ANNUAL REPORT 2011

One Heart World-Wide

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One Heart
WORLD-WIDE

Table of Contents

"There is a light in this world, a healing spirit more powerful than any darkness we may encounter. We sometimes lose sight of this force when there is so much suffering and pain. Then suddenly, the spirit will emerge through the lives of ordinary people who hear a call and answer in extraordinary ways"

Mother Theresa

A Word From Our Founder: Arlene Samen

I want to take a moment to thank each one of you for your support this past year. None of our work would happen without you. **Your generosity has been vital** to the success of our programs and to the survival of mothers and infants in Nepal and Mexico.

One Heart World-Wide has spent more than a decade developing the "**Network of Safety"**, an effective, replicable and sustainable safe motherhood model to reduce preventable deaths related to pregnancy and childbirth. Our programs make health services more accessible to vulnerable indigenous populations in remote areas of the world. More specifically, our **Network of Safety** raises awareness, improves life-saving skills, and distributes basic pregnancy and birthing supplies.

In the last two years we have redirected our focus from Tibet to remote regions of **Nepal** and **Mexico**. Once again, we are working in rural areas to improve the health of local indigenous mothers and their infants. We go where no one else goes and where too many women are dying during unattended deliveries.

In **Nepal** our programs are located in the foothills of the **Himalayas**, in two districts (Baglung and Dolpa) where 90% of all deliveries occur in a home setting, and less than 20% of all births take place with the assistance of a Skilled Birth Attendant (SBA). To increase the number of safe deliveries, One Heart World-Wide has trained 290 Female Community Health Workers and 11 SBAs, equipped 3 new birth centers, distributed 50 stretchers and trained 41 health providers in neonatal resuscitation. Our efforts are providing mothers with better access to care and healthier birth outcomes.

In **Mexico** we are working among the **Tarahumara Indians** of the **Copper Canyon**, where more than 50% of mothers still deliver at home without the benefit of a SBA. As a result, maternal mortality for the Tarahumara is nearly ten times that of Mexico as a whole. Physical, financial, geographic and cultural barriers prevent these mothers from accessing care. To date, we have trained 60 volunteers, 100 health providers and donated much-needed equipment and supplies. No maternal deaths have occurred in the Canyon since the implementation of our program.

We believe that every mother deserves a baby to cradle, not tiny body to bury. We hope you agree with us, and that you consider donating to One Heart World-Wide this year. Your donations will make a huge difference; we could not save lives without you.

Please visit our website: **www.oneheartworld-wide.org** to show your support today.

In gratitude,

Arlene Samen, Founder & President

Organizational Structure

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Introduction

One Heart World-Wide (OHW) is a 501(c)3 organization with over ten years of experience providing on-the-ground training in newborn and maternal health from the village level through secondary and tertiary care facilities, and with a variety of health care providers working across this spectrum. The long-term sustainability and demonstrated success of the OHW model in Tibet led us to expand our operations to other sites in need, including two districts of Northwestern Nepal (Baglung and Dolpa, both in the Dhaulagiri zone) and the Sierra Tarahumara in Northwestern Mexico (in the state of Chihuahua).

Based on our years of experience in Tibet, OHW has established the ***Network of Safety***, an effective, replicable and sustainable model to reduce preventable deaths related to pregnancy and childbirth among vulnerable indigenous populations. The OHW model improves the health and wellbeing of pregnant women and newborns that may not otherwise have access to medical or public health services due to socio-cultural barriers, limited personal resources, or living in remote locations. Essential to the OHW model are integration of local resources, collaboration with local communities and providers, and respect for cultural norms and practices.

The ***Network of Safety*** is a community-based participatory model aiming to build local capacity (training and equipment) at various levels. OHW works simultaneously with local communities and local health care providers to raise awareness, teach good practices, and distribute essential equipment/supplies to ensure that mothers and babies survive delivery and the first months of life. Our model includes:

1. **Community Outreach Programs** aimed at providing mothers, their family members and the community at large with knowledge surrounding:
   - Attendance to prenatal care and facilitated delivery services
   - Good nutrition/prenatal supplements
   - Recognition of danger signs during pregnancy/delivery
   - Delivery plans (promoting deliveries with a SBA)
   - Hands-on skills and Clean Birth Kits for emergency home births
   - Community planning for obstetric emergencies (transport, hospital fees, communications)

2. **Providers Training** (SBAs, clinic and hospital staff)
   - Community health workers receive training on safe pregnancy and delivery, recognition of danger signs and when to refer women at risk to a health care facility
   - SBAs are trained in prenatal services, delivery skills, newborn care, recognition of danger signs and when to refer women at risk to a health care facility
   - Clinic and hospital staff are trained in emergency obstetric care

3. **Health Facilities Improvement Program**
   - Facilities are upgraded
   - Equipment and supplies are provided
   - Training is provided for facility staff

4. **Partnerships** with other organization (governmental and non-governmental)
   - Program buy-in by local stake-holders and government officials
   - Collaboration between existing programs
   - Involvement of relevant agencies/officials
   - Policy changes based on program results

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NEPAL

2011 Highlights

290	**Community Volunteers** trained
50	**Stretchers** distributed
11	**SBAs** trained
70%	Of the **women** in our program area delivered with a SBA

One Heart World-Wide Nepal: Overview

Nepal has seventy-five administrative districts; those located in Northwestern Nepal are among the least developed areas in the world, where people lack access to basic health services, education and electricity. Difficult terrain, harsh climate, and poor socio-economic status are the major barriers to care. Because of this, the maternal and neonatal mortality rates have remained high in this region while these rates are on the decline in other areas of Nepal where more services are available. In Northwestern Nepal, maternal and neonatal mortality rates are reported at five times the rate of the national average. Northwestern Nepal currently lacks the infrastructure and capacity to care for its mothers and infants. Besides a lack of health facilities, these areas also face additional challenges, including:

- Lack of trained staff
- Lack of basic equipment to deliver basic maternal and neonatal care
- Lack of awareness about appropriate care-seeking behaviors, health-promoting behaviors and early identification/management of common conditions.
- Low population density and nomadic/semi-nomadic lifestyle

The populations of Baglung and Dolpa districts in Northwestern Nepal consist of more than 500,000 people living primarily in remote, rural communities in the foothills of the Himalayas, with Dolpa being the most remote of the two. Most women have no pregnancy-related contact with modern health services and maternity services are under-utilized and low in quality. About 90% of all deliveries occur in a home setting, as opposed to a health-care setting. As has been demonstrated worldwide, skilled attendance at delivery is a key factor to reduce maternal and perinatal deaths. However, in Baglung less than 19% of all births take place with the assistance of a Skilled Birth Attendant (SBA) and in Dolpa, less than 5%.



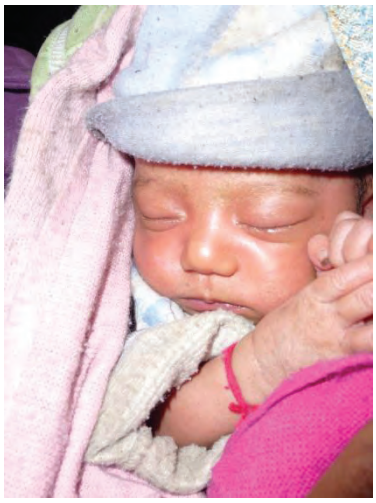
One Heart World-Wide Nepal: Programs

In Nepal, the ***Network of Safety*** is implemented through:

1. Community Outreach Programs: Training community health volunteers belonging to a national network who then reach out to their communities to serve as first responders for MCH; they are known as our foot soldiers.

Existing programs include:

- A Community-Based Newborn Care Package (C-BNCP): Effective newborn care involving recognition of warning signs, dealing with medical emergencies and counseling of families.



- Infection Prevention (IP) training: Fundamentals of disease transmission and strategies to reduce infections such as proper hand washing techniques, handling of the umbilical cord, and providing a clean delivery environment.

- A Birth Preparedness Package (BPP) with Misoprostol: Competencies in the counseling of mothers on the importance of prenatal visits, delivering with a clean birth kit, and how to recognize danger signs that may signify complications for pregnancy and delivery.

2. Health Care Providers Training:

- Skilled Birth Attendant (SBA) Training Program: Training in obstetrics and immediate neonatal care and provision of basic equipment. The curriculum is based on WHO's Integrated Management of Pregnancy and Childbirth (IMPaC).

- Infection Prevention (IP) training (for health-care providers): Knowledge and skills about sterilization of instruments and proper cleaning of the facility to reduce iatrogenic infections (infections inadvertently caused by medical staff or by treatment or diagnostic procedure).

- Advanced Training Programs for Physicians: Supplemental training in emergency obstetric care.

3. Health Facility Improvement Program:

- Facility Upgrades (birthing centers, health-posts, district hospitals)
    - Construction and building upgrades to create birthing centers
    - Provision of medical equipment
    - Construction of maternity waiting homes

Birthing Centers: Before

Birthing Centers: After

Nepal Accomplishments 2011

Organization

- Full program implementation is now under way in Baglung District.
- Based on need, the government recommended Dolpa District as a potential site for program expansion. A district needs assessment was conducted and Dolpa was confirmed as the next expansion site. Preliminary program implementation has started in Dolpa District.
- One Heart World-Wide now has one administrative office in Kathmandu for government and partner agencies contacts, as well as field offices in Dolpa and Baglung districts for local district-based operations with the district health office.
- We have a full staff complement (ten people) including a centrally based administrator and a coordinator in Kathmandu, and district-based master trainers and supervisors in Balgung (six people) and Dolpa (two people).
- We are officially registered in Nepal as an International Non-Governmental Organization (INGO).

- As per Nepali legal guidelines, we have established official partnerships with two local non-profit organizations at the district level (SWAN in Baglung and Dharma Karma in Dolpa) to facilitate field program implementation.
- We have signed a Memorandum of Understanding with the Nepali Ministry of Health and Population to be the agency deploying the Nepali Government Community-Based Newborn Package (C-BNCP) program in Baglung and Dolpa.

Training

- We have trained 199 female community health volunteers as outreach providers for our pregnancy and village outreach program (maternal care community-based outreach program) this year, bringing our grand total for 2010 and 2011 to 290.
- We organized a TOT (Training of Trainers) program for the Nepali government community-based newborn care program. The training was held in Kathmandu from November 19th to 25th for our staff and district-level governmental representatives from Dolpa and Baglung districts. Implementation is scheduled to start in Baglung in December and the following year in Dolpa. Partnerships have been established with the government, Save the Children, UNICEF and other partners to facilitate implementation.
- We have trained all our staff members as well as 41 community health workers (doctors, nurses and community health volunteers) on neonatal resuscitation using the "Helping Babies Breathe" (HBB) curriculum. HBB is a neonatal resuscitation protocol specifically designed for remote rural areas of the world (http://www.helpingbabiesbreathe.org/).
- We sponsored 11 eligible health workers (including our staff member Anji Sherpa) to complete the two-month SBA training course in Baglung.
- We have distributed 20 SBA delivery bags among existing and newly trained SBAs.
- We have distributed 50 stretchers throughout five sub-districts of Baglung.
- We equipped two birthing centers in Baglung (Hatiya and Paiyunpata birthing centers) and one in Dolpa (Dunai).

Program Monitoring and Evaluation

- Monitoring and evaluation processes, reporting systems, data collection instruments and a database were developed. We introduced a pregnancy report card to track pregnancies and birth outcomes.
- Program evaluation will be implemented on three levels: (1) knowledge/skills acquisition following training; (2) pregnancy report card completed by trained outreach providers; and (3) birth outcomes evaluation.
- Data quality assurance: information provided by a trained outreach provider will be verified with a family interview for 10% of the overall sample. Collection of outcomes and process data is scheduled biannually.
- We have completed quality assurance and follow-up data collection on our maternal community based outreach program in 15 sub-districts of Baglung. Knowledge acquisition was documented through pre- and post-training testing. Knowledge increased significantly ($p<0.01$) following completion of training. Focus group and community surveys following trainings revealed high acceptance among trainees and praises for trainers throughout.
- We have completed baseline surveys on the C-BNCP in 30 VDCs of Baglung. Results are currently being analyzed.

- This year out of 237 births there were zero maternal deaths and only two neonatal deaths.
- The percentage of women who delivered with a trained medical professional (i.e. doctor, nurse, midwife) has jumped from 20% to 70%.
- The percentage of women who delivered alone at home or who were attended by a friend, family member, neighbor (or other non-medical person) dropped from 80% to 20%.
- More than 95% of women had three or more prenatal visits.
- 85% of women took prenatal supplements.

Nepal Challenges 2011:

- The INGO registration process was a lengthy process.
- Transportation can be a real challenge, particularly in the most remote areas of our program (Dolpa district).

Nepal Goals for 2012:

- Continue the district-level training in Dolpa and Baglung on community-based newborn care program
- Start the community-level training program for FCHVs, health post management committee and stakeholders
- Continue to support two birthing centers in Baglung and one in Dolpa
- Continue to work on strengthening the Dolpa hospital
- Continue our partnership with various partners such as UNICEF, Save the Children and Ministry of Health to start the Birth Preparedness Package with Miso in Baglung and Dolpa
- Create a radio communication network between our volunteers and the health service in the most remote communities
- Combine the HBB with community-based newborn care program in all levels of training in Dolpa and Baglung
- Train the trainers in Helping Babies Breathe
- Continue to share health messages and obtain approval when necessary of the local authority
- Train SBAs in Dolpa (five) and Baglung (ten)
- Furnish the training hall in Baglung District Health Office and open the contact office there to coordinate with government health workers
- Continue our follow-up data collection on birth outcomes on PAVOT
- Establish a database at the community and district levels with the Ministry of Health and the Population and Health Management Information System (HIMS)

Huma's Story *(by Anji Shepa, OHW Master Trainer)*

Amalachaur is a very remote part of Baglung District. One Heart World-Wide recently trained Huma Sharma, a resident of Amalachaur, as an SBA. There are no birthing centers in Amalachaur and before Huma, there were no SBAs either. One night, Huma was called to attend a delivery. She went to the mother's home with her equipment. This was the mother's first baby and she was having strong labor pains. Her labor was not progressing well and became prolonged. Transporting the woman to the

nearest health facility would have been difficult because there is no road and therefore takes six hours to reach the hospital even when you are healthy and can walk easily. In this case, with the prolonged labor and the amount of pain the mother was in, Huma felt that attempting transport in the middle of the night was too dangerous as the risk of the mother dying on the way was high. After another hour of labor, the woman was able to push and deliver the baby's head but his shoulders became stuck in the mother's pelvis and the baby could not come out. Everyone in the family was afraid. Huma recognized the problem as shoulder dystocia. She remembered the procedures she was taught during her SBA training for shoulder dystocia and successfully delivered the baby. The baby then had difficulty breathing but Huma was able to save his life when she dried and stimulated him then cleared his airways. Huma told me that the SBA Training Course was really helpful to her as she is now able to recognize and properly manage birth complications. Because there are so many women dying due to these factors in her area, Huma feels that with her recent training she will be able to save many lives and for this, she is deeply grateful to One Heart World-Wide.

Successful Delivery Stories in Dolpa: *(by Dr. Fassl, Nepal Program Manager)*

One case involved a mother who had hiked from Saldang in Upper Dolpa to camp outside the hospital until her water broke. She has heart disease and signs of congestive heart failure, making her a high-risk delivery. Despite her condition, she managed the eight-day hike over two passes above 17,400 feet, all while being 8 ½ months pregnant. After camping for several days outside of the Dunai hospital with her family and herd of sheep, her water broke and we assisted her in delivering a healthy baby boy without complications.

Another young mother delivered a low birth weight and apparently premature baby, weighing only 2100g (4.6 lbs.), and we were instructed by staff to "not do too much because the baby will die anyway; they always die." Over the course of the next few days, we worked intensely with the mother and father to feed the baby hourly, provide extra warmth through skin-to-skin contact, as well as initiating antibiotic therapy. As the baby was too weak initially to latch and suck from mother's breast, we taught the mother manual expression of breast milk and to feed ten spoonfuls (about 20ml) every one to two hours. The baby gained strength and was able to breastfeed at three days of life.

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MEXICO

2011 Highlights

60	**Community volunteers** trained
100	**Rural Health Providers** trained
70%	**Women** in our program area delivered with a Skilled Birth Attendant

One Heart World-Wide Mexico: Overview

According to the World Health Organization, the Mexican state of Chihuahua's maternal mortality ratio (MMR) is 53.7 per 100,000 live births (well above the ratios of nearby Arizona, 3.4/100,000 and New Mexico, 10.8/100,000 live births). Chihuahua's rate of skilled birth attendance at delivery was the lowest in Mexico, with only 63% of pregnant women delivering with a skilled birth attendant. Matters are much worse for the indigenous population of the State of Chihuahua. Most Tarahumaras live many hours or days from the road. Once on the road, they often must travel several additional hours to reach a clinic or a hospital. The vast majority of Tarahumara women still give birth at home, unattended, and many women and children are born and die without either birth or death being accounted for and/or being registered by a governmental entity. The state health system of Chihuahua reports that among the top ten municipalities with high maternal mortality, eight are municipalities with indigenous majorities located in the Sierra Tarahumara. The Tarahumaras represent only 3% of the state population and 38% of the maternal deaths in the state.

In June 2009, OHW, in collaboration with Rancho Feliz, conducted a needs assessment study among the Tarahumaras of the Copper Canyon. The average number of births per woman was five and almost 90% of all births were unattended by a medical professional. Among the women who delivered without a medical professional, 30% delivered entirely alone. Most houses were at least three hours away from the nearest clinic or hospital and 40% of all families were uninsured. The maternal mortality ratio was 998/100,000 live births. The mortality rate among children under five years was 40%, and among these, 27% died in the neonatal period (between birth and 28 days of life).

Pregnancy, birth and postpartum recovery in the Sierra Tarahumara are still very dangerous for indigenous women and their newborns. While the primary cause is the lack of access to care due to the distance to medical facilities, other important barriers include:

- The Tarahumara's fear that medical providers will disrespect them, violate their right to make informed medical and family planning choices, and otherwise mistreat them.
- The lack of trained traditional birth attendants within this population, and;
- Other Tarahumara-specific cultural barriers such as (1) the private nature of the Tarahumara people; (2) the belief that because childbirth is a natural process and not a sickness, it does not necessitate medical attention nor attendance during delivery; and (3) *machismo* that can prevent a woman's freedom to make her own reproductive health choices.

One Heart World-Wide Mexico: Programs

The goal of the OHW program in the Sierra Tarahumara is to implement a ***Network of Safety*** in order to increase access to safe motherhood messages, essential resources and skilled health providers. Specific OHW programs currently underway in Mexico include:

1. Community Outreach Programs:

- Community Volunteer Training: OHW trains community outreach providers who then help pregnant women in their areas by providing them with information on safe pregnancy and delivery, in addition to resources such as prenatal supplements and Clean Birth Kits.

A Clean Birth Kit includes:

- A sheet of plastic to contain blood on the floor/bedding
- A pair of gloves
- A bar of soap
- A disposable razor blade to cut the umbilical cord
- Two pieces of string to tie the umbilical cord
- A small hat and a blanket for the newborn baby

- Emergency Evacuation System:

Because most women live two to six hours by foot from the nearest clinic it has been necessary to implement an emergency evacuation system. OHW volunteers encourage all women and their families to make an evacuation plan in the case that a medical emergency arises.

In collaboration with the local government, OHW will equip each trained volunteer with a solar powered radio (to notify referral hospital of patient's arrival) and a stretcher.

2. Health Care Providers Training:

This program is designed to strengthen existing governmental training efforts in collaboration with local health authorities and will provide supplemental training to the physicians, nurses and other health service staff members who provide care to the indigenous mothers and infants of the Sierra Tarahumara.

Specific programs include:

- Helping Babies Breathe (HBB) - training on neonatal resuscitation
- Training providers on ultrasound use
- Training in basic and emergency obstetric, neonatal, and postpartum care

3. Health Facilities Improvement Program:

OHW works with foreign donors and the local government to provide necessary equipment and supplies as well as training to ensure the local staff is sufficiently acquainted with and capable of using all tools.

Mexico Accomplishments 2011

Organization

- We opened an office in Urique, Chihuahua to serve as home base for our program in Mexico
- We are now officially registered as an *asociación civil* (non-profit equivalent) as One Heart-Mexico. This will allow us to:
    - Sign contracts directly with the Ministry of Health for the state of Chihuahua
    - Officially hire employees
    - Seek funding and accept donations within Mexico
- We signed an agreement for 2012 goals with reproductive health representatives from the Ministry of Health for the state of Chihuahua.

Training

- We have trained 60 community members as volunteer outreach providers in our life-saving skills methodology.
- All of our volunteers were equipped with a first response backpack containing a stethoscope, a blood pressure cuff, a thermometer, clean birth-kits, gloves, gauze, alcohol pads, a plastic apron, prenatal vitamins, teaching tools, and a headlamp. The volunteers use these materials to provide support to remote rural Tarahumara women, check for danger signs and when necessary, help provide a clean delivery for women who did not make it to the clinic on time.
- We trained 12 doctors in hands-on 1st and 2nd trimester obstetric ultrasound usage.
- We donated a handheld ultrasound to the clinic in Urique. This clinic is one of the most remote first-response posts in the municipality as it serves a large area and is difficult to access.
- We trained 30 rural health providers in HBB (Helping Babies Breathe) and emergency obstetrics, including the use of the condom tamponade to prevent post-partum hemorrhage (PPH).

- We trained 26 indigenous governors on safe motherhood messages to share with their communities.
- We trained 58 governmental health workers in our life-saving skills methodology, as well as on the infrastructure and goals of OHW.

Program Monitoring and Evaluation

- Monitoring and evaluation processes, reporting systems, data collection instruments and a database were developed. We introduced a pregnancy report card to track pregnancies and birth outcomes.
- Program evaluation will be implemented on three levels: 1) knowledge/skills acquisition following training; 2) Pregnancy report card completed by trained outreach providers; and 3) birth outcomes evaluation.
- Data quality assurance: information provided by trained outreach provider will be verified with a family interview for 10% of the overall sample. Collection of outcomes and process data is scheduled biannually.
- From the data we have analyzed so far, the percentage of women delivering unattended by a medical professional has declined by 40%.
- This year, 70% of all Tarahumara births in the communities in which we work were attended by a trained attendant.
- To date, we have experienced zero maternal deaths.
- 100% of the mothers we serve received prenatal vitamins.

Mexico Challenges 2011

- Registering as a non-profit in Mexico was a lengthy and difficult process.
- The difficult terrain (paved roads are almost inexistent)
- The lack of existing communication infrastructure such as internet, landline, and cell phone services in the Canyon

Mexico Goals 2012

- Train an additional 56 new volunteers and equip them to work in the area of the municipality we have not yet reached
- Create an emergency evacuation system among our volunteers, using radios and stretchers to facilitate evacuation of obstetric and neonatal emergencies in the most remote communities
- Offer two trainings for a total of 90 medical personnel trained on safe motherhood, emergency obstetrics and cultural sensitivity
- Offer a Training of Trainers (TOT) program in Helping Babies Breathe for nine trainers
- Continue to share safe messages among Indigenous Governors
- Train the municipal police on emergency evacuation procedures (as the police is often called to deal with medical emergencies including obstetric and neonatal cases)
- Reach out to school teachers, students, and parents on safe motherhood. This will be done as a part of the health curriculum, and to raise the general awareness on this issue within the community. This is also an important target demographic since it is not unusual for 12 to 16 year-old girls to become pregnant.
- Start soliciting funds from Mexican entities to ensure long-term project sustainability

Adalina's Story: From One of the Mothers Served by OHW Volunteers

I was almost due and I had not been feeling well. My head started to ache. I felt it was harder and harder to stay awake. I finally could not take the pain any longer and had my cousin go get Carlos. He is the One Heart volunteer that had been visiting me. He gave me prenatal vitamins and classes on what to do during my pregnancy. Since he lives 20 minutes away, it was 2:20 am by the time he arrived. He checked my blood pressure and he said it was high. I needed to go to the clinic right away. After that I don't remember much because I started to feel more and more pain. It was unbearable. Carlos and my family had to find four men to help me down the mountain. They made a hammock to carry me out. By the time we left, the sun was coming up. There was no way to communicate with the clinic to tell them we were on our way and we needed their help (cell phone service is extremely unreliable). The pain increased as we went on. The men became tired of carrying me and they had to ask me to walk. I felt like I was walking on broken glass; every step was more painful than the last. Carlos decided to run ahead to the nearest community to find a fellow volunteer to help. There he called the clinic in Urique to send the ambulance. In the meantime, the other volunteer came to meet me. The volunteers helped me until the ambulance arrived. Once at the clinic, the doctor gave me some medicine. I started to feel better. The doctor told me that I would have to go to the hospital to have the baby right away. I was scared and tired. Unfortunately, the ambulance to go the hospital was out of gas. We reached out to the One Heart World-Wide office and they paid for the gas. Once I was at the hospital I was able to have my baby. Today he is healthy because Carlos was able to help me.

One Heart World-Wide Volunteer Close-Up: Victoria's Story

Though she is only 15 years-old, Victoria Cienega Castro has already been helping mothers in her community. She joined One Heart World-Wide's ***Network of Safety*** *to learn valuable skills and experience and to help her realize her dream to study nursing. As one of our trained volunteers, Victoria serves an area consisting of 13 communities. It takes her 2½ hours walking (there is no vehicle access) from her home to reach the most remote community she serves. From Victoria's home to the nearest clinic, it is another two hours by truck or four hours walking during the rainy season when roads are not accessible. It is another six hours by car to reach the nearest hospital. Despite her young age, Victoria currently oversees six pregnant women. She gives them safe motherhood messages during and after pregnancy, prenatal vitamins, and clean birth kits. One Heart World-Wide provides Victoria with training and equipment to be able to measure blood pressure and heart rate, as well as recognize the danger signs of pregnancy and delivery before a complication occurs. At this point, Victoria is the only consistent medically trained person in her community. With the skills she has learned, she has helped evacuate a pregnant woman with preeclampsia and a baby with complications. Since her training, Victoria has attended two deliveries for mothers who could not reach the clinic on time. For one of them, Victoria told us: "We had to walk two hours to reach her only to find it was too late and she had to deliver at home." Because of the unsanitary conditions in which the mother lives, Victoria had to use One Heart World-Wide's Clean Birth Kit. "Her delivery was successful without any complications," she said to us proudly. Victoria's community admires her dedication to her people.*

Technical Assistance Programs:

Democratic Republic of Congo:

The population of the DRC is estimated to be about 68,000,000. It is one of the poorest countries in the world, with a gross national income per capita around $270. The maternal mortality rate, among the highest in the world, hovers at around 1,800 per 100,000 live births, and the infant mortality rate is 79.36 deaths per 1,000 live births. Pre-term birth and birth asphyxia account for nearly 50% of infant deaths. The majority of maternal mortality is caused by post-partum hemorrhage (34%). Poor infrastructure, widespread poverty, corruption, infectious diseases, malnutrition and ongoing violence have all contributed to these poor health indicators. Kinshasa, the capital city, is a very large metropolis (population estimated between 10 and 12 million) consisting of a few affluent neighborhoods surrounded by many slums. Compared to the rest of the country, Kinshasa has less violence associated with war, but the city is overcrowded, corruption is rampant, and poverty is extreme.

Over the last decade the country has experienced several wars, leading to the disintegration of an already fragile health care system. The current health expenditure of the DRC is roughly 4% of the GDP. Most health facilities lack basic medical supplies, particularly those needed for safe motherhood programs. Corruption is widespread within the system and there is a lack of well-trained medical personnel in the healths. Many among the medical personnel have not received their salary in years, and therefore lack motivation and refuse to treat patients until payment is received. Health facilities are run on a cost-recovery system, in which people are expected to pay up-front for consultations and medicines. Health care is no longer perceived as a basic human right and public service but as a free-market commodity. As many as two out of ten households in Kinshasa are unable to access health services due to lack of money. The patients who cannot afford to pay either do not receive services (and sometimes die because of it) or are held as hostages at the health facility long after treatment is received until their families manage to pay their fees.

Through the Clinton Global Initiative, Mr. Jim Greenbaum (long-time supporter of OHW) asked OHW to assess the feasibility of establishing a MCH program in DRC in collaboration with the Dikembe Mutombo Foundation (DMF).

DRC Achievements 2011:

- OHW conducted an in-depth maternal and neonatal health needs assessment in the Democratic Republic of the Congo (DRC) to determine whether an OHW program could be implemented in

Kinshasa in collaboration with the Hospital Biamba Marie Mutombo created by the DMF (an ultra-modern facility established in one of the poorest neighborhoods of Kinshasa).

- A preliminary Memorandum of Understanding (MOU) for collaboration was drafted and reviewed by the OHW and DMF Boards. The MOU outlined expectations from both sides. While Kinshasa is a somewhat unusual setting for our work, as it is a large metropolis, OHW offered to pilot test our ***Network of Safety*** model in the health zone of Kinshasa where the DMF Hospital is located. Because the chosen setting is urban and access to mobile phones is widespread, OHW proposes to integrate Medic Mobile (MM) systems within its ***Network of Safety*** to facilitate communications and monitoring. The ***Network of Safety*** would have to be: (1) adapted to the local Congolese context; (2) modified for an urban setting; and (3) supplemented by cellular phone technology.
- After deliberations, the Boards decided against establishing a OHW program in DRC at this point in time, because:
    - The OHW ***Network of Safety*** is a community-based model specifically designed for remote, rural populations. The situation in the interior of DRC is a better fit to the OHW model (difficult access to care, low rate of deliveries with skilled birth attendants, high maternal and infant mortality). However, OHW does not have a partner in the interior of DRC and our current partner, the DMF Hospital, is located in an urban area.
    - Establishing an OHW program would sharply increase the number of unpaid deliveries at the DMF hospital and is unlikely to bring in revenue to the hospital.

DRC Plans for 2012:

Because OHW is keenly sensitive to the need to establish community-based MCH programs in the DRC, and because we are aware of the DMF's wish to help women and infants in need, OHW formally offered our services as advisors to the DMF, should they decide to independently implement an MCH community-based intervention.

China:

The Amitabha Foundation Clinic and Health Care Program assists in the improvement of the health care of the nomadic families living outside the town of Yushu in Prefecture County, Qinghai Province, PRC. Yushu was devastated by an earthquake in April 2010 leaving all buildings either in ruins or badly damaged and uninhabitable. Thousands of people died and many more were left with permanent injuries and were incapacitated. The 100,000 or so survivors of the earthquake were subsequently housed in a makeshift city of tents. More than one year later, the population continues to live in basic conditions in the tent city while the city center and surrounding areas are a hub of ongoing construction activities. Over the past few years the Amitabha Foundation has been introducing various strategies to address the high maternal and newborn mortality in their community. Some of these strategies include the supply and distribution of clean birth kits, prenatal vitamins, baby blankets, and hats.

Direct Relief International has asked OHW to provide assistance to the Amitabha Foundation in designing and implementing their MCH programs.

China Achievements 2011:

- In July 2011, Mary Richards (Nepal in-country coordinator and certified midwife) conducted a ten-day intensive training for three master trainers and 23 midwifes in our community-based maternal and neonatal health program
- In order to assess their understanding of the training materials and their performance post-training, Ms. Richards observed the three master trainers in several community outreach activities among the nomadic community outside of Yushu. All three master trainers performed well.

China Plans for 2012:

- Dr. Kristensen (a trained perinatal epidemiologist and OHW Executive Director) and Ms Arlene Samen (Nurse Practitioner and OHW Founder and Director) will visit the Amithbha project next summer to provide support for the implementation of their monitoring and evaluation processes.

Liberia:

Traditional hospital-based services are failing to reach the world's most remote villages. Nowhere is this crisis worse than in post-war Liberia, where more than 60% of the nation's rural population lacks access to essential health care. Tiyatien Health is a non-profit organization dedicated to the creation of a new health workforce to bring care to remote villages. They train community members and former patients to serve as frontline health workers, delivering comprehensive home-based medical and social services to communities previously deemed unreachable.

During the Clinton Global Initiative (CGI) meeting last October, Mr. Jim Greenbaum asked One Heart World-Wide to help Tiyatien Health design and implement new community-based MCH services for their Liberia program.

Liberia Achievements 2011:

- One Heart World-Wide president and founder (Arlene Samen) and Executive Director (Dr. Sibylle Kristensen) met with representatives of Tiyatien Health and started preliminary planning.

Liberia Plans for 2012:

- An OHW visit to Liberia is planned for 2012 to conduct a feasibility study and a training session for Liberian staff.

Thank you from the One Heart World-Wide Team