

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.

Summary/Conclusion: Strategies to decrease deliveries with TBAs should focus on helping women to develop concrete delivery plans to cope with the potential social or situational obstacles of getting to a facility. They also need to ensure that health facilities provide quality care and that women receive the emotional support and personalized care that they desire during labor and delivery.

Designing a participatory model for the creation of women's health education materials

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Background: While there are a wealth of materials discussing difficult topics in women's health—including such topics as sexuality, family planning, unsafe abortion, HIV, and violence against women—few exist that help health educators to broach these topics in a way that reduces stigma and creates an open dialogue. A group of women's health activists and care providers approached Hesperian Health Guides, publisher of *Where There is No Doctor and Where Women Have No Doctor*, and asked us to work with them to create a new health education and community organizing resource to address this gap. The result, *A Health Action for Women*, has activities and strategies to help health promoters tackle discussions and act upon on these difficult topics.

Structure/Method/Design: In order to ensure that Hesperian materials reflect the needs and resources of local communities, all Hesperian books are field tested during development. During the development of *A Health Action for Women*, we included a pre- and post-field test survey, in order to gauge participants' level of comfort discussing challenging topics discussed in the material. We wanted to gauge whether this field test process itself had an empowering aspect, and to identify existing shortfalls in popular health education so that the materials produced could be more relevant, practical, and motivating. The five-question survey was designed by a qualitative researcher and program evaluation specialist, incorporating input from end users, and was distributed to participants before field-testing started and after it was completed. The surveys evaluated community leader's feelings presenting on topics before and after using the materials, as well as community response to the health issues presented.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): In total, 49 surveys were sent to 17 organizations in 14 countries.

Summary/Conclusion: Results indicate that prior to reading and using the materials, field testers had varying levels of experience and comfort addressing the topics covered, and that exposure to the information in the guide gave users more confidence in leading challenging discussions. Respondents not only reported that they felt comfortable giving presentations to a variety of audiences (including, men, mixed groups, women, and adolescents) but that they also felt more comfortable addressing controversial topics. For example, with the topics "How Gender Roles Affect Health," "Sexuality," and "Violence Against Women," over 80% of respondents reported that they felt "a lot more comfortable" presenting on these topics than they had previously.

High breast cancer-related mortality in Armenia: Examining the breast cancer knowledge gap

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Background: Breast cancer, the most common invasive cancer among women, has high incidence and mortality rates among women in the Republic of Armenia. According to the World Health Organization, the age-standardized death rate due to breast cancer in Armenia is 38.6 per 100,000, making it the fourth highest nation globally for breast cancer deaths and the highest in its region. The object of this study was to assess the knowledge about risks factors, signs and symptoms, and early diagnosis of breast cancer among women in Armenia. Understanding the connection between women's breast cancer knowledge in Armenia and high mortality will help guide targeted intervention programs addressing this major public health concern.

Structure/Method/Design: A cross-sectional study was performed over a 2-week period of time from June 20 to July 4, 2012. Face-to-face intercept interviews were conducted among 229 women ages 18 to 70 attending regional health centers in Yerevan, Armariv, Ararat, Shirak, and Kotayk provinces. A standardized questionnaire was administered by an interviewer. Surveys were coded and the analysis of the data was accomplished using Stata statistical software. Standard descriptive statistical analyses were conducted and associations among variables explored using regression-based approaches for continuous variables and non-parametric techniques for categorical variables.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): The mean age among those surveyed was 39 years old with a standard deviation of 1.29 years. 62% of participants self-identified as urban dwellers, and 96% reported having at least a high school education. The mean overall knowledge score was 71% with significant differences among age ($P = 0.0008$), living area ($P = 0.0015$), and education ($P = 0.0001$). Knowledge questions were divided in three categories: risk factors, signs and symptoms, and early detection. The mean knowledge score concerning risk factors was 59%, with marked differences based on education level ($P < 0.0001$). The mean score for signs and symptoms was 70%, with only 74% of respondents indicating painless breast lumps among signs and symptoms. The mean score for early diagnosis was 80% with 13% of participants claiming annual mammograms do not decrease the risk for dying of breast cancer.

Summary/Conclusion: Based on both overall scores and subscores, breast cancer knowledge gaps exist among women in Armenia with the most significant disparity concerning breast cancer risk factors. Additionally, these results identify specific knowledge gaps among distinct demographics. Future public awareness campaigns targeting those with knowledge disparities may prove efficacious in decreasing both mortality and morbidity due to breast cancer within the Republic of Armenia.