visit, the fellow aimed to assess and evaluate current clinical practices and monitoring and evaluation procedures. Also, the fellow endeavored to provide guidance to staff on the most current HIV screening and treatment options and developing a final evaluation framework. The fellow engaged in key informant interviews to gather data on individuals' experiences with the project. An English interpreter assisted in interviews for those who spoke the local language.
Outcomes & Evaluation: Achievements: As of March 2014, 98 pregnant mothers enrolled 100% HIV exposed infants were negative at 6 week PCR test 50 different parishes/villages.
Going Forward: Challenges: Delay in enrollment at inception of program; Long wait time for HIV testing; 50% turnover of nurses; Recurrent stock rupture of HIV tests; 20% turnover of CHWs and inadequate supervision by nurses; Challenge for enrolled mothers to visit clinic monthly for medication refills. Recommendations: Final evaluation of project to highlight PCR results at 6 weeks of age; Long lab wait time may be reduced by allowing nurses and HIV counselors to complete HIV rapid testing; Assess supply of ARVs for exposed infants and provide >30 day supply of medications to adherent mothers who live in far away communities.
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Improving rural health through capacity building and training of rural health workforce using e-Learning

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Program/Project Purpose: India is the second most populous country in the world with a population of 1.21 billion. With nearly 72 percent of the country's population living in rural areas, there is a need to improve the quality of care for rural population. Huge disparities exist in the healthcare status of urban and rural India. The doctor patient ratio in rural India is 1:20,000, while the urban ratio is 1:2,000 against the statutory 1:250 ratio from WHO for which India requires 6,00,000 doctors. Capacity building of healthcare workforce at all levels has, thus, been a key focus of the National Rural Health Mission (NRHM), a flagship scheme of Government of India to improve healthcare delivery in rural India. However, continuous skill development is a huge challenge, given the large number of rural health workforce. As per the Indian Public Health Standards (IPHS) for Primary Health Centres (PHCs), training of health workers is crucial to maintain quality of services being offered at PHCs. e-Learning has evolved as a preferred mode to deliver training solutions for rural health workforce, globally. In one of the instances, African Medical & Research Foundation (AMREF), in partnership with the Nursing Council of Kenya (NCK), Accenture, Kenya Medical Training Colleges, several private and faith-based nursing schools and the Ministry of Health Kenya, pioneered a country-wide e-Learning program for upgrading community nurses in Kenya. Similarly, the Indian states, which have adopted e-training of rural health workforce of NRHM have demonstrated improved healthcare statistics owing to better delivery by highly skilled staff.
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Implementation of a trauma response system, San Salvador, El Salvador

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Background: El Salvador has a high mortality rate caused by both accidental and intentional trauma. The World Health Organization estimates that trauma was responsible for 32% of all deaths between the ages of 15-60 in El Salvador in 2011. Currently, there is a lack of standardized, formal trauma training in El Salvador. We recently developed and administered a trauma response training in El Salvador. Here we report on the preliminary data from our first trauma training and its impact on trauma care during the single center, pilot phase of our study.
Methods: The pilot phase of the study is taking place at Hospital Nacional San Rafael (HNSR), a major hospital in the metropolitan area of San Salvador. Clinical residents and medical students observed emergency ward (EW) shifts, 24 hours per day, and filled out a standardized checklist of critical actions performed by clinicians during the trauma resuscitation, including use of bedside ultrasound. Victims of trauma over the age of 12 years that met the criteria for the American College of Surgery's trauma team activation were included in the study. Patients that were dead on arrival and refused consent were excluded. Critical actions assessed include checking vital signs, primary and secondary surveys, and measures such as EW to operating room time, mortality, and ability to use available ultrasound equipment to perform a FAST exam. Partway through the pilot phase, the medical personnel at HNSR underwent a two-day course in Primary Trauma Care (PTC), which is a trauma training curriculum developed in the UK that uses a sustainable train the trainer model to teach trauma care in limited resource settings. Additional didactic and simulation-based training such as hands-on ultrasound training were also provided. In addition, a two week in-service FAST training was performed in the EW by trained staff. The data from the observation checklists were divided into pre and post PTC training.
Findings: While data collection to get to our sample size of 200 is still ongoing, we have enrolled 162 patients, including 49 patients pre-intervention and 113 patients post-intervention. Significant results in the subgroup for use of FAST exam in trauma have been noted with 9.52% of correctly performed FAST exams occurring in the pre-intervention group compared with 23.90% in the post-intervention group ($p = 0.034$).
Interpretation: This is the single center, pilot phase of a larger project designed to assess the impact of providing trauma-response trainings for emergency room staff at HNSR in San Salvador. The interim results show a dramatic improvement in physician FAST usage in major trauma cases. The final data collected in our study will be used to develop a nationwide trauma training program.
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From global partnerships to pay for performance (P4P): Opportunities for achieving academic excellence in higher learning institutions in Rwanda

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