

AMCHP Annual Conference, 2010

Moving Ahead Together:

Celebrating the Legacy, Shaping the Future of Maternal and Child Health

From Analysis to Action:

Addressing Maternal Morbidity and Mortality at the State and International Levels

March 6-10, 2010

UNKNOWN SPEAKER: (Inaudible)...

CONNIE MITCHELL: How far are we in the process was the question and we're still doing the scavenger hunt and trying to fill in all of the quadrants for it but it's already clearly identifying where our gaps are. And maybe the gap is we don't have an effective measurement identified for it or maybe that contributing factor we don't have any programs for.

SHABIR AHMAD: Any other question?

UNKNOWN SPEAKER: I have a question for Betsy from White Ribbon Alliance. How do you measure your success of the International Women's Day in the countries that you implement it in?

BETSY MCCALLON: Thanks, well measurement in general for an overall kind of movement on advocacy is sometimes challenging. You know and we typically measure that in terms of specific policy changes or specific investment whether that's at a national budget level or sub national. But in this quite specific case of really trying to make a lot of noise today around this issue and united one of the things that we're measuring is media. So number of media pieces, types of media pieces, diversity of that in terms of geographic but also different mediums and how many people reached through that particular mechanism as well as new members joining up either in countries or internationally who will then be part of the movement when they are particular policy calls to action.

UNKNOWN SPEAKER: I was wondering how the case reviews of the Fitelli case reviews fit into the framework or (Inaudible)...?

CONNIE MITCHELL: The PAMR the Pregnancy Associated Mortality Reviews we look at every pregnancy related death and do a medical record abstraction and then it goes before a committee of experts who review the medical records and try to look for contributing factors that might help to inform you of where you might do quality improvement. So now there was a few things I said there that would help you to identify where it fits and that's a medical record review of the hospitalization. So what we're getting from that is information about what's happening around the time of delivery and get a little bit of prenatal records in there not as much as we would like so we're putting that into it would be the third column and it would be the community level so it that

would be 3C. Because it gives us very clear information about what's happening in terms of hospital maternity care and some obstetrical care but it's not giving us enough yet around the community and also it doesn't tell us anything about the pregnancy associated deaths like motor vehicle crashes and homicides and cancer and those are things we might have to use a different methodology for.

UNKNOWN SPEAKER: (Inaudible)...

CONNIE MITCHELL: She's asking is there any thought about including family members? And he would love to do that if any of you are doing surrogate interviews in your mortality reviews that's a very classic methodology that's been incorporated with some child death review teams and also domestic violence mortality review teams. And if anyone's doing it for maternal mortality I'd love to talk to them about it because that would be something we would really want to add. I think it really enriches and gives some context to the woman's life, I think it's a great thing.

UNKNOWN SPEAKER: (Inaudible)...

UNKNOWN SPEAKER: I have a question for Jason...regarding the Deadly Delivery, the report that's going to be released on March 23rd, can you give us some information about the methodology used in this report and what indicators were used? And are you going to give any information to the maternal and child health departments of the states prior to releasing it to the press?

JASON DISTERHOFT: So let's see several steps to the research process, desk review of relevant data, reaching out to officials at the federal and selected state levels, surveys of things like the accountability indicators that I pointed to, so maternal mortality review boards, check boxes, that sort of thing. And the bulk of the research time was spent in interviewing loved ones, family members, of women who passed away or suffered a near miss and providers as well. Just to get as many stories as we could to bring the issue to life.

You know we'll be reaching out systematically to everyone we can within our capacity starting at the federal level and as we move down to working on particular states, we'll certainly be reaching out there as well.

SHABIR AHMAD: Join me in thanking our speakers today.

(Applause)

Excellent representations at both the national, international and state level. Thank you very much and our speakers are here if there are any remaining questions so they can address it individually. Thank you very much.