order of prevalence were education/knowledge, health care system, culture/religion, and empowerment.

Interpretation: Our retrospective data shows that the prevalence of contraception within the NMI women at our practice is 44%, which is low compared to the US prevalence in 2010 (62%). This may be partially explained by the lack of documented counseling with almost 1/3 of our patients. However, our data does show that the number of women who start contraception increases steadily throughout the first year after arrival. Our qualitative research revealed that a majority of participants had knowledge of family planning prior to coming to the US through word of mouth and/or formal education. However, many were embarrassed to address the topic themselves. Ultimately, access to healthcare and our ability as providers to deliver culturally sensitive care will dictate whether this population receives quality healthcare in the US. Limitations of the retrospective portion include possible errors secondary to abstraction by multiple personnel, missing or incorrect information in patient's charts, and limited documentation about barrier methods and sexual activity. Limitations of the qualitative portion are possible translation error and social desirability bias. Strengths of our study are its large sample size as well as the study's involvement of three major refugee populations in the US.

Funding: There was no external funding used for this research study.

Abstract #: *02ETC080*

Program leadership council: Collaborative, peer-to-peer learning to strengthen global health residency education

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Program/Project Purpose: Over 25% of medical school graduates participate in a global health experience during their training. These experiences are a critical introduction to the field of global health. Continued exposure during residency training is critical to the development of future global health leaders. Residency programs, such as those at the Stanford University School of Medicine, are facing significant challenges in addressing this recognized need while meeting ACGME requirements and in a setting of limited infrastructure and funding. Opportunities to collaboratively surmount shared challenges are often missed as individual specialty program leadership teams struggle in isolation. The goal of the Stanford University Program Leadership Council (PLC) is to facilitate global health training at the post-graduate level by bringing together residency program leaders to share resources, to support educational initiatives, and to provide peer-to-peer learning.

Structure/Method/Design: The PLC aims to build collaboration across residency programs to strengthen global health training opportunities that support the professional development of future global health leaders. A formal consensus building strategy was applied to achieve this goal. First, a representative leading global health work in each residency program was identified. These individuals were invited to a structured initial PLC meeting. Prior to the meeting, participants were asked to prepare: (a) one slide introducing the residency program's global health training opportunities and (b) a focused list of challenges faced in global health education. Participants were led through an interactive consensus building activity to identify common challenges across programs over the course of one hour, followed by a formal closing evaluation to define steps forward.

Outcomes & Evaluation: This meeting was the first of its kind to bring together residency programs in the Stanford University School of Medicine. Fifteen residency training programs were represented, and 10 cross-program challenges were identified. Many participants expressed surprise to learn about the activities or infrastructure present in other residency programs. Other participants have begun discussing opportunities to expand program offerings and to collaborate on education and service projects. Following the meeting, a formal evaluation tool indicated that all a participants found the meeting to be (a) beneficial and (b) worthy of continuation.

Going Forward: Moving forward, the PLC will continue to meet every two months to address the challenges identified in the consensus building activity through peer-to-peer learning, network building, and administrative support. It will also continue to identify novel met

Funding: No project funding is currently required.

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Strengthening nursing workforce: A key ingredient for achieving PEPFAR HIV prevention, care & treatment priorities

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Program/Project Purpose: Long standing underinvestment in nursing and midwifery education continues to limit the ability to train sufficient number of nurses and midwives with the appropriate clinical skills to meet population health needs. When HIV positive patients seek care in Africa, they will in all likelihood get treated by a nurse. They will also have their babies delivered by, their children immunized from, and their common as well as uncommon ailments, whether diarrhea, pneumonia, tuberculosis, malaria, cholera or Ebola, treated by a nurse. Increased investment is required to address the need for more nurses, training them better, and ensuring they have the necessary support to remain at the front lines, caring for the most vulnerable.

Structure/Method/Design: In 2009, ICAP at Columbia University began implementation of the PEPFAR funded Global Nurse Capacity Building Program (GNCBP), which consists of two subprojects, Nursing Education Partnership Initiative (NEPI) and General Nursing (GN). GNCBP aims to improve population health by fostering individuals, institutions, and networks to expand, enhance, and sustain the nursing and midwifery workforce by achieving three objectives: (1) Improve the quantity, quality, and relevance of nurses and midwives to address essential population-based health care needs, including HIV and other life-threatening conditions; (2) Identify, evaluate and disseminate innovative human resource for health models and practices that are generalizable for national scale-up of nursing and midwifery education; and (3) Build local and regional partnerships to provide technical and capacity building support for nursing and midwifery policy, regulatory and faculty development, curricula reform, continuing professional development and retention, and high impact nursing leadership. ICAP works collaboratively with relevant ministries, nursing bodies and education institutions to build local capacity and country ownership in the 13 countries where GNCBP is implemented.

Outcomes & Evaluation: To date, efforts to equip nurses and midwives with the clinical skills needed to meet population health needs, have led to over 10,000 pre-service nurses enrolled in 19 NEPI-supported nursing schools, 9 simulation skills labs and 4 model wards established, 15 curricula newly developed or revised to