February 8, 2016 TESTIMONY: Written only

To: The Honorable Rosalyn H. Baker, Chair
The Honorable Michelle N. Kidani, Vice Chair
Members of the Senate Committee on Commerce, Consumer Protection, and Health

From: **Hawaii Public Health Association**

Subject: **SUPPORT – SB 2234** RELATING TO CHILD AND MATERNAL DEATH REVIEWS

Hearing: February 9, 2016 at 9:00 am at State Capitol Room 229

The Hawaii Public Health Association (HPHA) is an association of over 600 community members, public health professionals, and organizations statewide dedicated to improving public health. HPHA also serves as a voice for public health professionals and as a repository for information about public health in the Pacific.

HPHA **supports the passage of SB 2234** which appropriates funds to the Department of Health to conduct child death reviews and implement a program to perform maternal death reviews.

The Hawaii Child Death Review (CDR) system was established in 1997 by the Legislature through Hawaii Revised Statute §321-345. The CDR teams conducted comprehensive and multidisciplinary reviews of child deaths 0-17 years to understand risk factors of child deaths. The reviews focused on prevention of future child deaths and have also led to recommendations in ensuring child safety and providing optimal child health. CDRs require adequate resources to conduct the reviews and passage of this bill would enable this process to resume, since it has been inactive since 2011. Within a family and a community, every child's death is a tragedy.

The United States maternal mortality ratio has increased and the Centers for Disease Control and Prevention (CDC) states that maternal mortality review committees are necessary for ensuring all pregnancy-related deaths are identified and reviewed, and that effective prevention actions are developed. The Association of Maternal and Child Health Programs also supports a maternal mortality review

process as pregnancy-related deaths are an indicator of the overall health of women of reproductive age. Many of these deaths are preventable. According to the American Congress of Obstetricians and Gynecologists, state-level maternal mortality review committees are an important obstetric care and maternal public health function. Hawaii is one of fourteen states that does not conduct maternal mortality review in a comprehensive statewide system.

Child death and maternal death reviews would provide critical data to support prevention efforts to reduce child and maternal mortality and morbidity in Hawaii.

Thank you for the opportunity to testify in support of **SB 2234**, which would resume child death reviews and implement a program to conduct maternal death reviews.

Respectfully submitted,

Hoce Kalkas, MPH
HPHA Legislative and Government Relations Committee Chair