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Mortality after near-miss obstetric complications in Burkina Faso: medical, social and health-care factors

Katerini T Storeng, Seydou Drabo, Rasmané Ganaba, Johanne Sundby, Clara Calvert & Véronique Filippid

Objective To investigate mortality in women in Burkina Faso in the 4 years following a life-threatening near-miss obstetric complication and to identify the medical, social and health-care-related causes of death.

Methods In total, 1,014 women were recruited after hospital discharge and followed for up to 4 years: 337 had near-miss complications and 677 had uncomplicated pregnancies. Significant differences in mortality between the groups were assessed using Fisher’s exact test. The medical causes of death were identified from medical records and verbal autopsy data; social and health-care-related factors associated with death were identified from interviews with the deceased women’s relatives.

Findings In the 4 years, 15 (5.3%) women died in the near-miss group and 5 (0.9%) died after uncomplicated pregnancies ($P < 0.001$). More than half the deaths after a near miss, but none after an uncomplicated delivery, were pregnancy-related. Indirect factors contributed to many of these deaths, particularly human immunodeficiency virus infection. Relatives’ accounts suggested that the high cost and poor quality of health care, a lack of follow-up care and an unmet need for contraception contributed to the excess mortality in the near-miss group.

Conclusion Women in Burkina Faso who initially survived a near-miss obstetric complication had an increased risk of all-cause and pregnancy-related death in the ensuing 4 years. The likelihood of survival over the longer term could be increased by offering a continuum of care that addresses the indirect and social causes of death and supplements the emergency intrapartum obstetric care provided by current safe motherhood programmes.

Introduction

International discussions about maternal health in low-income countries tend to focus on maternal deaths. However, there is increasing concern that these deaths are only the tip of the iceberg in terms of the health effects of the poor availability and quality of maternity services. In addition, countries with high maternal mortality also have a large burden of pregnancy-related complications and associated disabilities. It is estimated that “for every woman who dies from a pregnancy-related cause, about 20 more – roughly 7 million women yearly – experience injury, infection, disease or disability”. Of growing interest are “near-miss” obstetric complications – complications so severe that they would probably have killed the woman had she not received timely medical care.

In low-income countries, near misses are often considered obstetric successes because ultimately the woman’s life was saved by a focused medical intervention. However, little is known about long-term outcomes following these complications. Recent studies document a substantial degree of physical and psychological morbidity in their aftermath and the high cost of emergency obstetric care has serious social and economic consequences. Although women’s lives are known to remain at risk for several months beyond the 42-day cut-off used in standard definitions of maternal death, few studies have examined survival beyond this period in women who experience severe obstetric complications.

To what extent does surviving a near-miss obstetric complication mean that a maternal death has actually been averted? Our aim was to investigate maternal mortality in the 4 years after hospital discharge following a near-miss complication in Burkina Faso. We used data from a longitudinal, mixed-methods, cohort study to describe patterns of mortality and analysed the medical, social and health-care-related causes of death after near-miss complications. Finally, we considered the implications of our study findings for strategies that promote safe motherhood.

Methods

Study setting

Burkina Faso is an impoverished country in western Africa that is ranked 177th out of 182 countries in terms of human development; 81% of the population live on less than 2 United States dollars a day. The country’s scores on reproductive health indicators are among the worst in the world. The fertility rate is 6.2 children per woman. According to the most recent national census, the maternal mortality ratio is 307 per 100,000 live births, and the World Health Organization’s estimate is 560 per 100,000 live births. Burkina Faso’s district health system functions poorly and existing safe motherhood programmes do not address the availability of comprehensive obstetric care. Only 73.2% of births are assisted by a skilled birth attendant – a figure that hides significant regional and socioeconomic disparities. User fees for maternal health care, especially emergency care, are often unaffordable. In 2007, the health ministry introduced an 80% subsidy for facility-based delivery to reduce out-of-pocket expenditure, but its effect is still unclear.

Abstracts in Arabic, Français, Русский and Español at the end of each article.
Data collection

We followed a cohort of 1014 women for 4 years after they were discharged from seven hospitals across Burkina Faso between November 2004 and March 2005. Women were recruited at hospital discharge to avoid exposure misclassification.21 Of the 1014 women in the cohort, 337 had experienced a near-miss obstetric complication: the pregnancy ended in a live birth in 199 cases, in a perinatal death in 74 and in a miscarriage, ectopic pregnancy or abortion in 64. For each woman who had a near miss, we recruited an average of two unmatched controls from the seven hospitals. Usually the next two women to have an uncomplicated live delivery, as confirmed by medical notes, were selected, though some hospitals recruited more controls than others. The total number of controls was 677.

Trained lay interviewers made six follow-up visits: on day three after discharge, at 3 months, 6 months and 12 months, and in the third and fourth years after the end of the pregnancy. We investigated whether any woman not found for the interview had moved away or died. Interviews explored women’s health, reproductive history, socioeconomic status, experience of health care, and health-care costs. Medical information was extracted from routine hospital records at discharge and from reports of medical examinations conducted 6 and 12 months later. In parallel, anthropologists carried out a detailed follow-up of a subsample of 82 women: 64 had near misses and 18 had uncomplicated deliveries. Findings from the first year of follow-up have been reported elsewhere.8,11,12

We used the verbal autopsy method to make detailed enquiries about any woman who died. This approach determines the cause of death by asking lay respondents about the signs exhibited and the symptoms experienced by the deceased and is used when data from routine information systems are incomplete.26 Generally, respondents were the woman’s husband, relatives who had participated closely in the woman’s care and, when possible, health workers. A physician conducted verbal autopsies at the end of the first year, and the anthropologist conducted interviews at the end of follow-up. Additionally, an open-ended in-depth interview or social autopsy23,26 was carried out to identify any social or health-care-related factors that could have contributed to the death.

Data analysis

The proportion of women who survived at each follow-up visit was calculated for women who experienced near misses and for those who had uncomplicated deliveries. We used Fisher’s exact test to determine whether the post-discharge mortality rate differed significantly between the two groups. We compared the marital status, age and parity at baseline of women who survived and who died within 4 years of follow-up in both the group of women who had uncomplicated deliveries and in the group that had near misses. We used the chi squared test to assess the association between baseline characteristics and death.

The most likely medical cause of death was assigned independently and agreed on by two clinical researchers on the basis of data from the verbal autopsy combined with additional information from medical records and reports of medical examinations (Table 1, available at: http://www.who.int/bulletin/volumes/90/6/11-094011). Comorbid conditions that may have contributed to the death were taken into account. In addition, we assessed records of the in-depth interviews thematically to derive non-medical causes of death.21 This analysis was guided by our knowledge of the social circumstances of women in Burkina Faso and the health systems they use, gained over the course of the study.11,12 Moreover, two of the deceased women belonged to the anthropologists’ subsample and had participated in several interviews before their deaths.

Ethical approval

The study was approved by the ethics committees of the London School of Hygiene and Tropical Medicine, United Kingdom of Great Britain and Northern Ireland, and the Ministry of Health of Burkina Faso. Study participants gave their free and informed consent.

Results

Mortality

Fig. 1 shows the number of participants included at each stage of the study. Of the 1014 women recruited, 695 attended the final interview at the end of the 4-year follow-up and 20 had died. Post-discharge mortality was significantly higher among women who had a near-miss obstetric complication than among controls who had uncomplicated deliveries (P < 0.001).

Fig. 2 shows the proportion of women who survived at each follow-up visit. Six (1.9%) women in the near-miss group died within 1 year, and none died in the control group. The corresponding figures at the end of the 4-year follow-up period were 15 (5.3%) and 5 (0.9%) in the two groups, respectively.

No significant difference was found in age (P = 0.47) or parity at baseline (P = 0.42) between women in the near-miss group who died and those who survived and completed follow-up. However, women who died were more likely to be single at baseline (P = 0.001; Table 2). We could draw no such comparisons in the control group because of the small number of deaths.

Medical causes of death

Verbal autopsy data were available for 18 of the 20 deaths (Table 1). The relatives of the remaining two women could not be located.

In the near-miss group, 9 of the 15 deaths (60%) were pregnancy-related, compared with none in the control group (Table 1). Moreover, six of these nine pregnancy-related deaths occurred within 1 year of the near-miss obstetric complication or the end of the pregnancy. The most likely medical causes of these six deaths were: organ failure following septic abortion in one woman with a human immunodeficiency virus (HIV) infection; tuberculosis related to HIV infection in one woman with puerperal sepsis; anaemia with possible sepsis or immunity problems in one woman; probable anaemia in one; infection in one; and hypertension (i.e. eclampsia) in one. The remaining three pregnancy-related deaths in the near-miss group occurred within 42 days of a subsequent pregnancy: one was due to hypertension, one to septic abortion and one to haemorrhage following caesarean section suture complications. At least three of the nine women who died from a pregnancy-related cause were HIV-positive. The causes of the remaining six deaths in the near-miss group were: HIV infection in one, hypertension in one, possible infection related to tuberculosis in one, a suspected traffic accident in one and unknown due to insufficient data in two.

Of the five deaths in the control group, one was caused by malaria and three by acquired immunodeficiency syndrome (AIDS); the cause of one death remained undetermined due to insufficient data. The contribution of
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HIV infection and tuberculosis to deaths in the two groups is notable.

By the end of follow-up, three of the seven babies born to women who had a near-miss complication and who subsequently died had also died. One of the babies died a few days before his mother, at the age of 28 days. This baby was probably born with intrauterine growth retardation. The other two died after their mothers: one from malnutrition at 5 months and one from an unknown cause at 15 months. No deaths occurred among the five babies born to women in the control group who subsequently died. These babies were older at the time of their mothers’ deaths and therefore less vulnerable.

Health-care-related and social causes of deaths

Relatives of the women who died within a year of a near-miss complication believed the women had been discharged prematurely. Correspondingly, 17% of these women had not fully recovered when discharged, according to medical records. Some left hospital because they could no longer afford to pay for care or to remain absent from their regular activities. Inadequate follow-up of unresolved health problems may have compounded the burden of premature discharge, as in the case of a 25-year-old woman who died of sepsis 7 months after an unsafe abortion (Box 1). As a whole, respondents noted that poor links between different parts of the health-care system (e.g. between a district hospital and a national hospital) delayed or prevented access to care.

Similarly, relatives of the three women in the near-miss group who died of pregnancy-related causes after a subsequent pregnancy identified a range of health-care-related contributing factors. None of these women received specific follow-up during antenatal care despite having had a near-miss complication in a recent pregnancy. The reason may be that in Burkina Faso no midwife and certainly no specialist normally participates in antenatal care, which is often delivered in a ritualistic way without addressing chronic ailments or risk factors. An unmet need for contraception, which is costly and poorly available, contributed to one of the maternal deaths because it led to an unwanted pregnancy. According to this woman’s husband, the new pregnancy exacerbated the hypertension that resulted in the near miss less than 2 years earlier (Box 2). Both relatives and health-
Table 2. Maternal mortality in the four years after pregnancy, by pregnancy outcome, age, parity and marital status, Burkina Faso, 2004–2009

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Uncomplicated pregnancy</th>
<th>Pregnancy outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women alive at 4 years$^b$</td>
<td>Women deceased at 4 years</td>
</tr>
<tr>
<td>Age (years)</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>&lt; 20</td>
<td>90</td>
<td>18.7</td>
</tr>
<tr>
<td>20–24</td>
<td>135</td>
<td>28.1</td>
</tr>
<tr>
<td>25–29</td>
<td>117</td>
<td>24.3</td>
</tr>
<tr>
<td>≥ 30</td>
<td>139</td>
<td>28.9</td>
</tr>
<tr>
<td>Parity</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>0</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>1–3</td>
<td>344</td>
<td>71.4</td>
</tr>
<tr>
<td>4+</td>
<td>138</td>
<td>28.6</td>
</tr>
<tr>
<td>Marital status</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Married or in a relationship</td>
<td>446</td>
<td>92.5</td>
</tr>
<tr>
<td>Single</td>
<td>36</td>
<td>7.5</td>
</tr>
</tbody>
</table>

NA, not applicable.

$^a$ A near-miss complication is a severe obstetric complication that would probably kill the woman without timely medical care.

$^b$ Data were missing on age for two women, on parity for two and on marital status for one.

$^c$ Data were missing on age for two women, on parity for one and on marital status for two.

$^d$ $P$-values were calculated using the chi squared test, where possible, for differences between women who died and those who were alive and completed follow-up.

Due to the small number of deaths among women with an uncomplicated delivery, it was not possible to calculate a $P$-value for the difference in age or marital status between women who died and those who survived.

$^e$ Data were missing on age for three women, on parity for two and on marital status for two.

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Box 1. Example of a late pregnancy-related death after a near-miss complication,$^a$
Burkina Faso, 2005

The 25-year-old woman$^a$ moved from a rural village to a town to work in a bar. She became pregnant while in a relationship with a visiting bureaucrat. Her partner revealed he was married with children, pressured her to terminate the pregnancy and paid for an illegal abortion. She was hospitalized with a near-miss septic abortion after intense stomachaches resulting from the botched abortion, underwent manual vacuum aspiration for the incomplete abortion and was treated for infection before discharge. She suffered stigmatization, lost her income and job and became disillusioned. An unresolved abortion-related infection left untreated due to the cost of care resulted in another hospitalization 6 months after discharge. The woman’s brothers paid for her hospitalization for more than 1 month but were unable to afford prescribed referral to a tertiary hospital in a major city 170 km away. The woman died at her brothers’ home 7 months after the septic abortion.

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$^a$ A near-miss complication is a severe obstetric complication that would probably kill the woman without timely medical care.

$^b$ Woman 4 in Table 1 (available at: http://www.who.int/bulletin/volumes/90/6/11-094011).

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Discussion

Our findings show that the limited availability and poor quality of maternal health-care services can lead not only to immediate death or longer-term disability or illness in women who experience a near miss from severe pregnancy complications, but also to an increased risk of death as long as 4 years after the event. Although targeted emergency care initially saved many women who experienced obstetric complications, those who had a near miss were significantly more likely to die within the
next 4 years than those who had an uncomplicated hospital delivery. Notably, these women had a higher risk of dying from a pregnancy-related cause, whether associated with the initial near miss or with the complications of a subsequent pregnancy. Single women were at a particularly high risk, perhaps because of poor material and social support. In addition, an infant born to a woman who had a near miss and subsequently died was also at an increased risk of death. The risk was higher both after the mother’s death and before, as the mother may have been too sick or poor to produce breast milk or to properly care for her infant. By contrast, no women with an uncomplicated delivery died from a pregnancy-related cause, and the babies of those who did die survived. Although we lack survival data on women lost to follow-up, we observed that those who had a near miss were more often lost to follow-up than those who did not. Consequently, unrecorded deaths were more likely among these women than among controls.

The verbal autopsy approach used in this study has well-known limitations, including recall bias, since data are sometimes collected months or years after a death. The validity and reliability of lay respondents’ reports of medical symptoms can also be problematic; their descriptions can be vague and non-medical and can point to a diagnosis that differs from the physician’s. Moreover, respondents cannot provide information on signs that are not detectable without laboratory testing or clinical autopsy. Although verbal autopsies cannot unequivocally identify the immediate cause of death or exclude competing causes, they can indicate the most likely contributing factors. In the absence of death registries, verbal autopsies provide the best means of identifying the likely medical cause of death.

Women clearly remain at risk of a pregnancy-related death for longer than the 42 days used in standard definitions of maternal death. Consequently, the contribution of pregnancy-related deaths to mortality among women of reproductive age is likely to be underestimated. Indeed, extending the definition to include all deaths within 3 months of delivery increases current estimates of maternal mortality in low-income settings by 10% to 15%. Incorporating late maternal deaths within 1 year of the end of pregnancy would further increase the figure.

Current assessment methods may underrepresent indirect causes of maternal death, which could be aggravated by pregnancy. Our study showed that co-morbid conditions, such as HIV/AIDS, and diseases of poverty, such as anaemia, contributed to late pregnancy-related deaths after a near miss. Except for direct obstetric complications, HIV infection was the most important contributor to pregnancy-related deaths in our study. This finding supports recent analyses that highlight the contribution of HIV infection to high maternal mortality rates in Africa.

Our analysis of the structural constraints that limited access to health care and reduced the quality of the care received by women in our study helped us to understand the broader circumstances leading to their deaths. The relatives of women who died highlighted various possible contributing factors: premature hospital discharge; poor postpartum follow-up; inadequately treated underlying conditions; unmet need for contraception; lack of appropriate antenatal care, and inadequate emergency obstetric care in subsequent pregnancies. Although firm general conclusions about the health-care system cannot be drawn without supporting data from health-care providers and other stakeholders, studies from Burkina Faso and other high-mortality countries support our informants’ reports that poor service supply and demand act as barriers to maternal health care, both during and after pregnancy.

**Policy implications**

Because most maternal and neonatal deaths occur around the time of delivery, the maternal health strategy throughout the world has long emphasized intrapartum care. This includes skilled birth attendance for all women and emergency obstetric care to prevent maternal death from direct causes such as haemorrhage, obstructed labour, hypertension, infection and anaemia. However, although good intrapartum care can ensure safe delivery, it does not suffice to prevent death in the aftermath of severe complications, sometimes over the long term.

Our study findings on the indirect causes of maternal death, the weaknesses in the health-care system and the social and structural barriers to health care suggest the need for a more comprehensive, life-cycle approach to women’s health. The solution may be longer and more differentiated clinical management, including family planning. Moreover, we also found that underlying chronic health problems increase the risk of maternal death. The solution may be integrated health care, with integration across the entire reproductive cycle (i.e. family planning, pregnancy and delivery care, and postpartum care) and across different vertical treatment programmes, and with integration of specialist and generalist care.

It has become evident in recent years that a well-functioning health-care system and the provision of a continuum of care are essential for achieving the United Nations Millennium Development Goals pertaining to health. For instance, international policy-makers postulate a continuum of care for maternal, neonatal and child health that

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**Box 2. Example of a maternal death from a new pregnancy after a near-miss complication, Burkina Faso, 2006–8**

The 23-year-old Muslim woman divorced after the death of her first child and was betrothed to a subsistence farmer, a relative, as his second wife. She experienced a stillbirth after a near-miss delivery involving eclampsia; the resulting health-care expenditure was “catastrophic” for the household. She had difficulty participating in household activities due to chronic ill health related to hypertension that started in pregnancy. The support of her partner and his co-wife enabled the woman to be temporarily absent from subsistence agricultural work and domestic chores. She took medication only on alternate weeks due to its cost. She wanted to delay a new pregnancy, but was unable to acquire appropriate contraception because it was costly and unavailable at the local health centre. She had a new pregnancy within 1 year of the near-miss complication. The new pregnancy was difficult because of hypertension and she had a hospital delivery. She became ill in the postpartum period and died while asleep 28 days after delivery, most likely from hypertensive disease. The baby died shortly afterwards. Her husband was financially ‘ruined’ by the health-care expenditure, which was exacerbated by new responsibilities for the widow and three children of a brother who had died.

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A near-miss complication is a severe obstetric complication that would probably kill the woman without timely medical care.

Woman 8 in Table 1 (available at: http://www.who.int/bulletin/volumes/90/6/11-094001).
involves integrating health care for these different groups across time and place.8 Such a continuum would include postpartum care as a priority and provide links between reproductive and sexual health-care services and maternal health care. In addition, ways of simultaneously addressing the social and economic determinants of health are receiving increasing attention.9

Despite these policy changes and the greater priority afforded to maternal health both internationally and nationally, achieving a comprehensive continuum of care remains challenging. For example, few health-care services address the specific needs of women in the year following childbirth.7 More often, safe motherhood programmes in low-income countries, including Burkina Faso, are implemented vertically and focus almost exclusively on emergency intrapartum obstetric care that targets the direct causes of maternal mortality. These programmes are insufficient for tackling excess mortality over the longer term. Survival in this period requires the introduction of a comprehensive continuum of care that addresses the indirect and social causes of death.

Mortality after obstetric near misses in Burkina Faso

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Objective: The objective of this study is to estimate the number of obstetric near misses in Burkina Faso and determine the number of women dying after obstetric near misses.

Methods: Using a near-miss obstetric surveillance system, we identified 1,907 near misses between 2002 and 2009 from 12 maternity facilities in Burkina Faso. A cohort of all near-miss complications and matched control women who had births in the same facilities were followed-up for 4 years. The fifth year was included to capture deaths occurring up to 18 months after discharge from the hospital. Deaths that were obstetric near misses were identified through active recall of the near-miss obstetric surveillance system and passive mortality surveillance. Deaths that were not obstetric near misses were identified through passive mortality surveillance.

Results: Mortality up to 4 years after obstetric near misses was 39/1,907 (2.0%) women, 10.2% higher than mortality after matched normal births. Of these deaths, 20.5% were due to obstetric near misses. Kaplan-Meier analysis showed a hazard ratio of 2.20 (95% CI 1.58 to 3.05). There were no statistically significant differences in age, region, and education of women dying after obstetric near misses compared with matched control women. There was a statistically significant difference in obstetric risk factors between women dying after obstetric near misses and matched control women. Women dying after obstetric near misses were younger than 30 years old, had lower obstetric risk factors, and had a lower proportion of women who delivered by cesarean section.

Conclusion: The mortality up to 4 years after obstetric near misses was 2.0% higher than that of matched normal births. The findings of this study provide new evidence for the need to improve access to comprehensive maternal health care following obstetric near misses to reduce maternal mortality.

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Competing interests: None declared.
Resumen

Mortalidad suite aux complicaciones obstétricales évitées de justesse au Burkina Faso: facteurs médicaux, sociaux et sanitaires

**Objetif** Explorar la mortalidad entre las mujeres del Burkina Faso durante los 4 años siguientes a una complicación obstétrica fatale de justesse (“near-miss”) y identificar los factores médicos, sociales y sanitarios del fallecimiento.

**Métodos** Au total, 1 014 mujeres ont été recrutées après la sortie de l'hôpital et suivies durant 4 ans: 337 ont vécu des “near-miss” et 677 ont eu des grossesses sans complications. Des différences significatives de mortalité entre les groupes ont été identifiées en utilisant le test exact de Fisher. Les causes médicales du décès ont été identifiées à partir des dossiers médicaux et des données verbales d’autopsie; les facteurs sociaux et de soins de santé liés au décès ont été constatés à partir d’entretiens avec les proches des femmes décédées.

**Résultats** Durant les 4 années, 15 (5,3%) femmes sont mortes dans le groupe “near-miss” et 5 (0,9%) sont décédées après des grossesses sans complication ($P<0,001$). Plus de la moitié des décès après un “near-miss”, mais aucun après un accouchement sans complications, étaient liées à une grossesse. Des facteurs indirects ont contribué à bon nombre de ces décès, en particulier les infections par le HIV. Les comptes rendus des proches font supposer que le coût élevé et la mauvaise qualité des soins de santé, un manque de suivi des soins et un besoin non satisfaite de contraception ont contribué à la mortalité augmentée dans le groupe “near-miss”.

**Conclusion** Les femmes au Burkina Faso qui ont initialement survécu à une complication obstétricale évitée de justesse présentaient un risque accru de décès pour toute cause ou lié à la grossesse les 4 années suivantes. La probabilité de survie sur le long terme pourrait être augmentée en offrant un continuum de soins qui s’attaque aux causes indirectes et sociales des décès et complémente les soins obstétricaux d’urgence fournis par les programmes actuels de maternité sans risque.
References


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Table 1. Women who died within four years of the end of a pregnancy, Burkina Faso, 2004–2009

<table>
<thead>
<tr>
<th>Case</th>
<th>Date of end of pregnancy</th>
<th>Woman’s age and no. of pregnancies at study recruitment</th>
<th>Marital status at recruitment</th>
<th>Pregnancy outcome, known medical condition</th>
<th>Time woman reported as lost to follow-up</th>
<th>Time of woman’s death after the end of pregnancy</th>
<th>Medical cause of deatha</th>
<th>Status of index child at last interview</th>
<th>No. of pregnancies since index pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>26 January 2005</td>
<td>23 years, first pregnancy</td>
<td>Single</td>
<td>Near-miss complication, live birth, hypertension</td>
<td>Year 4 interview</td>
<td>2 years and 5 months</td>
<td>Hypertension, possible hypertensive stroke unrelated to pregnancy</td>
<td>Alive</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>27 January 2005</td>
<td>25 years, first pregnancy</td>
<td>Married</td>
<td>Near-miss complication, live birth, infections</td>
<td>Year 3 interview</td>
<td>Unknown, 1–3 years</td>
<td>Unknown</td>
<td>Unknown</td>
<td>Unknown</td>
</tr>
<tr>
<td>3</td>
<td>13 March 2005</td>
<td>26 years, third pregnancy</td>
<td>Single</td>
<td>Near-miss complication, early pregnancy loss, haemorrhage, infections</td>
<td>Year 3 interview</td>
<td>2 years and 5 months</td>
<td>Possible traffic accident</td>
<td>NA</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>Around 9 February 2005</td>
<td>25 years, third pregnancy</td>
<td>Single</td>
<td>Near-miss complication, early pregnancy loss, sepsis, HIV+</td>
<td>Month 12 interview</td>
<td>7 months</td>
<td>Septic abortion with general infection complicated by organ failure, HIV infection (late pregnancy-related death)</td>
<td>NA</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>17 March 2005</td>
<td>30 years, fourth pregnancy</td>
<td>Married</td>
<td>Near-miss complication, live birth, dystocia</td>
<td>Year 3 interview</td>
<td>1 year and 2 months</td>
<td>Unknown</td>
<td>Alive</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>26 March 2005</td>
<td>34 years, eighth pregnancy</td>
<td>Single</td>
<td>Near-miss complication, live birth, infections, HIV+</td>
<td>Month 3 interview</td>
<td>35 days</td>
<td>Tuberculosis, HIV infection (late pregnancy-related death)</td>
<td>Dead at 28 days, possible intrauterine growth retardation</td>
<td>0</td>
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<tr>
<td>7</td>
<td>30 December 2004</td>
<td>30 years, first pregnancy</td>
<td>Single</td>
<td>Near-miss complication, perinatal death, infections</td>
<td>Year 3 interview</td>
<td>2 years and 12 months</td>
<td>Sepsis, organ failure, HIV/AIDS</td>
<td>NA</td>
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<tr>
<td>8</td>
<td>26 January 2005</td>
<td>23 years, second pregnancy</td>
<td>Cohabiting (polygamy)</td>
<td>Near-miss complication, perinatal death, hypertension</td>
<td>Year 3 interview</td>
<td>Between 1 and 3 years (the date provided was unlikely)</td>
<td>Essential hypertension, possible HELLP syndrome, maternal death in new pregnancy (possibly pregnancy-related)</td>
<td>NA</td>
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<tr>
<td>9</td>
<td>2 March 2005</td>
<td>40 years, sixth pregnancy</td>
<td>Married (polygamy)</td>
<td>Uncomplicated birth</td>
<td>Year 4 interview</td>
<td>Around 4 years</td>
<td>Tuberculosis, HIV/AIDS, organ failure</td>
<td>Alive at year 3 interview</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>25 February 2005</td>
<td>32 years, sixth pregnancy</td>
<td>Married (polygamy)</td>
<td>Near-miss complication, early pregnancy loss, haemorrhage</td>
<td>Year 3 interview</td>
<td>1 year and 6 months</td>
<td>Septic abortion, organ failure, maternal death in new pregnancy</td>
<td>NA</td>
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(continues …)
<table>
<thead>
<tr>
<th>Case</th>
<th>Date of end of pregnancy</th>
<th>Woman's age and no. of pregnancies at study recruitment</th>
<th>Marital status at recruitment</th>
<th>Pregnancy outcome, known medical condition</th>
<th>Time woman reported as lost to follow-up</th>
<th>Time of woman's death after the end of pregnancy</th>
<th>Medical cause of death</th>
<th>Status of index child at last interview</th>
<th>No. of pregnancies since index pregnancy</th>
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<tbody>
<tr>
<td>11</td>
<td>15 March 2005</td>
<td>26 years, eighth pregnancy</td>
<td>Married (polygamy)</td>
<td>Near-miss complication, live birth, anaemia</td>
<td>Month 3 interview</td>
<td>2 months</td>
<td>Anaemia, possible immune problems, possible sepsis, (late pregnancy-related death)</td>
<td>Dead at 5 months</td>
<td>0</td>
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<tr>
<td>12</td>
<td>7 March 2005</td>
<td>30 years, fourth pregnancy</td>
<td>Married (polygamy)</td>
<td>Near-miss complication, early pregnancy loss, haemorrhage, infections, organ failure</td>
<td>Year 3 interview</td>
<td>3 years</td>
<td>Caesarean complication involving haemorrhage, suture failure and subsequent infection, maternal death in new pregnancy</td>
<td>NA</td>
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<tr>
<td>13</td>
<td>23 December 2004</td>
<td>29 years, fourth pregnancy</td>
<td>Married</td>
<td>Uncomplicated birth</td>
<td>Year 4 interview</td>
<td>Between 3 and 4 years</td>
<td>Malaria</td>
<td>Alive at verbal autopsy in 2010</td>
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<tr>
<td>14</td>
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<td>38 years, seventh pregnancy</td>
<td>Married (polygamy)</td>
<td>Near-miss complication, perinatal death, infections</td>
<td>Year 3 interview</td>
<td>2 years and 1 month</td>
<td>Chronic infection possibly related to tuberculosis, sepsis, renal failure</td>
<td>NA</td>
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<tr>
<td>15</td>
<td>10 January 2005</td>
<td>26 years, second pregnancy</td>
<td>Cohabiting (polygamy)</td>
<td>Uncomplicated birth</td>
<td>Year 3 interview</td>
<td>2 years and 4 months</td>
<td>Sepsis with chronic infection or immune dysfunction, possibly related to HIV infection</td>
<td>Alive at verbal autopsy interview</td>
<td>0</td>
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<tr>
<td>16</td>
<td>19 January 2005</td>
<td>17 years, first pregnancy</td>
<td>Single</td>
<td>Near-miss complication, perinatal death, anaemia</td>
<td>Month 6 interview</td>
<td>4 months</td>
<td>Infections (late pregnancy-related death)</td>
<td>NA</td>
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</tr>
<tr>
<td>17</td>
<td>19 February 2005</td>
<td>25 years, second pregnancy</td>
<td>Married</td>
<td>Near-miss complication, live birth, sepsis, HIV+</td>
<td>Month 3 interview</td>
<td>40 days</td>
<td>Possible anaemia (late pregnancy-related death)</td>
<td>Dead at 15 months</td>
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<tr>
<td>18</td>
<td>23 February 2005</td>
<td>29 years, fourth pregnancy</td>
<td>Married</td>
<td>Uncomplicated birth</td>
<td>Year 4 interview</td>
<td>Unknown, 1–3 years</td>
<td>Tuberculosis or possible HIV infection</td>
<td>Alive at year 2 interview</td>
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<tr>
<td>19</td>
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<td>27 years, third pregnancy</td>
<td>Married</td>
<td>Uncomplicated birth</td>
<td>Year 4 interview</td>
<td>3 years and 11 months</td>
<td>Coma, possible eclampsia (late pregnancy-related death)</td>
<td>Alive at verbal autopsy interview</td>
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<td>20</td>
<td>22 February 2005</td>
<td>18 years, first pregnancy</td>
<td>Cohabiting (polygamy)</td>
<td>Near-miss complication, live birth, pre-eclampsia</td>
<td>Month 6 interview</td>
<td>Unknown, within 6 months</td>
<td>Infections (late pregnancy-related death)</td>
<td>Alive at verbal autopsy interview</td>
<td>0</td>
</tr>
</tbody>
</table>

AIDS, acquired immunodeficiency syndrome; HIV, human immunodeficiency virus; NA, not applicable.

*The medical cause of death was determined from verbal autopsy data, medical records and reports of medical examinations.

*A near-miss complication is a severe obstetric complication that would probably have killed the woman had she not received timely medical care.