health fairs, and games to promote behavior change. Clinical partners focus on training health care personnel in GBV service delivery. Three of the five clinical partners plan to facilitate access to psychosocial support and develop protocols for the care of child victims. Several of the partners expressed a need for improved coordination among the various social services required for GBV victims. Common challenges include cultural and social barriers, lack of psychosocial support for victims, poor communication between partners and funders, and difficulty monitoring and evaluating partner activities.

CDC Mozambique partners reported successful outputs from their GBV activities, such as varied teaching methods and well-trained staff; however, the ability to measure impact remains difficult. With an annual CDC budget of approximately $3.1 million, refocusing support toward integrated services, improving communication among partners and funders, and standardized evaluation tools would allow for greater impact.

Does birth preparedness package increase facility delivery? Results from a prospective cohort study in Nepal

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Background: A key strategy of safe motherhood programmes to reduce the maternal mortality is to ensure that pregnant women deliver at a health care facility. Birth preparedness package has been widely promoted and accepted as a demand-creation behavioural intervention to increase the ratio of facility delivery. Studies have been undertaken to measure change in birth preparedness level after this behavioural intervention, rather than measuring the impact on facility delivery. The aim of this study was to assess birth preparedness in expectant mothers and to evaluate its association with facility delivery in a central hills district of Nepal where birth preparedness package has been implemented.
Structure/Method/Design: A total of 701 pregnant women of more than 5 months gestation were recruited from randomly selected five urban wards and seven rural illakas in Kaski district of Nepal. Fifteen local female data collectors conducted baseline interview at respondents' houses at recruitment to assess birth preparedness activities and followed them by a second interview within 45 days of delivery.
Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Level of birth preparedness was high with 65% of the women reported preparing for at least four of the five arrangements: identification of delivery place, identification of transport, identification of blood donor, money saving, and antenatal care check-up.

Place of delivery was identified for 644 participants: 97 (15%) at homes and 547 (85%) at facilities. The more arrangements made, the more likely were the women to have facility delivery (OR, 1.51; $P < 0.001$). For those pregnant women who intended to save money, identified a delivery place or identified a potential blood donor, their likelihood of actual delivery at a health facility increased by two- to three-fold.
Summary/Conclusion: Intention to deliver in a health care facility as measured by birth preparedness indicators was associated with facility delivery. Birth preparedness package could increase the proportion of facility delivery in the pathway of maternal survival.

Effects of HIV and age on cervical cancer risk in Malawi: implications for screening

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Background: Background: Cervical cancer is the most common cancer and a leading cause of death among women in Malawi. National guidelines recommend screening women aged 30 to 45 years using visual inspection with acetic acid (VIA) every 5 years; however, no specific recommendations exist for women with HIV.

Objective: Our primary objective was to assess the frequency of high-grade cervical dysplasia (cervical intraepithelial neoplasia [CIN] 2 or CIN 3), and cervical cancer among women referred for colposcopy at a national teaching hospital in Lilongwe, Malawi. Our secondary objective was to examine associations between HIV and age with high-grade cervical dysplasia and cancer.
Structure/Method/Design: Methods: We analyzed the Kamuzu Central Hospital pathology database from November 2012 through November 2013. Cervical Pap smear, cervical biopsy, loop electrosurgical excision procedure (LEEP), and uterine specimen reports were included. For women with multiple reports, we analyzed the result with the most advanced diagnosis. We used logistic regression to estimate associations with high-grade dysplasia and cervical cancer (CIN2+).
Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Results: We reviewed 1,037 reports of cervical and uterine specimens from 824 unique women. Of these, 194 (23%) were excluded due to unknown HIV status, leaving 630 women in the analytic sample. Median age was 38 years, and 36% were HIV-infected. Twelve percent had high-grade dysplasia and an additional 109 women (17%) had cervical cancer. Thirty-five percent of women diagnosed with cancer and 25% of those with high-grade dysplasia were not within the recommended screening age range. HIV significantly increased the odds of having CIN2+ (adjusted OR, 6.55; 95% CI, 4.43-9.67). For each additional year of age the odds of having CIN2+ increased by 4%.
Summary/Conclusion: Conclusion: High-grade dysplasia and cervical cancer were very common in this sample of Malawian women, especially among HIV-positive women. A large proportion of this sample diagnosed with CIN2+ was outside of the recommended screening age range. HIV infection was strongly associated with CIN2+. Expanding cervical cancer screening and treatment services to all HIV-infected women and to sexually active women outside the currently recommended screening ages would likely avert a substantial proportion of cervical cancer cases in Malawi.

Strengthening health system response to gender-based violence though multisectoral collaboration and best practices in evidence collection and documentation

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Background: The Program on Sexual Violence in Conflict Zones at Physicians for Human Rights (PHR) builds the capacity of health and legal professionals to document and collect forensic evidence of sexual violence according to best practices in support of women and girl survivors. PHR is currently implementing this program in Kenya, Democratic Republic of the Congo (DRC), Uganda, South Sudan, and Central African Republic (CAR).

Health professionals are crucial first responders to survivors of sexual violence, yet many receive little training in the documentation of court-admissible forensic evidence. PHR's program

demonstrates that bridging this gap through education in best practices can make a vital contribution to the abilities of health and legal communities to build prosecutions of sexual violence crimes. These prosecutions, in turn, uphold women's rights and provide survivors with access to justice.

Structure/Method/Design: PHR's primary strategies include:

1. Capacity building—training doctors, nurses, and psycho-social trauma and recovery counselors in best practices for the collection of forensic evidence of sexual violence, including documenting health consequences, assuring appropriate treatment, and supporting legal assistance and advocacy
2. Cross-sectoral network—facilitating a forum for essential cross-training and professional collaboration among members of the health and legal sectors
3. Advocacy—advocating for national and international reforms addressing the political, health, legal, social, and cultural obstacles that derail efforts toward prosecution

This presentation will discuss how PHR's work presents an innovative and replicable model for strengthening the collaboration of health and legal professionals on sexual violence crimes through the adoption of best practices.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): None

Summary/Conclusion: We will list the obstacles and barriers to adequate documentation of forensic evidence of sexual violence and to prosecuting cases.

Opportunities for intervention to reduce postpartum hemorrhage in rural Uganda: Using task-shifting to build on existing community strengths

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Background: Postpartum hemorrhage (PPH) is a leading cause of maternal death worldwide, responsible for >25% of maternal deaths each year in Uganda. Oral misoprostol has been shown to be effective in the prevention of PPH in low-resource settings.

We sought to understand the landscape of maternal health care in rural Uganda, exploring alternative opportunities to reduce PPH.

Structure/Method/Design: Focus groups and interviews were conducted with community health workers (n = 19), traditional birth attendants (n = 9), pregnant/postpartum women (n = 10), and health facility workers (n = 9) across seven rural villages in Uganda. Qualitative data were analyzed and coded utilizing grounded theory to discover and develop themes.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): The Ugandan health care system is a stratified collection of government clinics operating at different levels of care, NGOs, and traditional healers. Village Health Teams (VHTs) volunteer to act as educators and liaisons to the system. Women access care at different levels throughout their pregnancies. Their stated preferences and the realities of how they access care are dictated by their perceptions of needs, risks, quality of care they will receive, and barriers faced.

Most prefer to deliver at private clinics, where care is perceived to be superior. However, they may access free antenatal care at government clinics, and may also utilize traditional herbs. VHTs provide antenatal/perinatal support.

Various barriers prevent women from using the system as planned including cost, lack of transportation, and timing. Traditional birth attendants provide a safety net, with reputations for being trustworthy, knowledgeable, and providing excellent care.

Risk for bleeding is recognized, but approaches to address it are inconsistent. No standard means to recognize or measure blood loss exist. Injectable prophylaxes is widely used in clinics in the third stage of labor to prevent bleeding; misoprostol is available but not widely used.

Summary/Conclusion: Any intervention to reduce PPH should address all levels of care, as women are likely to access all of them during pregnancy. Opportunities to integrate and coordinate across tiers to serve communities exist; VHTs may help bridge gaps. Task-shifting can be a useful strategy for community-based oral misoprostol interventions to reduce PPH. WHO guidelines endorse the use of community health workers to distribute misoprostol in low-resource settings.

A local health NGO has provided training and support to VHTs to coordinate across systems in the past; this partnership could augment a community-based effort to distribute misoprostol to at-risk women giving birth in non-clinic settings.

Why do women deliver with traditional birth attendants and not at health facilities?: A qualitative study in Lilongwe, Malawi

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Background: Malawi has one of the highest rates of maternal and neonatal mortality in the world, with a maternal mortality ratio of 675 deaths per 100,000 live births and a neonatal mortality ratio of 31 deaths per 1000 live births. In 2007, the Malawi Ministry of Health banned the use of traditional birth attendants (TBAs), which has been associated with higher rates of obstetric complications and maternal and perinatal death when compared with the use of skilled birth attendants.

Structure/Method/Design: Our study qualitatively explored the beliefs and experiences influencing decisions on place of delivery among Malawian women who delivered at least one baby with a TBA. Twenty face-to-face in-depth interviews and three focus group discussions were conducted in Chichewa, the local language. The participants were recruited from the antenatal clinics, antiretroviral therapy clinics, and under-5 clinics at three health centers in Lilongwe District. Interview questions addressed three domains: reasons for delivery with a TBA, experiences during the delivery with a TBA, and finding solutions to prevent future deliveries with a TBA. Participant responses were independently coded by two authors, and content analysis was used to develop themes and subthemes.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Most participants cited difficulties relating to transport and/or unsupportive or unavailable husbands as factors that prohibited delivery at a health facility. In addition, a majority lacked a concrete delivery plan, which contributed to their delivery with a TBA. Participant responses indicated discordancy between knowledge and practices for safe delivery. Women knew about the benefits of delivering at the health center and said that they preferred to deliver there but also reported positive experiences with the TBA, who they felt was more nurturing and attentive than health center providers. Participants were ambivalent about the TBA ban as they felt that readily accessible options for health center delivery were not always available.