providing a most enlightening glimpse into the commitments, hopes, and fears that shape our times and our competing conceptualizations of what it means to be a “collective.” Most recently, I have been intrigued to examine the *category of the patient*,

arguably the first universal identity ever inscribed – mapped (as the patient is) upon virtually every other modernist category of identity: citizen, child, tourist, student, immigrant, employee, refugee, etc.; and trailing us (as the patient does) over a life cycle (not to mention, before and after).

Finally, in closing, let me simply add that I love my work and deeply appreciate the opportunity it provides to seek answers, but most of all, to ask questions – about our world, where we've been, where we are, and where we may be going.

[1] Landzelius, Kyra (ed.) (2006) *Native on the Net: Virtual Diaspora in the Digital Age*. London and New York: Routledge.

[2] See: Landzelius, Kyra (ed.) (2006) Introduction: Patient organization movements and new metamorphoses in patienthood. *Social Science and Medicine* 62(3):529-37.

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ANNOUNCEMENTS

1) JOB VACANCY

Regional Trainer in Human Rights (English speaking countries), Deaf Human Rights, and Capacity Building Training Project in Western and Central Africa

The World Federation of the Deaf (WFD) is seeking a qualified Regional Trainer to provide Capacity Building Training in the Western and Central African Region (WCAR), responsible for providing the 2nd training module on the UN Convention on the Rights of Persons with Disabilities (CRPD), advocacy work for national Deaf association representatives, and for leading open seminars addressed to a wider Deaf community in 4-5 countries in Western and Central Africa.

This position is for a period of approximately 5 months starting from 1st of September 2010 (subject to change) with a three-year project that has commenced in August 2009.

The successful Regional Trainer needs to have the following essential requirements:

1. Extensive experience in organisational development training in the areas of lobbying and advocacy;
2. Proven knowledge of the Human Rights instruments, CRPD, and UN;
3. Experience in planning training modules, developing training materials, and writing reports;
4. Proven organisational and planning skills, and accuracy in the training programme;
5. Excellent communication, intercultural, and conflict resolution skills;
6. Good judgment and ability to work in a multicultural team, as well as the ability and willingness to cope under difficult and stressful situations;
7. Willingness and interest to travel in up to 6 developing countries and to maintain good working relationships with national Deaf associations;
8. Flexibility and ability to work and make decisions independently in a challenging environment;
9. Understanding of the work of the WFD and national Deaf associations in developing countries;
10. A degree and first-hand experience from Africa is an advantage;

11. Knowledge of American Sign Language and English is essential;
12. International Sign is an asset, as are the ability to understand other local and national sign languages.

If you are interested in this position, please express your interest by email **by 4th of June 2010**. Please send a cover letter outlining the essential requirements together with a copy of your recent Curriculum Vitae and a salary request to Ms Heidi-Maria Helenius, Project Manager: heidi-maria.helenius@kl-deaf.fi.

About the Project:

The overall objective is that Deaf people's human and linguistic rights become better regarded in Western and Central African countries. The project aims at empowering Deaf people to defend their rights and enhancing their equal opportunities to participate in society by improving access to information, services, and bilingual education.

The first goal is to strengthen National Associations of the Deaf in the Western and Central African Region in order to create pre-requisites for stronger advocacy work in regards to human and linguistic rights of Deaf people. During the three year project, Regional Trainers together with Regional Co-ordinators arrange 2 training sessions in each of the 13 national associations in those countries that are regarded as lower risk countries. Representatives of the remaining six associations can participate in the training session arranged in the neighbouring country. At the end of the project, board and staff members of 13 and two staff members of 6 National Associations of the Deaf will have participated in two training sessions. They will have tools to develop their national organisations as well as increased knowledge on human rights and practical advocacy work to improve living conditions of the local Deaf community.

The second goal is to increase awareness of the larger Deaf community on Deaf Issues

(Deaf Studies) and human rights, including gender aspects. Two open seminars addressed to the wider community are to be held at the end of the staff and board member trainings in those 13 countries where the trainings take place. Also, Deaf-Blind and hard of hearing persons and other interested parties can attend the seminars. At the end of the project, these 2 seminars in 13 countries will have increased the knowledge of all the interested parties on Deaf related issues and human and linguistic rights, and empowered local Deaf people to take action.

The third goal is to promote regional networking and the establishment of the Western and Central African Regional Secretariat (WCARS). The objective is to support the creation of a platform for dialogue in order to establish a permanent Regional Secretariat aimed at the improvement of Deaf people's welfare in the Western and Central African region. The project will arrange a regional seminar for the participants in one of the WCAR countries, or preferably in conjunction with the WFD World Congress in South Africa. This regional seminar will create opportunities for wide networking of participants. A follow-up of the project will be done during the seminar. At the end of the project, a regional seminar will have been arranged to increase networking and regional planning opportunities for the 19 country representatives.

2) Call for Emerging Voices in Global Public Health – "Towards Universal Health Coverage in Developing Countries"

ITM Colloquium

8-10 November 2010

Antwerp

The global health scene is still largely dominated by Northern stakeholders. The Institute of Tropical Medicine in Antwerp, Belgium (ITM) wants to encourage "Emerging Voices" from developing countries to participate actively in international academic

conferences and to raise their voice in the scientific debate. To identify those promising experts, we launch an essay competition for “Emerging Voices” from developing countries on “how health research can foster significant progress towards universal health coverage in low income countries”.

We invite “Emerging Voices” from developing countries to submit a personal single author essay. The essay can be in English or French, and should not exceed 1500 words. The submission of an abstract related to the research the author is participating in is encouraged. Potential participants must inform us about their intention to participate by 4 June 2010. By 30 July 2010 we should receive the final submission (by email at emergingvoices2010@itg.be).

Authors of selected essays will be invited to present their work at the colloquium and to participate in the First Global Symposium on Health Systems Research (Montreux, Switzerland, November 16–19, 2010) <http://www.hsr-symposium.org/>

We encourage potential participants to send us a pre-submission enquiry for further orientation: emergingvoices2010@itg.be.

Detailed rules and additional information can be found on the website of the colloquium: <http://www.itg.be/colloq2010>.

3) CALL FOR ABSTRACTS

“Good Life Better – Anthropological, Sociological, and Philosophical Dimensions of Enhancement”

An interdisciplinary workshop for young scholars

11-16 October 2010

University of Lübeck, Germany

The workshop is part of a series of interdisciplinary study weeks on ethical, social, and legal aspects of the modern life sciences, funded by the German Federal Ministry of Education and Research (BMBF). The event will be organised by the Institute for the History of

Medicine and Science Studies (IMGWF) at the University of Lübeck, in cooperation with the Institut für Mensch, Ethik und Wissenschaft (IMEW) in Berlin. The target groups for the workshop are PhD candidates, post-docs, and young scholars in the fields of ethics, philosophy, theology, social and political sciences, cultural studies, disability studies, medicine, and the life sciences.

This workshop aims to intensify an interdisciplinary bioethical discussion on “human enhancement” by explicitly connecting it to disability studies research, and by integrating philosophical, ethical, anthropological, sociological, cultural, and feminist points of view. How do people with and without disabilities see “enhancing medicine” and the enhancement discourse? Looking through the lenses of disability and gender, how can we distinguish between wishes and desires that are improvements and those that are not? Which experiences of medicine and technology are key for understanding possibilities and limits of enhancement in medicine? If an inclusive societal reflection is important, are there new discrimination risks and emancipation opportunities?

Questions that will be discussed are: What relates “norms” and “normality” to “normative” considerations? How will these terms be defined in political and social arenas as well as in cultural contexts? Which visions of and options for technical enhancement of human bodies are desirable and reasonable – and why? How might a pluralist approach look, which is inspired by “thinking through the variant body”?

Through interdisciplinary discussions, methods can be found that allow us to study the values and the underlying key differentiations in ideas of human identity. If somebody believes that a particular enhancing intervention is actually “improving”, he or she makes use of such values and differences. How we think about “enhancement” (what contributes to enhancement?) says a lot about what we emphasize in human life. Which

frames of perception are debated in discourses, and how can they be made explicit and fruitful for further discussion?

Contributions in the following areas in particular are welcome: (1) experience and evaluations of enhancement; (2) converging biotechnologies and phenomenology; (3) norms and needs; (4) fulfilment of desires in technology and medicine; (5) governance and biopolitics. Contributions are also welcome that contrast body experiences with more speculative visions like “posthumanism” and “transhumanism”.

Applications in German or English can be made via email to: klausurwoche@imgwf.uniluebeck.de until **1st July 2010** and should include an abstract (500 words), Curriculum Vitae, and a list of publications, if existing. All applicants will be informed whether or not their abstract has been accepted by 31 July 2010. The number of participants is limited to 15. Conference languages will be German and English. If an abstract is accepted, all travel and accommodation costs will be met. Accepted participants will receive an honorarium of €300.

Deadline for final discussion drafts (if possible in English): **1 October 2010**.

Significant outcomes will be published as an English book.

The venue is accessible for wheelchairs.

Chair: Christoph Rehmann-Sutter
Professor für Theorie und Ethik der Biowissenschaften, Institut für Medizingeschichte und Wissenschaftsforschung der Universität zu Lübeck

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