≥4 surveillance visits as compared to those who had received ≤3 surveillance visits ($P = 0.000$).

Antenatal complications and treatment: There was a significant increase in the number of respondents reporting at least one antenatal complication in the last pregnancy as compared to the previous one ($P = 0.000$).

Early detection and treatment of antenatal complications increased significantly among those who had a "high" level of exposure to surveillance ($P = 0.048$).

Intranatal care: A significant reduction in home deliveries was observed in the last pregnancy as compared with the previous one, which was significantly associated with the number of surveillance visits. ($P = 0.000$).

Neonatal care: An increase in early treatment for neonatal complications was observed in the last pregnancy as compared to the previous one. There was a significant increase in the proportion of women who sought treatment for neonatal complications within 24 hours of their onset ($P = 0.000$).

Summary/Conclusion: Several developing countries employ community health workers to modify health-seeking behaviors, generate demand for health services, and link beneficiaries with the health system. If community health workers undertake monthly surveillance and monitoring it can result in a significant increase in the utilization of services, effective coverage of pregnant women with standard maternal and neonatal health services, and effective and timely referral for those who need specialist care.

The baby shower initiative: A framework for interventions to promote birth outcomes

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Background: Twenty-two priority countries have been identified by the WHO that account for 90% of pregnant women living with HIV. Nigeria is one of only 4 countries among the 22 with an HIV testing rate of less than 20% for pregnant women. Despite expansions of HIV prevention programs in Nigeria, only 14% of pregnant women were tested for HIV; while 9% of pregnant women living with HIV received WHO recommended antiretroviral (ARV) therapy; and only 11% of HIV-exposed infants received ARV prophylaxis for prevention of mother-to-child HIV transmission (PMTCT) resulting in an estimated 75,000 HIV-infected infants in 2010. Currently, most pregnant women must access a health care facility (HF) to be screened and receive available PMTCT interventions. This clinic-based approach is challenging when only 35% of pregnant women deliver in a HF and only 2.9% of HF have an established PMTCT program. Finding new approaches to translate evidence-based PMTCT programs to community-based setting is necessary if we are to realize the PEPFAR goal of 80% HIV screening rate among pregnant women by 2015

Structure/Method/Design: Cluster randomized trial to evaluate the feasibility and acceptability of a congregation-based Baby Shower Initiative (BSI) delivered by lay health advisors at local churches (Intervention Group; IG), versus a clinic-based approach (Control Group; CG) on the HIV testing rate and PMTCT completion among pregnant women. Forty churches in Southeast Nigeria were randomly assigned (1:1) to either the IG or the CG. BSI combines a family educational game and integrated on-site laboratory testing (Hepatitis B, HIV, and sickle cell genotype) delivered in the context of a baby shower. Monthly prayer sessions for pregnant women were used for recruitment and baby receptions following infant baptisms were used for follow up after delivery

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): From March 1 to Oct 31, 2013, we recruited 1654 pregnant women in the IG (76% of male partners recruited) and 1371 pregnant women in CG (85% of male partners recruited). Seventy-seven percent of pregnant women in the IG completed testing during baby showers

Summary/Conclusion: BSI was well accepted by pregnant women and communities. BSI successfully recruited pregnant women and their male partners to participate in baby shower programs where interventions were implemented. Further analysis at completion of deliveries will determine the comparative effectiveness of this initiative in improving HIV testing among pregnant women

The study was cofunded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), the National Institute of Mental Health (NIMH), the President's Emergency Plan for AIDS Relief (PEPFAR) under award number R01HD075050. The funding agencies played no role in the study conception, design, data collection, data analysis, data interpretation or writing of the report.

Examining GBV programmatic efficiency in Mozambique: An analysis of CDC partnerships

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Background: The Gender-Based Violence (GBV) initiative was launched in 2011 to reduce GBV in Mozambique by building on activities supported by the President's Emergency Plan for AIDS Relief (PEPFAR). The objectives are to: 1. Expand and improve coordination and effectiveness of GBV prevention efforts 2. Improve GBV policy implementation 3. Improve the availability and quality of GBV services. In Mozambique, there is a lack of integrated procedures, guidelines, and trained professionals addressing GBV, as well as challenges with implementation of GBV programs at the community level. 2 Experience elsewhere suggests that community level approaches can be effective in changing gender norms and violence-related attitudes and behaviors, thereby promoting gender equality and the empowerment of women.5

Local partnerships with the Centers for Disease Control and Prevention (CDC) in Mozambique were established to achieve this goal. We sought to complete a qualitative evaluation of their experiences, outcomes, and challenges to date.

Structure/Method/Design: After reviewing the GBV Initiative Strategic Plan, the financial structure, and the CDC reports on GBV activities in Mozambique, the 10 CDC partners with GBV activities were assessed. Guided small-group discussions were conducted with five partners to further explore program outputs and actual outcomes.4

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): CDC:Mozambique

Summary/Conclusion: Partner GBV prevention activities are innovative and community-based, including theater, debate, concerts, videos,

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