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.