

Beyond the Numbers

Reviewing maternal deaths and complications to make pregnancy safer



World Health Organization, Geneva, 2004

WHO Library Cataloguing-in-Publication Data

World Health Organization.

Beyond the numbers : reviewing maternal deaths and complications to make pregnancy safer.

1. Maternal mortality 2. Pregnancy complications 3. Cause of death 4. Quality of health care 5. Data collection - methods 6. Qualitative research. 7. Guidelines
I. Title.

ISBN 92 4 159183 8

(NLM classification: WA 900)

© World Health Organization, 2004

All rights reserved. Publications of the World Health Organization can be obtained from Marketing and Dissemination, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel: +41 22 791 2476; fax: +41 22 791 4857; email: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to Publications, at the above address (fax: +41 22 791 4806; email: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

The World Health Organization does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.

Printed in

Table of Contents

Preface	1
What is this guide about?	1
Who is this guide for?	2
What is the structure of this guide?	2
How to use this guide	3
1. Introduction	5
1.1 Background	5
1.2 The purpose of this document	6
1.3 Why mothers die: a new approach	7
1.4 The importance of “telling the story”	7
1.5 Learning lessons is a prerequisite for action	8
2. The approaches	11
2.1 Introduction	11
2.2 Deciding which approach to use	11
2.3 Advantages and disadvantages of different approaches	13
2.4 Principles for adaptation	14
3. Practical issues in implementing the approaches	19
3.1 Introduction	19
3.2 General information requirements	20
3.3 The surveillance cycle	21
3.4 Deciding which approach to adopt	21
Community-based surveys	22
Facility-based surveys	22
Regional/nationwide approaches	23
3.5 Definitions of maternal death	23
3.6 Identifying maternal deaths	26
Vital records	26
Patient records	29
Community identification	29
Disease surveillance systems	30
3.7 Planning and implementing the approach	30
Key principles for data collection	31
Selecting and training data collectors, interviewers and assessors	31

3.8	Analysing results	33
	Quantitative analysis	33
	Qualitative analysis	34
3.9	Translating findings into action	35
	What sort of recommendations should be made?	35
3.10	Disseminating findings and recommendations	36
	Who to inform of the results	37
	Methods that can be used	38
3.11	Evaluation	38
3.12	Ensuring confidentiality and the legal and ethical framework	39
	Legal considerations	40
	Ethical considerations	41
3.13	Sources of further information	42
4.	Verbal autopsies: learning from reviewing deaths in the community	43
4.1	What is a verbal autopsy for maternal deaths?	43
4.2	The purpose of verbal autopsies	45
4.3	The advantages and disadvantages of verbal autopsies	46
4.4	Step-by-step process for carrying out verbal autopsies for maternal deaths	48
4.5	Variants of the verbal autopsy	54
5.	Facility-based maternal deaths review: learning from deaths occurring in health facilities	57
5.1	What is a facility-based maternal deaths review?	57
	The levels at which a review may take place	58
5.2	The history of maternal death reviews	60
5.3	The advantages and disadvantages of a facility-based maternal deaths review	61
5.4	Step-by-step process for undertaking a maternal deaths review	63
6.	Confidential enquiries into maternal deaths	77
6.1	Lessons from the first fifty years of the United Kingdom confidential enquiries into maternal deaths	78
6.2	What is a confidential enquiry into maternal deaths?	82
	Characteristics of a confidential enquiry into maternal deaths	82
6.3	The advantages and disadvantages of a confidential enquiry into maternal deaths	84

6.4	Key principles	86
	The importance of national and local ownership	86
	Time scales	86
	Identifying maternal deaths: the advantages of health care worker reporting	87
	The use of death certificates	88
6.5	Translating findings into action	88
6.6	Step-by-step process for setting up a confidential enquiry	89
7.	Reviewing severe maternal morbidity: learning from survivors of life-threatening complications	103
7.1	Explanation of the terminology used in this chapter	105
	Pregnancy as a continuum between good and poor health	105
	Definition of a near miss	106
	What is a near-miss review?	107
7.2	The advantages and disadvantages of near-miss reviews or other studies of severe morbidity	107
7.3	Key principles	110
	Reviews must be developed and conducted within the local health care context	110
	All participants in the review must understand, agree and adopt the local context specific definitions	111
7.4	Step-by-step process for undertaking a near-miss review	111
7.5	Variants of investigating severe maternal morbidity	116
8.	Clinical audit learning from systematic case reviews assessed against explicit criteria	125
8.1	The clinical audit cycle	126
8.2	Key principles	127
	Topic selection	127
	Explicit criteria	127
	Targets	128
	Time scale	129
	Where it may be applied	129
	Representativeness of findings	129
8.3	The purpose of clinical audit	129
	The feasibility of conducting clinical audit in developing countries	130
8.4	The advantages and disadvantages of clinical audit	131
8.5	Step-by-step process for conducting clinical audit at a health facility	131
8.6	Other sources of information	137

Acknowledgements

The impetus for this document arose during a series of inter-regional meetings on monitoring maternal mortality organised by WHO Headquarters and Regional Offices during 1998 and 1999. At these meetings, participants stressed that measuring the levels of maternal mortality was not enough and called for methods and approaches that would help elucidate the underlying causes of maternal deaths and identify what could be done to avert them. *Beyond the numbers* is a response to such calls.

Many talented and committed individuals have contributed to *Beyond the numbers*. Authors of specific approaches, named in each relevant chapter, are Cynthia Berg, Colin Bullough, Jean-François Etard, Veronique Filippi, Wendy Graham, Gwyneth Lewis, Carine Ronsmans and Gijs Walraven.

In addition, WHO is grateful to the following for sharing their experiences which are reflected in this document, Marie-Hélène Bouvier-Colle, Ruy Laurenti, Candy Longmire, Eddie Mhlanga and Glen Mola.

WHO staff contributing to the document were Carla AbouZahr, Luc de Bernis, Richard Guidotti, Paul Van Look and Jelka Zupan.

Finally, particular thanks to Gwyneth Lewis who took on the onerous task of final consolidation and editing.

Foreword

Pregnancy is a normal, healthy state which most women aspire to at some point in their lives. Yet this normal, life-affirming process carries with it serious risks of death and disability. The statement that worldwide, over half a million young women die every year as a result of complications arising from pregnancy and childbirth has been repeated so often that it no longer shocks. Yet most of these deaths could be avoided if preventive measures were taken and adequate care available. For every woman who dies, many more suffer from serious conditions that can affect them for the rest of their lives.

The international health and development community has repeatedly called for action to address this problem and governments have formally committed themselves to doing so, notably at the *International Conference on Population and Development* (Cairo 1994) and the *Fourth World Conference on Women* (Beijing 1995) as well as their respective five-year follow up conferences, and more recently in the *Millennium Declaration* in 2000. Improvement of maternal health is enshrined in the Millennium Development Goals as one of the essential prerequisites for development and for poverty reduction.

Maternal mortality offers a litmus test of the status of women, their access to health care, and the adequacy of the health care system in responding to their needs. However, it is difficult to measure, particularly where civil registration of deaths and of causes of deaths is weak. Different approaches have been developed for measuring maternal mortality in such circumstances but they are of limited use for regular, short-term monitoring.

Furthermore, the information that countries need to address maternal mortality goes beyond just measuring the level of the problem. Policy-makers ask "Why do maternal deaths occur and what can be done to prevent them?" Programme managers ask "Where are things going wrong and what can be done to rectify them?" Answering these questions is as important as knowing the precise level of maternal mortality. *Beyond the numbers* proposes ways of finding the answers to such questions and offers diagnostic tools that shed light on what needs to be done to prevent maternal deaths. We hope that all those working in the area of maternal health will find this document useful.

Joy Phumaphi
Assistant Director-General
Family and Community Health

预览已结束，完整报告链接和二维码如下：

https://www.yunbaogao.cn/report/index/report?reportId=5_30090

