

Checklist for evaluating a mortality report

(from F. Checchi and L. Roberts, 2005)

Retrospective surveys

- The choice of a recall period is justified by quantitative or anecdotal evidence about past mortality in the population, and by the stated survey objectives.
- A sample size calculation is provided that corresponds with the stated survey objectives.
- The sampling design (simple random, systematic random, cluster) is clearly explained.
- The method for defining, identifying and enrolling households is described.
- A copy of the questionnaire is provided, and authors report that it was field-tested before the start of the study.
- An attempt was made to classify causes of death, at least into the two main categories of 'violent/accidental' and 'medical'.
- The proportion of households replaced during sampling is reported.
- 95% CI are reported alongside each point estimate, and (if a cluster design was used) the design effect is provided, or the authors state that they accounted for design effect in their calculation of 95% CI.
- Potential sources of bias are listed, and their potential effect on the validity of the study is discussed.

Prospective surveillance

- The population size (denominator) used to calculate MR is clearly reported (as well as the date when it was last updated), and the method by which this was estimated (census of households; area mapping; collation of agency data from food and other registrations) is described.
- The division of the population into sectors under the responsibility of each home visitor is clearly shown (ideally a map should be provided).
- The method of mortality data collection is described (frequency of visits to households; method of ascertaining deaths, and prevention of likely biases such as multiple reporting of the same death among neighbors).
- A copy of the questionnaire/data collection tool is provided.

Note: No mortality report should be dismissed simply because the MR findings are 'obviously too low' or 'obviously too high' – at least not before very detailed site assessments have taken place. Certain MRs can, however, justify some degree of suspicion, and should lead to a more detailed evaluation of the work behind such estimates. In particular:

- Any CMR below 0.5 per 10,000 per day (or any U5MR below 1 per 10,000 per day) in the acute phase of a crisis should be viewed as exceptionally low, at least in Sub-Saharan Africa; there may be a problem with under-reporting bias; and
- It is exceptional, at least in Sub-Saharan Africa, for CMR to be higher than U5MR, unless a known cause of mortality, such as armed attacks, disproportionately affects adults.