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Reproductive Health Matters 2007;15(30):145–152
0968-8080/06 $ – see front matter
PII: S0968-8080(07)30334-0

www.rhmjournal.org.uk

The Introduction of Confidential Enquiries into Maternal Deaths and Near-Miss Case Reviews in the WHO European Region

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Abstract: *Most maternal deaths can be averted with known, effective interventions but countries require information about which women are dying and why, and what can been done to prevent such deaths in future. This paper describes the introduction of two approaches to reviewing maternal deaths and severe obstetric complications in 12 countries in transition in the WHO European Region – national-level confidential enquiries into maternal deaths and facility-based near-miss case reviews. Initially, two regional meetings involving stakeholders from 12 countries were held in 2004–2005, followed by national meetings in seven of the countries. The Republic of Moldova was the first to pilot the review process, preceded by a technical workshop to make detailed plans, provide training in how to facilitate and carry out a review, finalise clinical guidelines against which the findings of the confidential enquiry and near-miss case review could be judged, and a range of other preparatory work. To date, near-miss case reviews have been carried out in the three main referral hospitals in Moldova, and a national committee appointed by the Ministry of Health to conduct the confidential enquiry has met twice. Several other countries have begun a similar process, but progress may remain slow due to continuing fears of punitive actions against health professionals who have a mother or baby die in their care.* ©2007 Reproductive Health Matters. All rights reserved.

Keywords: maternal mortality, near-miss case review, confidential enquiry into maternal deaths, Republic of Moldova, Eastern Europe

OVER 80% of maternal and newborn deaths can be averted with basic and effective low-cost interventions, even in resource-limited settings.[1–4] The World Health Organization (WHO) Safe Motherhood Initiative was launched in 1987 and WHO's Making Pregnancy Safer initiative in 2000, based on the concept that most clinical interventions to prevent the major causes of maternal and newborn death are already known and can be implemented in all settings within a continuum of skilled care during pregnancy and childbirth, adequate preparation within the household, the early detection and appropriate management of complications and the provision of quality maternal and neonatal health services, accessible to all women in their local communities. Making Pregnancy Safer promotes the commitment of governments and partner agencies to safe motherhood,

to making technical support available and ensuring that mother and child health is a priority in both national policies and budgets, and the use of national, evidence-based guidelines.[5]

As the Making Pregnancy Safer initiative gained momentum, it became clear that to act effectively to prevent maternal deaths, countries required more information than maternal mortality ratios or death certificate data, as neither of these on their own give enough information about which women are dying or why they died, or what can been done to prevent such deaths in future.[6–8]

As a result, WHO published the manual *Beyond the Numbers: Reviewing Maternal Deaths and Complications for Making Pregnancy Safer*[9] in 2004, which outlines five approaches to identifying the barriers to optimal maternity care (Table 1). The philosophy of these approaches is simple: maternal deaths can be avoided even in resource-poor settings. However, this requires the right kind of information on which effective interventions can be based and a better understanding of all the factors that led to the deaths. The types of review proposed in *Beyond the Numbers* provide evidence of where the main problems lie and what can be done to address them in practical terms.

In countries where most women die in the community, the verbal autopsy approach provides most information. In countries with very high numbers of deaths in hospitals and few resources, facility-based reviews are an excellent first step. For countries with a low number of deaths, an organised health care system and established professional associations, confidential enquiries may yield the best results, often boosted by the additional information that can be gained from near-miss reviews. Clinical audit is most suitable in facilities or situations where evidence-based clinical guidelines already exist, so that the care women received can be measured against them.

Regional and national workshops organised by WHO Regional Office for Europe

The WHO European Region is comprised of 53 Member States, which differ widely in political and socio-economic status as well as in national health system organisation and health outcomes. It contains both some of the richest countries in the world, with high development profiles and very low maternal and neonatal mortality, and some of the poorest. The average maternal mortality ratio for the whole of the European Region, including both eastern and western countries, is 19 maternal deaths per 100,000 live births.[2] However, this ranges from nil in Iceland and 4 in Austria to

Table 1. Methodologies for maternal death and near-miss reviews in *Beyond the Numbers*

Approach	Definition
Community-based maternal death review (verbal autopsy)	A method of finding out the causes of death and the personal, family and community factors that may have contributed to the deaths of women who died outside of a medical facility.
Facility-based maternal death review	A qualitative, in-depth investigation of the causes of and circumstances surrounding maternal deaths occurring at health facilities, including the combination of factors at the facility and in the community that contributed to the death, and if they were avoidable.
Confidential enquiry into maternal deaths	A systematic, multi-disciplinary, anonymous investigation of all or a representative sample of maternal deaths in a local area, state/province or nationally. It identifies the number of deaths, causes and associated avoidable or remediable factors.
Surveys of severe morbidity (near-misses)	The identification and assessment of cases in which pregnant women survive obstetric complications. There is no universally applicable definition for near-misses; the definition used should be appropriate to local circumstances.
Clinical audit	A systematic review of aspects of the structure, processes and outcomes of care assessed against a set of explicit criteria and recommendations for the subsequent implementation of change, whether at individual, team or ward/facility level.

110 in Kyrgyzstan and 210 in Kazakhstan. Similarly, the average neonatal mortality rate is 11 per 1,000 live births, but ranges from 3 in Iceland and Finland to 35 in Turkmenistan, 36 in Azerbaijan and 38 in Tajikistan, while the perinatal mortality rate, ranges from 4 in the Czech Republic and 5 in Sweden to 62 per 1,000 live births in Tajikistan.[10]

Beyond the Numbers was launched internationally by WHO at a workshop in Nairobi in 2004. Following this, the WHO Regional Office for Europe developed a framework to provide technical support and guidance to member countries for the implementation of this tool. To date, this has consisted of: 1) two five-day regional-level workshops, in 2004 and 2005, in which representatives selected by Ministries of Health from 12 countries,* as well as UNFPA, UNICEF, USAID and others, were represented and the rationale for reviewing maternal and perinatal deaths was presented; and 2) seven four-day country workshops in 2005–2006 to disseminate knowledge of the five approaches, help countries to decide which approaches were suitable for them and develop a national action plan. Two technical workshops were then organised for the Republic of Moldova in 2005 and Uzbekistan in 2007, and two more are planned for Kyrgyzstan and Tajikistan by the end of 2007.

During the regional workshops[11,12] the attending country representatives were encouraged to present the national status of maternal and child health, and their current maternal health programme, its successes and problems. The benefits and drawbacks of the five approaches for reviewing maternal deaths were set out by WHO experts. Each country team then met separately to choose which methodologies they would implement, discuss issues to be addressed and devise a practical workplan. All of the countries initially chose to hold a confidential enquiry into maternal deaths and a near-miss case review.

The use of best practices and evidence-based guidelines were also discussed. Problematic issues were raised, such as the legal framework and the status of women in each country, the punitive actions that were being taken against health care providers who had a mother or baby die in their care, and how best to ensure confidentiality and commitment to making pregnancy safer from all health professionals.

The WHO facilitators agreed to continue to work with individual countries as they developed their plans further, and each country asked for a follow-up meeting to exchange information and to learn from each other's successes and failures. For many, the workshop was a turning point for adopting new points of view; for some, it was also an emotional journey as they listened to the many individual stories the participants shared of recent deaths of women.

The seven country workshops to date have been in the Republic of Armenia, Republic of Moldova, Uzbekistan, Kyrgyzstan, Tajikistan, Romania and Kazakhstan.[13,14] They included a broad representation of national stakeholders from the Ministry of Health, Department for National Statistics, leading academic institutions, professional associations of obstetricians, midwives, neonatologists, family practitioners, anaesthesiologists, social workers and psychologists, women's groups and district representatives. UN agencies, non-governmental organisations and donors involved in maternal and newborn health care projects were also present.

Participants were introduced to the principles behind *Beyond the Numbers*, the benefits and disadvantages of each of the five approaches and how

KAREN ROBINSON / PANOS PICTURES

Village health centre, Tajikistan, 2004

*Kazakhstan, Kyrgyzstan, Republic of Moldova, Tajikistan and Uzbekistan were represented in 2004, and Albania, Armenia, Former Republic of Macedonia, Romania, Russian Federation, Turkey and Turkmenistan were represented in 2005.

and why their delegation at the regional workshop had chosen confidential enquiries and near-miss case reviews. The example of the United Kingdom was given; the UK has been conducting confidential enquiries into maternal deaths for 50 years now, and these have had a significant impact on maternal and neonatal survival.[15,16] Near-miss reviews were described as a useful adjunct to confidential enquires.[17,18]

Each country workshop involved intensive group work to enable participants to develop detailed plans for the implementation of their chosen methodologies. This included defining national and local case ascertainment systems, methods for assessment and review, key roles and responsibilities, data collection forms and how to develop and disseminate recommendations. It is not always easy to identify a maternal death, so each country identified which deaths they wished to include in the confidential enquiry and how these would be reported, as well as drafting a working definition of the criteria for including a case of severe morbidity in the near-miss case review. Participants learned the main principles of undertaking face-to-face interviews of women who had survived obstetric complications and the staff who had cared for them, and drafted plans for implementing these reviews at facility level. Once these plans had been approved by the Ministry of Health and key stakeholders, a pilot process was then agreed.

The Republic of Moldova: the first country to launch the review process

Technical workshop

The Republic of Moldova was the first WHO European Region country to pilot *Beyond the Numbers* in 2003, before its publication. The preparatory work was undertaken by a national working group nominated by the Ministry of Health, which chose to introduce near-miss case reviews at hospital level and a confidential enquiry into maternal deaths at national level. Their decision was validated during the subsequent national workshop, previously described. The need for a technical workshop became obvious during the national workshop, when participants acknowledged that much more preparatory work needed to be done before implementation could be started. The technical workshop took place at national and subnational level, as well as training for future facilitators.[14] The near-miss case review session brought together Ministry of Health officials and teams from three referral-level institutions: the Mother and Child Health Care Research Institute, the Chisinău Municipal Perinatal Centre and the Bălţi Perinatal Centre, to which most complicated cases are referred, and which had been selected as pilot sites. Facility teams were represented by the head of each institution, an obstetrician-gynaecologist, a midwife and a social worker or psychologist.

The definition of near-miss cases needed to be refined and finalised, the WHO guidelines for conducting and recording near-miss meetings needed to be adapted locally, and clinical standards of care for the management of near-miss cases – obstetric haemorrhage, sepsis, severe pre-eclampsia/eclampsia and uterine rupture were refined and agreed upon, and audit meeting guideline forms were reviewed. To have best-practice standards of care against which to discuss near-miss cases was considered very important by the national working group. The concept of evidence-based management of complications is not obvious in the country context, and even though capacity-building over the previous year through WHO-supported activities took place, not every provider had internalised the concepts and changed their practice accordingly. It was therefore thought that making the standards explicit during the meeting would facilitate structured and evidence-based case reviews. Retrospectively, that was considered a very good decision as it prevented a number of near-miss case review meetings from becoming just the sum of different opinions.

Mock near-miss reviews were carried out for each of the three facilities, to test these instruments and build staff capacity to conduct and facilitate review meetings and interview women. The session concluded with the preparation of a time-frame for the remaining steps before implementation, including the official institutionalisation of the review, each participant's roles and responsibilities, mechanisms for accountability within the existing health care system and a detailed budget for the pilot phase in each facility, including hidden costs.

The confidential enquiry into material deaths required a session of its own during the technical workshop, with its own target audience. This session brought together leading professionals and stakeholders as well as the heads of local

(*rayon*) Maternal and Child Health Departments who, in line with the recommendation of the first national workshop, became the local coordinators responsible for obtaining the data for the enquiry. The first objective of the session was to reinforce national and local ownership of the confidential enquiry and a firm commitment from the Ministry of Health, national and local health care planners, professional organisations, facilities and individual health professionals. Secondly, the future local coordinators were introduced to the principles of the confidential enquiry and the differences to the current system in Moldova of case reviews of maternal deaths. Confidential enquiries seek to improve care by reviewing cases confidentially, and even anonymously, in order to improve quality of care and – crucially – avoid blaming individual health professionals and punishing them. The meeting also provided an opportunity for the local coordinators to comment on the proposed national mechanisms for case ascertainment, anonymisation and the collation and publication of findings and recommendations. The participants provided feedback on the new Maternal Death Report Form and discussed the constraints they anticipated on qualitative data collection and how to overcome them.

Implementation of near-miss case reviews

Implementation of both methodologies was planned to start in October 2005. Local audit teams were set up, and roles and responsibilities assigned. Pilot near-miss reviews took place from October 2005 to May 2006 in the three participating institutions. The Mother and Child Health Care Research Institute carried out six audit meetings and discussed six cases, four of severe pre-eclampsia and two of obstetric haemorrhage. The Chisinău Municipal Perinatal Centre held five audit meetings and discussed nine cases: seven cases of severe pre-eclampsia and one each of sepsis and obstetric haemorrhage. The Bălţi Perinatal Centre carried out six audit meetings and discussed six cases: four of obstetric haemorrhage and one each of severe pre-eclampsia and chorio-amnionitis. Two facilitators were present at each meeting to support the audit teams if required. Their role was as active observers, intervening only when something appeared to be missed or was going wrong. Each meeting was documented in the summary audit meeting form, a locally adapted WHO tool.

These pilot experiences showed that the presence of a senior manager from the hospital at near-miss sessions was crucial for the effective implementation of remedial solutions, but should not interfere with the full participation and involvement of other staff members or the free expression of opinion. It was also found to be necessary to develop a standard, structured framework and form of documentation for near-miss case reviews, in order to improve the efficiency, usefulness and timeliness of discussions.

A weak point identified during the reviews concerned the need for greater skills among the social workers and psychologists who conducted the interviews with women. Because these professionals had a medical background, the interviews often seemed to be more about taking a medical history than getting the woman's perspective on the quality of care she received. It was concluded that further training for the interviewers was required, and that these interviews should be conducted, as far as possible, outside the medical facility.

It was also recognised that a number of recommendations from the audit meetings, including action needed for improvements, had been formulated in vague terms and were therefore difficult to monitor. It was recommended that when formulating these in future, more specific action needed to be proposed.

It was concluded that before scaling-up the near-miss reviews to other maternity hospitals at national level, the pilot teams in the three institutions should become more confident in using the methodology. They decided that another six months of piloting would provide valuable additional experience and confidence, and that a further in-depth review should be carried out at the end of that period to identify other crucial lessons requiring action before national expansion. Since January 2007, a near-miss case review meeting has been conducted every five weeks in each pilot facility, and WHO Regional Office for Europe support is still being provided.

The Republic of Moldova's experience of carrying out near-miss case reviews is starting to be known in other countries in the region. In June 2007 a study tour to the Republic of Moldova of representatives of the Ministries of Health of Tajikistan and Turkmenistan was undertaken, to learn about reproductive health service organisation. Two days were dedicated to the sharing of

experience on near-miss case reviews. The delegations had the opportunity to observe two near-miss review meetings, in the Municipal Perinatal Centre and the Balti Perinatal Centre, and highly appreciated the insights these gave.

Implementation of the confidential enquiry into maternal deaths

To date, two meetings of the Confidential Enquiry National Committee have taken place in which maternal deaths have been reviewed. While it is too early to evaluate the impact, the first report is due out in 2009 and has already started to contribute to positive changes. As a result of one of the meetings, for example, it was acknowledged that there was an urgent need for a national clinical guideline on the management of post-partum haemorrhage, which was developed soon after the meeting. In two cases, the final cause of death was changed as a result of the confidential enquiry, and some changes were made in the way the meetings were run compared to what had been traditional practice in the country.

The Republic of Moldova, as the pilot country for the Making Pregnancy Safer programme in the European Region, received intensive technical support from WHO Regional Office for Europe. Experts from the Republic of Moldova are now able to share their experiences and lessons learnt within the Region and act as additional facilitators as other countries start this process.

Discussion

The introduction of maternal death reviews in countries in transition in the European Region did not start from scratch just in the past few years. Most of the countries in the former USSR have historically carried out some form of maternal audit at national level. All of the countries who attended the regional workshops have well-defined systems of maternal death case reviews. While this may initially seem to facilitate the introduction of the approaches in *Beyond the Numbers*, it has in fact acted as a disincentive because the traditional system includes features that conflict with the guiding principles of *Beyond the Numbers*. For instance, the traditional systems were mostly top-down and aimed at pointing out "mistakes" and publicly identifying the "guilty" professionals, so that administrative and punitive measures could be taken. This culture of blame and punishment does not nurture or support the principles of confidentiality and "no name, no blame" called for in all the *Beyond the Numbers* approaches.

One of the most pressing challenges in every former USSR country is the compulsory involvement of the judiciary in any case of maternal death. These historic systems were based on apportioning blame rather than learning lessons from cases. Such a system is not conducive to open and frank reporting, and instead has led to suspicion and fear. A large part of all the workshops at both regional and country level was devoted to developing confidential and anonymous mechanisms for case reporting which were reassuring and encouraged participants to learn lessons whose aim was to save women's lives. Experience to date has shown that initial mistrust of a radical change of approach can be overcome by the piloting of the new systems of review alongside the existing structures until the differences become self-evident. Whilst not ideal, this pragmatic approach is enabling the introduction of robust maternal death audits and near miss-reviews in countries which still have punitive legislation.

Other challenges were the historical lack of involvement of midwifery and community representatives, and little or no attention being given to factors related to women themselves, their families or their communities, or organisational problems such as delays in communication or transport. A further problem was the lack of understanding of the value of evidence-based clinical guidelines, which should be part of routine practice and in use systematically throughout the region.

Sustainability was identified as an issue that needed to be addressed from the outset. Medium- to long-term support, both technical and financial, as well as professional recognition, will be needed to support the implementation of any *Beyond the Numbers* methodology as well as using the results to carry out changes and further refine the review process.

It was evident to the international experts involved that all concerned were aware of the need for change that would set health workers free to consider cases and learn lessons instead of spending valuable time covering up details of serious cases they have been involved in and "cleaning" records and reports for fear of being punished.

Since the regional workshops, there has been a difference in the speed with which countries have made progress towards the introduction of maternal death reviews. In the Republic of Moldova, it was possible to implement the process of maternal death reviews within seven months of the technical workshop, due to the endorsement of the Ministry of Health and enabling regulations. Other countries have made slower progress. Among the most important factors in these countries is a continuing concern about legal protection for health care professionals who provide information about maternal deaths, delays in enacting enabling legislation and in finalising clinical guidelines. Further, the concept of honesty in reviewing deaths has required a much more basic level of understanding, discussion and debate. In addition, limited funds have restricted the ongoing technical support that can be provided by WHO Regional Office for Europe. However, the regional and national meetings and the progress thus far in the Republic of Moldova have demonstrated that what is needed is a change of mind-set rather than significant financial investment. Punitive action following a death creates a lack of openness and sometimes frank cover-ups. Although health services in countries in transition in the European Region have the resources and health workers to be able to implement evidence-based best practices, until there is a belief that it is necessary to learn and disseminate the lessons from maternal deaths in order to help save women's and infants' lives in future, actual changes in practice could remain slow.

Acknowledgements

The authors would like to thank Dr Maria Tarus, Head of the Maternal and Child Health Department; Professor Valentin Friptu, Head Specialist of Obstetrics and Gynaecology; and Professor Petru Stratulat, Head Neonatologist, all from the Ministry of Health, Moldova, for their valuable support and inputs.

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Résumé

La plupart des décès maternels peuvent être évités par des interventions connues et efficaces, mais les pays ont besoin de renseignements sur les femmes qui meurent, sur les raisons de ces décès et sur les mesures susceptibles de les éviter à l'avenir. L'article décrit l'introduction de deux méthodes d'étude, des décès maternels et des complications obstétricales graves, dans 12 pays en transition de la région d'Europe de l'OMS – des enquêtes confidentielles au niveau national sur les décès maternels et des études des « échappées belles » (*near-miss*) au niveau des établissements. Initialement, deux réunions régionales de responsables de 12 pays ont été organisées en 2004–2005, suivies de réunions nationales dans sept des pays. La Moldova a été la première à piloter le processus d'examen, avec un atelier technique préalable pour définir des plans détaillés, former à l'animation et la réalisation d'une étude, rédiger les directives cliniques pour juger les conclusions des enquêtes confidentielles et des études des échappées belles, et divers autres travaux préparatoires. À ce jour, les trois hôpitaux centraux moldaves ont mené une étude des échappées belles et le comité national nommé par le Ministère de la santé pour réaliser l'enquête confidentielle s'est réuni à deux reprises. Plusieurs autres pays ont entamé un processus semblable, mais les progrès demeurent lents en raison des craintes de sanctions à l'encontre des professionnels ayant perdu une patiente ou un nouveau-né.

Resumen

La mayoría de las muertes maternas pueden evitarse con intervenciones eficaces conocidas, pero se exige información sobre las mujeres que mueren y las causas, y lo que se puede hacer para evitar tales muertes en el futuro. En este artículo se describen dos estrategias para revisar las muertes maternas y complicaciones obstétricas graves en 12 países en transición en la Región Europea de la OMS: investigaciones confidenciales de muertes maternas a nivel nacional y revisión de casos que casi conducen a la muerte, en los establecimientos. Inicialmente, en 2004 y 2005, se celebraron dos reuniones regionales con partes interesadas provenientes de 12 países, seguidas por reuniones nacionales en siete de los países. Realizado en la República de Moldavia, el primer piloto del proceso de revisión fue precedido por un taller técnico para formular planes detallados, proporcionar capacitación sobre cómo facilitar y realizar una revisión, finalizar las directrices clínicas para juzgar los resultados de las investigaciones confidenciales y revisión de casos que casi conducen a la muerte, así como varias otras tareas preparatorias. Hasta la fecha, la revisión de casos se ha llevado a cabo en los tres principales hospitales de referencia de Moldavia, y el comité nacional, nombrado por el Ministerio de Salud para realizar las investigaciones confidenciales, se ha reunido dos veces. En varios países más se ha iniciado un proceso similar, pero los avances llevan tiempo debido a los continuos temores a medidas punitivas contra los profesionales de la salud que pierden a una madre o a un bebé bajo su cuidado.