

# AMDD

## NOTEBOOK

Meeting Challenges, Making Changes, Saving Lives

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### DEAR COLLEAGUES

Those of you who participated in the 2nd Annual AMDD Workshop held in Bangkok 19–21 February know that Implementation was the overarching theme. We decided to focus on implementation for three reasons.

Our first aim was to help all of us—project partners, technical partners, service providers, policy makers, and the AMDD core team—keep the ultimate objective clearly in view. We have come together to improve access to life-saving obstetric services, and that is how our efforts will be judged, at the end of the day.

We believe we can avert many deaths and disabilities by improving the availability, quality and utilization of emergency obstetric care (EmOC). People often think this will happen if they support training, purchase of equipment, and renovation of facilities. But if we keep our objective in view—saving women's lives and health—we know that the job is not finished when such activities have been carried out.

Thus, our second aim was to highlight the full set of activities necessary to ensure that EmOC is available, accessible, and used. Learning from your projects, we identified two stages for upgrading services, as is set out in the Box on page 6, and the activities necessary for each stage. We made sure that the Workshop included sessions on key activities so as to support you in your work.

Our third aim was to provide a set of tools and resources that will assist you in your work, many of them produced by international organizations in partnership with AMDD. Many of these tools and resources are now available on the AMDD website.

In short, the Workshop was about working together to identify and remove constraints to EmOC. Some of these constraints are outside our control. But by working together in the growing AMDD global movement, even those constraints that we cannot address today will one day be overcome.

Zafarullah Gill

*Associate Director, Program Implementation*

*Averting Maternal Death and Disability Program (AMDD)*

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## THE AMDD PROGRAM

The AMDD Program was launched in 1999 at Columbia University's Heilbrunn Center for Population and Family Health, Mailman School of Public Health, to work with developing countries on improving the availability, quality and utilization of EmOC.

The basic premise of the AMDD program is that most of the obstetric complications that lead to maternal death can neither be predicted nor prevented, but the vast majority of women can be saved through prompt treatment. AMDD addresses three inter-connected areas: technical know-how, management capacity, and respect for human rights.

AMDD has established partnerships with organizations that already have field operations. These partners are now implementing AMDD-supported projects in close to 50 countries:

United Nations Children's Fund (UNICEF): projects in Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka.

United Nations Population Fund (UNFPA): projects in India, Morocco, Mozambique, and Nicaragua.

Regional Prevention of Maternal Mortality (RPMM) Network: teams and projects in 19 sub-Saharan African countries.

CARE: projects in Ethiopia, Rwanda, Tanzania, Peru, and Tajikistan.

Save the Children: projects in Mali and Vietnam.

Reproductive Health for Refugees (RHR) Consortium: projects in 12 countries.

Among the key Program tools are the process indicators developed at Columbia University and issued by UNICEF, the World Health Organization (WHO), and UNFPA.

AMDD technical partners include:

Family Health International

John Snow International

Indian Institute of Management at Ahmedabad (IIMA)

JHPIEGO

EngenderHealth (formerly AVSC International)

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## GOOD PRACTICES

### Ambulance Response Time:

#### When Monitoring Saves Lives

Hospitals that provide comprehensive emergency obstetric care (EmOC) are at the top of the referral chain, linking women with serious complications to the services that can save their lives. But, for a referral system to function well, quick and easy access to transport is essential.

Frequently, there is no way to contact ambulances directly. In other cases, they are not available when called because they are being used for supervisory visits, or distributing supplies or equipment. Sometimes, they serve as a taxi to take women home from the hospital. At other times, more unfortunately, officials use them on unauthorized missions.

Experience shows that rigorous control can be established and maintained if hospital management is committed to the use of emergency vehicles exclusively for emergencies.

**José Macamo Hospital in Maputo, Mozambique**, with support from UNFPA (the United Nations Population Fund), provides comprehensive EmOC 24 hours a day. The Hospital has developed a good referral system that includes monitoring the use of the ambulances, as an AMDD technical team found during a recent visit.

José Macamo is the referral hospital for Bagamoyo and Catembe, two health centers that deliver more than 350 births a month. An important element of the referral system is 24-hour radio communication. Inexpensive radios are found at both centers, in the two ambulances, and at the hospital. The radios must be on 24 hours a day. The health center maternities can call the ambulance drivers directly wherever they are, and the drivers are required to respond as quickly as possible.

At the suggestion of Dr. Emmanuel Rwamushaija, the technical advisor to the UNFPA project, each of the health centers maintains a referral registry in which staff logs the patient's name, reason for referral, the time when the ambulance was requested, and the time of arrival, plus the staff's signature. What was remarkable about the registry at the Bagamoyo health center was the short time interval between the call and the arrival of an ambulance.

A less satisfying experience has been that of a neighboring health center less than 20 km from José Macamo Hospital, but not officially part of its jurisdiction. This center depends on another facility's ambulance in the case of emergencies, and has to rely on the telephone system. Unfortunately, the telephone service is interrupted frequently because bills are not

paid on a regular basis. Furthermore, the facility with the ambulance does not contract a driver at night, and thus, the ambulance cannot be used 24 hours a day.

The referral registry used by the Bagamoyo and Catembe health centers not only serves to monitor the response time of the ambulance, but it also documents all referrals and reasons for referral, thus providing almost immediate information on referral trends: how many women are referred and why. When staff is trained to perform MVA (manual vacuum extraction), for example, far fewer women will be referred for the treatment of incomplete abortion, and the registry will quickly reflect a decrease in referral.



Photo by Czikus Carriere

Such a registry does not provide complete assurances that the ambulance is not used for non-authorized reasons. But it does assist management to monitor the use of its ambulance, and reinforces the idea that ambulances should be used exclusively for emergency patient care. The registry is easy to implement and requires very little time to complete.

**Patricia Bailey**  
*Columbia University Senior  
Lecturer  
MCH Evaluation Specialist, Family  
Health International*

## USING PARTNERSHIPS TO GET A PROJECT BACK ON TRACK

**Hemant Dwivedi** UNFPA/India Project Coordinator, Jaipur and **Dileep Mavalankar**, Senior Management Advisor to AMDD and Professor at the Indian Institute of Management at Ahmedabad report on the way in which creative team problem-solving efforts helped to unblock a stalled hospital improvement project in Chittorgarh sub-district in Rajasthan.

The Nimbahera Hospital in the sub-district of Chittorgarh serves a population of 1.3 million; people from a neighboring state also come to seek medical care at this center. As part of the effort to improve EmOC at the Nimbahera Hospital, UNFPA (with AMDD support) had planned, among other things, renovation of the facility within the UNFPA Integrated Population and Development project.

Extensive renovation was necessary because the hospital itself was only half finished due to prior problems involving non-payment of contractors' fees. However, despite the allocation of resources for renovation, work could not begin because the problem regarding unpaid fees remained unresolved. This situation was bureaucratically messy and very difficult to solve.

In September 2001, a site visit by UNFPA and an AMDD team along with the district health officials to the half-constructed hospital provided an opportunity for all stakeholders to meet and discuss the problems. Participants in the meetings included the hospital doctors, the Public Works Department engineer, the Sub-Divisional Magistrate (an important officer in the Indian context), and district health officers, as well as AMDD and UNFPA staff. The main focus of the discussion was how to make the new, half-built facility functional. Participants agreed on specific steps to move the project forward, and ways to modify the plans of the half-constructed hospital to ensure the availability of comprehensive EmOC services, including the operating theatre, labor room, utility rooms, postnatal wards, and laboratories, keeping cost and time at a minimum.

As a result of the meetings, the following steps were taken within a month:

- The UNFPA team helped convince the state government to allow use of World Bank-assisted Reproductive and Child Health project funds for completion of the existing operating theatre instead of constructing a new one as originally planned.
- The Magistrate convinced the town council to pay the contractor for past fees, which enabled the project to move forward and UNFPA to allocate the second installment for renovation.
- The Magistrate convinced the community and local industry to contribute to the project, as part of efforts by government to raise support from both private and public sector representatives, in accordance with the agreement reached on the day of the joint visit.

The joint problem-solving visit and the steps taken to seek funds from different stakeholders increased confidence of the local partners in the hospital improvement project. By April 2002, stakeholders had given substantial financial support to the hospital, and much of the work needed to make it functional was complete. It is expected that by the end of June 2002, the maternity ward, the operating theatre, and related areas of the hospital will be ready for in-patient and emergency services.

In sum, a local site visit by development partners, pro-active roles by key local officials, and leveraging partnerships can resolve some of the most complicated problems in public systems. ■

# BANGKOK AND BEYOND: HOW THE GLOBAL MOVEMENT GROWS

AMDD Program Coordinator **Katrina Stamas** spoke to participants about the consultations that took place alongside the formal sessions at the Bangkok Workshop, as well as the follow-up activities that have already taken place since the meeting. For an overview of the formal working sessions and panels, please consult the Workshop Report at which is now on the AMDD website at [www.amdd.hs.columbia.edu/WorkshopReport.pdf](http://www.amdd.hs.columbia.edu/WorkshopReport.pdf)

**Partner Agencies** The United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and CARE took advantage of the fact that project teams had traveled to the meeting from many parts of the world to review the status of their AMDD-sponsored projects.

In fact, the UNICEF Regional Office in South Asia (ROSA) held the mid-term review of the Women's Right to Life and Health Project in Bangkok just before the AMDD Workshop convened. The UNICEF project involves government departments and UNICEF offices in six South Asian countries (Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka). The 50 participants in the mid-term review also included a team from Afghanistan.

According to ROSA Project Officer Dale Davis, the purpose of the review was to assess progress, identify successes, and learn from experiences to address ongoing challenges. The provision and utilization of EmOC was reviewed within the project framework of rights, management, and technology, and results were shared. The country teams agreed to:

- Strengthen commitment to EmOC as a national health priority;
- A shared vision for quality 24-hour EmOC within and among countries;
- More effective management through whole site facilitation and coaching using appreciative inquiry and breakthrough task management;
- Teamwork based on result-based planning and action to deliver quality EmOC in facilities; and
- Supportive participation of community



Photo by Czikus Carriere



Photo by Czikus Carriere

stakeholders in EmOC.

The mid-term review highlighted the need to consolidate the project's in-country practices and processes for replication in new facilities. The ROSA teams also met after the AMDD Workshop to review the knowledge they had gained and to share ideas for the year ahead. The discussions covered, among other things, planning and initiating competency-based training for EmOC teams (obstetricians, anesthetists, and midwives) to respond to the shortage of appropriately skilled medical personnel in peripheral facilities; developing in-country core facilitators to strengthen and expand hospital facilitation processes; and using criterion-based reviews to improve quality of care. The meeting concluded with a commitment to create a movement for saving women's lives and to have a regional Women's Right to Life and Health Day to keep the momentum going.

The UNFPA teams met prior to the Bangkok Workshop to discuss the status of their country projects, explained Dr. France Donnay, Acting Chief of the Reproductive Health Branch in the Technical Support Division in New York. This was followed up by individual team meetings during the course of the workshop. Representatives from UNFPA regional offices in Kathmandu and Bangkok were able to attend the UNFPA meeting, which provided "a great opportunity to share information regarding the UNFPA/AMDD projects in some depth."

Since some UNFPA projects had started later than UNICEF projects, Dr. Donnay invited Dr. Yasmin Ali Haque, Health Project Officer of UNICEF Bangladesh, to participate in the discussions in order to share the

objectives and agenda of the UNICEF meeting in Bangkok.

UNFPA intends to hold several meetings in the upcoming year to move the projects forward. The first such meeting is planned for October 2002 in Mozambique, which will bring together staff involved in AMDD programs. This will be followed by a policy meeting for senior management in New York to increase knowledge about AMDD within UNFPA.

Overall, the side meetings for the UNFPA team were "very exciting and useful" according to Dr. Donnay. By the time of the next AMDD Workshop, the UNFPA team looks forward to sharing more on their experience using the Process Indicators.

CARE held a two-day meeting after the Bangkok Workshop, which brought together CARE staff and government counterparts from Peru, Ethiopia, Rwanda, Tanzania, and Tajikistan. According to CARE Reproductive Health Director Susan Rae Ross, the main issues discussed were:

- A review of their experience using the UN indicators;
- Upcoming activities and technical assistance needs;
- The importance of looking at expenditures and determining implementation needs;
- How to prepare for the mid-term review; and
- Strategies to secure further funding for projects to improve EmOC.

**Women's Groups** As part of its human rights initiative, AMDD is working with women's rights activists affiliated with women's groups in several countries in Asia, Africa, and Latin America. Lynn Freedman, Associate Professor at Columbia University and Martha de la Fuente, Associate Research Scientist, are the AMDD staff members responsible for the

*Continued on next page*

## "Working Together to Implement Human Rights"

The Bangkok Workshop provided an invaluable opportunity for participants and experts to work out what it means to move from the theory of human rights to actual practice while implementing EmOC projects. This is one of the three areas in the AMDD framework: technical, management, and human rights. Six sessions were held on human rights in the facility, the community, and in government policy. AMDD Graduate Research Assistant **Sarah Blust** spoke to Lynn Freedman, Associate Professor at Columbia University, about the human rights workshop sessions.

Some of the issues highlighted at the workshop had not been previously considered as human rights issues. For example, the sessions on human rights in the facility used role plays to bring out the many dimensions of human rights implicated in patient-provider relationships: participants had to enact situations – two ideal, and two not – involving a pregnant woman and a midwife (in one group, participants switched genders, with a man acting the part of the pregnant woman). Lynn Freedman notes that, "Human rights in the facility begins with an acknowledgement that providers are living in a complicated environment. It also involves recognition of how neglected the provider's interests can be, particularly those providers at the ground level."

The sessions on human rights and the community proved to be an important learning opportunity drawing from the incredible experience of the participants. Freedman recalled that "participants were able to move from discussing broadly stated principles to grappling with specific fact-based problems from a human rights perspective." The specific issue of accountability is difficult to realize. For example, just because there is a community member present does not mean that there is accountability or that the system will automatically function better. Whether or not the participation of the community representative is real and actually responds to community interests is key to the process. "This session illustrated how challenging it is to find ways to bring about constructive accountability and move beyond a blame and punishment system".

In the sessions on human rights and policy, participants discussed issues such as the interests of the stakeholders, power dynamics in policy change, and the types of coalitions that could influence policy. They also discussed why certain policies came into being even when there was not much real evidence to support them. Many policies were simply transplanted from other countries. Participants broke into small groups and worked through a series of questions about how to provide EmOC services on "Saturn", a fictitious country where there is a large population with few anesthesiologists, but many midwives who have been trained to provide anesthesia services successfully. Participants were also urged to view human rights not only as a question of high quality services for individual patients, but also as a structural issue for which population coverage is key. Within this perspective, if government policies prevent whole categories of health professionals from being trained and licensed to provide good quality services, and patients are thereby unable to receive these services, this then implicates a violation of human rights.

Program's human rights aspects (see Box on page 5). Together, they facilitated a meeting of the Women's Groups in Bangkok to follow up on discussions held in July 2001. Among other things, they discussed and approved proposals from Ecuador and the Philippines.

In Ecuador, the NGO SENDAS is setting up a project in Cuenca this year that will build an alliance with the Health Council of Cuenca, women's organizations, the City Council, and the Sexual and Reproductive Health Network to implement the existing law which guarantees women's right to free maternal care. SENDAS will also upgrade two existing Basic EmOC facilities, introducing new registers to capture information on obstetric complications so as to facilitate monthly monitoring using the Process Indicators. If successful, the Health Council is likely to replicate this project in other facilities in the county health system. In order to ensure good quality care and the observance of women's rights, two citizens groups will monitor the EmOC services provided.

Likhaan, a women's health NGO in the Philippines, presented a very detailed project that aims to address the need for upgraded EmOC facilities, creating an environment that responds to women's needs. It will be developed in Malabon, located in the 'inner core' of two very large cities, Manila and Caloocan, covering a population of 339,000. The first 10 months of the project will consist of research to identify the economic and social barriers to EmOC access that women encounter, and to describe how these barriers relate to actual obstetric complications. The research results will shape the next steps both in terms of community mobilization and local and national policy advocacy activities.

**Senior Health Providers** Dr. Allan Rosenfield, an obstetrician and Dean of the Mailman School of Public Health at Columbia University and AMDD Program Co-Principal Investigator, took the opportunity of the Bangkok Workshop to convene a meeting of senior health providers.

According to Dr. Rosenfield, "We had a great deal of discussion about the challenges of 24-hour coverage seven days a week. The group was very supportive of the dramatic presentation given by the Minister of Health of Mozambique, Dr. Francisco Songane, an obstetrician/gynecologist, on their successful training and use of surgical technicians to provide comprehensive EmOC. There was equal enthusiasm for the talk given by Professor Tipu Sultan, Dean of the Faculty of Anaesthesiology at the College of Physicians and Surgeons in Pakistan, on the use of nurses to provide limited anesthesia services in

### EmOC: Two Stages of Implementation

Once country teams have conducted needs assessments and designed their projects, the global AMDD experience to date shows that there are two main stages in implementation. The 14 topics chosen for Bangkok's 41 working sessions covered both stages.

#### The Preparatory Stage

Preparing the facility renovation, supplies and equipment, facility set-up, and data collection.

Preparing the staff placement, training, and team building.

#### The Service Delivery Stage

Functioning ongoing readiness and 24 hour/7 day EmOC.

Quality onsite quality improvement processes together with external supervision.

Utilization analysis of data in evidence of improvement or otherwise.

AMDD Associate Director for Program Implementation Dr. Zafarullah Gill prepared a table with explanatory notes for each of these areas, which was shared with country teams in Bangkok.

response to the shortage of doctors and anesthetists in certain areas. Clearly, such innovative approaches to the delivery of care will be essential to the goals of AMDD".

### Beyond Bangkok

One of the many initiatives that followed from the networking and discussions at the Bangkok Workshop was a criterion-based review convened by UNFPA/India. The Government of Rajasthan has shown great interest in improving service quality and requested support from UNFPA/India. In March 2002, AMDD Technical Team Members, Dr. Barbara Kwast and Dr. Dileep Mavalankar, held two workshops on Criterion Based Review (CBR) of EmOC services in the districts of Jaipur and Udaipur. Those involved with AMDD project districts, supported by UNFPA and UNICEF, participated in these workshops to gain an understanding about the process and to improve the quality of EmOC services.

Mr. Paramesh Chandra, Principal Secretary of Health, Government of Rajasthan and professors of

obstetrics and gynecology also requested that the AMDD team organize CBR workshops for the faculty members of medical colleges in order to start using the CBR process in their hospitals and teach the process to post-graduate students. Considering the enthusiastic response of the participants, the next steps would include identifying two or three institutions, from the UNFPA-AMDD supported project districts, to initiate the CBR process.

In another spinoff, the Director of the Regional Prevention of Maternal Mortality Program (RPMM) Angela Kamara, invited Lynn Freedman to speak about human rights at the RPMM regional meeting convened in the Ivory Coast in April.

Overall, the Bangkok Workshop provided a rich and multi-faceted experience focused on making quality EmOC available and used. As AMDD Program Director and Co-Principal Investigator Deborah Maine

reflected, "It was exciting to see people from different continents and agencies come together again, and to feel the momentum of this worldwide network. It is truly a privilege to be able to bring people together in this manner."

Many other participants shared the sense of excitement.

As Suzanne Cluett, Associate Director of the Bill and Melinda Gates Foundation, put it, "Dr. Gordon W. Perkin and I were most favorably impressed with the AMDD workshop in Bangkok. It was wonderful for us to see, hear and meet with the individuals from nearly fifty countries who are working on the front lines to make life-saving emergency



Photo by Czikus Carriere

obstetric care available to women in their communities and in their countries. The level of commitment and passion of these representatives was very exciting and gratifying to observe." ■

## What You Said About Bangkok

Highlights of the participant evaluation forms, collated by AMDD Graduate Research Assistant **Jessica Guerrero**, include:

In all, 218 people representing 43 countries participated in the workshop.

- According to the end-of-workshop evaluation, participants saw the event as a great success. Of the 131 participants who responded to the survey question, "Overall how would you rate the workshop?", 77% rated the experience as very good or excellent. Similarly, 89% of respondents rated the organization and logistics of the meeting as very good or excellent.
- Apart from the sessions, many participants said "sharing experiences and meeting people" were most useful. The opportunity to learn from fellow professionals' experiences proved to be one of the participants' favorite aspects of the meeting.
- When responding to the question about the least useful aspects of the workshop: 17 out of 53 respondents felt that the time allotted for the meeting was too short.
- Fifty-five percent of participants reported that the content covered in the workshop sessions was what they found most helpful about the workshop itself. And 97% of respondents indicated that they would use the skills and knowledge acquired at the workshop once they returned to their home country.
- The workshop sessions that people noted as most beneficial were those on human rights, data collection and utilization, and the plenary sessions.
- Respondents suggested that next year the focus should be on creative solutions to problems by using examples.

*We thank you for your comments, and your responses will be taken into account in preparing for the AMDD workshop in 2003.*

## AWARDS

### Three Midwives Receive ICM/AMDD Award

The first Averting Maternal Death and Disability awards were presented to midwives from Malawi, Vietnam, and Trinidad and Tobago, at the 26th Triennial Congress for Midwives held in April, 2002 in Vienna, Austria. The AMDD Program established the award this year in collaboration with the International Confederation of Midwives (ICM) to recognize and honor exceptional efforts made to improve women's access to high-quality emergency obstetric care (EmOC).

Dr. Barbara Kwast, AMDD Senior Advisor, presented the 2002 awards at the opening ceremony to Martha Bokosi of Malawi, Phan Thi Hanh of Vietnam, and Venus Mark of Trinidad and Tobago.

These awards provide a \$5,000 grant to be used to support the activities of the midwives' association, to enable leadership and advocacy training, or other activities that would strengthen the effectiveness of

midwives' associations. There are also funds for a reception and lecture in the recipient's home country, held to celebrate the awarding of the grant and to draw attention to the work of the recipient.

The award winners intend to use their grants for activities that include: working with NGOs to leverage resources for EmOC; fostering teamwork among midwives, especially in rural areas; and organizing workshops on professional/clinical skills building and leadership.

As Dr. Kwast declared during the ceremony, "The purpose of these awards is to recognize the role of midwives not only as providers of supportive care to women in labor, but also as providers of life-saving midwifery services to save maternal lives."



L-R: Venus Mark of Trinidad and Tobago, Phan Thi Hanh of Vietnam, and Martha Bokosi of Malawi

## RESOURCES

### AMDD EmOC Tools & Resources Update

AMDD Staff Member **Rachel Waxman** compiled a list of new resources. Many of the presentations and resources from the Workshop in Bangkok are now available on <http://www.amdd.hs.columbia.edu/> These include: PowerPoint presentations for the plenary and panel sessions, presentations used in many of the workgroup sessions, the workshop report, and the "EmOC Challenge" game from the closing session. You can also find the *AMDD Program Orientation: A Tool for Self-Learning* PowerPoint presentation in English, French, and Spanish. It is a useful tool for orienting new staff and counterparts to the AMDD program approach (created by N. Hijab and C. Carriere, February, 2002).

#### New publications and resources:

"Program note: Using UN Process Indicators to assess needs in emergency obstetric services." P.E. Bailey and A. Paxton. *International Journal of Gynaecology and Obstetrics*, Vol. 76, Issue 3, March 2002.

"Editor's comment: Using the UN Process Indicators to assess needs in emergency obstetric services." J.A. Fortney. *International Journal of Gynaecology and Obstetrics*, Vol. 76, Issue 3, March 2002.

*Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors* (IMPAC) published by the World Health Organization (2000) is now available on ReproLine [www.reproline.jhu.edu/](http://www.reproline.jhu.edu/)

Previously shared in draft form are the *Emergency Obstetric Care: Leadership Manual for Improving the Quality of Services* and the companion *Toolbook for Improving the Quality of Services*, produced jointly by AMDD and EngenderHealth. They can be found on the website and will be finalized this summer. We welcome any comments and feedback.

AVERTING MATERNAL DEATH AND DISABILITY (AMDD)

HEILBRUNN DEPT. OF POPULATION AND FAMILY HEALTH, MAILMAN SCHOOL OF PUBLIC HEALTH, COLUMBIA UNIVERSITY

60 HAVEN AVENUE, B-3, NEW YORK, NY 10032

FAX: (212) 544-1933 WEBSITE: [HTTP://WWW.AMDD.HS.COLUMBIA.EDU](http://www.amdd.hs.columbia.edu)