

Rapid Mortality Surveillance Bangladesh Perspective

Dr. Mohammad Adnan Khan

MBBS, MPH (NIPSOM), M.Phil (NIPSOM), LLB (NU)

MS in Health Informatics (BUHS)

Assistant Chief (Medical)

MIS, DGHS

Ministry of Health & Family Welfare



Introduction

- Reliable cause-specific mortality data constitute a crucial resource for health monitoring, service planning and prioritization.
- However, in the majority of the world's poorest settings, systematic health and vital event surveillance systems are weak or non-existent. As such, deaths are not counted and causes of death remain unregistered for more than two-thirds of the world's population.
- At the end of 2003 data on death registration were available from 115 countries, although they were essentially complete for only 64 countries.

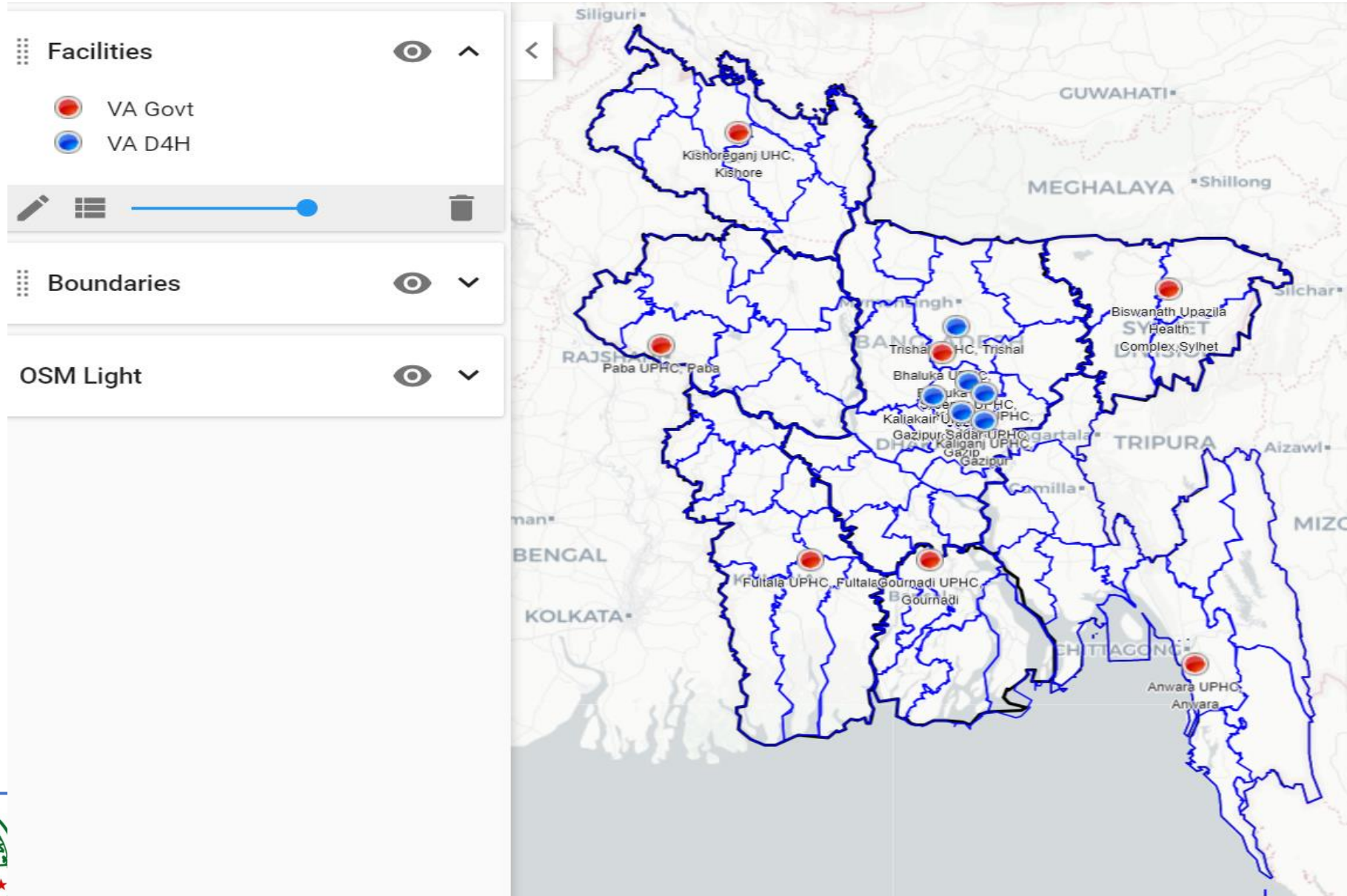


Background - Bangladesh

- Number of Sub districts: 493
- Districts: 64 & Division: 8
- Total Population : 160.5 million
- Population Coverage Under Community RMS: 4 million (.025%)
- Crude Death Rate: 5.1 (National)
- Estimated Facility Death: 15%,
- Community Death: 85%
- 1st COVID-19 case was identified in Bangladesh: March 8, 2020
- Total number of confirmed COVID-19 cases: 4,89,178
- Total number of death: 7,020 (COVID-19 +ve)



RMS sub-district Area in Bangladesh



Rapid Mortality Surveillance

- Community RMS started in 13 sub-districts where Kaliganj model are implemented;
- Health officials of 13 sub districts and 8 districts were trained;
- 650 Health Assistant and 130 supervisors were trained;
- RMS has been started from 10th May 2020 in Bangladesh
- A monitoring team was formed at MIS-DGHS and
- RMS data are monitored and feedback to sub district weekly basis
- Surveillance week starts Sunday ends Saturday



Sources:

- **Community RMS:**

- Historical death registration data of 13 upazilas from BDRIS
- Current death notification data of 13 upazilas by HAs using RMS data collection template

- **Facility RMS:**

- Still RMS data is not integrated with DHIS2.



Data collection format for community RMS

Sl No	Union	Union level restrictions on movement (stay at home, safe distancing etc.)	Ward #	House # or contact of family member If house number not available, please include description of house or contact of someone from the family for death registration follow-up when lockdown ends	Age of deceased	Gender of deceased	Date of death DD/MM/YYYY	Place of Death				Recently tested for Covid-19?			Screening questions / Symptoms (tick if yes)							Suspected Cause of Death	Remarks
								Com.	Hosp.	Yes*	No	Yes (tested +ve)	Yes (tested -ve)	Not tested	High Fever (for at least 3 days)	Extreme Fatigue	Cough	Recent loss of sense of smell or taste	Difficulty breathing	Diarrhea	Live, visit, or care for someone with these symptoms or COVID-19		

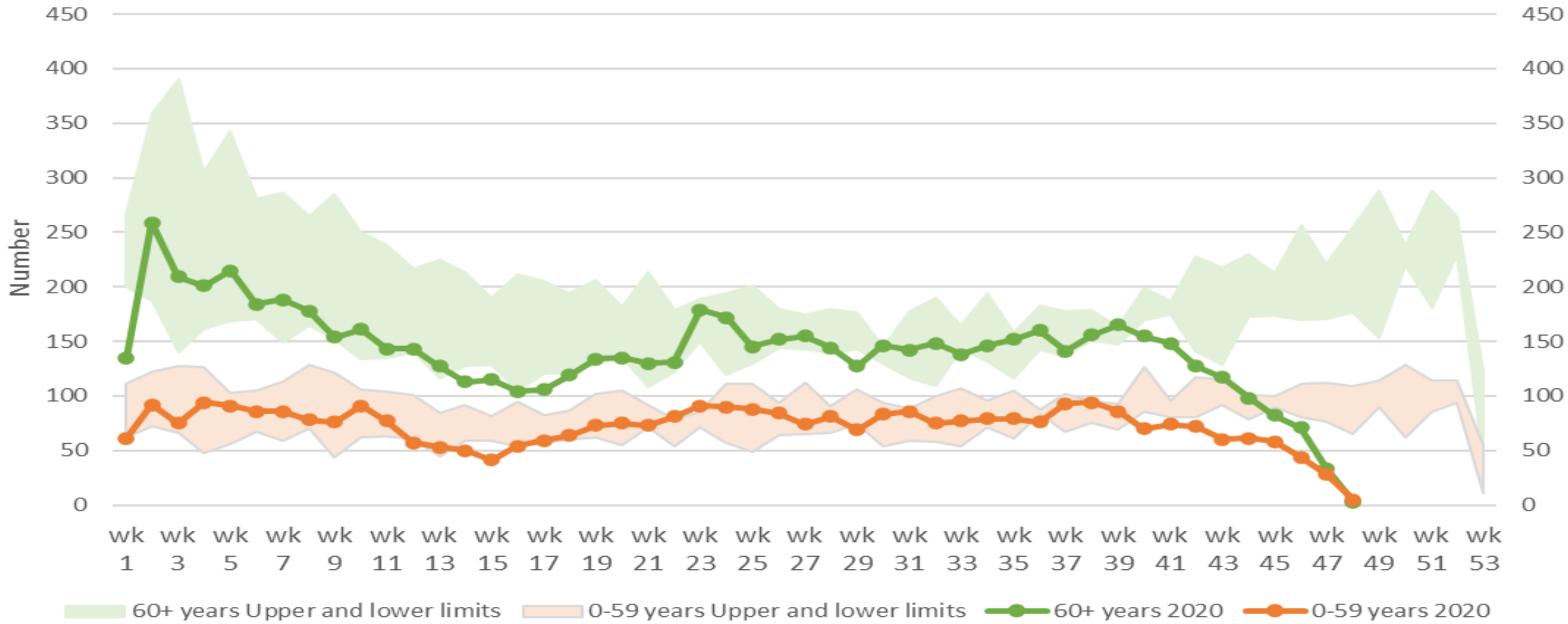


Benefits of RMS in Bangladesh

- Establishment of registration systems for entire populations is unlikely to occur in the short to medium term in Bangladesh.
- In the meantime, sample-based and sentinel population and mortality surveillance can yield sufficiently reliable and relevant information for Bangladesh.
- The data and evidence should be used while efforts continue to be made to improve the evidence base.
- RMS data is used to calculate excess mortality for a population of Bangladesh that has a high level death registration or for facility death.



Bangladesh 2020 deaths in people of 0-59 years and 60+ years by week compared to the upper and lower limits (95% CI) of historical average



COVID-19 Response

- Since the initial outbreak of COVID-19 in Bangladesh earlier this March, Bangladesh is at an economic and social standstill due to the government imposed nation-wide lockdown. Although every sector of the country is facing problems, the health sector is currently among the most affected sectors.
- RMS activities affected by COVID-19 and it is not integrated with DHIS2. Therefore, these data are not being used for policymaking yet.



Challenges

- Country was fully locked down from late March 2020-May 2020
- Domiciliary visit by HA was hampered
- Training done on virtual basis
- Shortage of PPE for field health workers
- Data quality initially was not up to the mark
- Extra burden for field workers



Challenges

- Central monitoring team was involved with COVID-19 surveillance
- Lack of skilled Human Resources.
- Internet connectivity problem.
- Insufficient dedicated human resources.
- Absence of Interoperability.



Thank You

