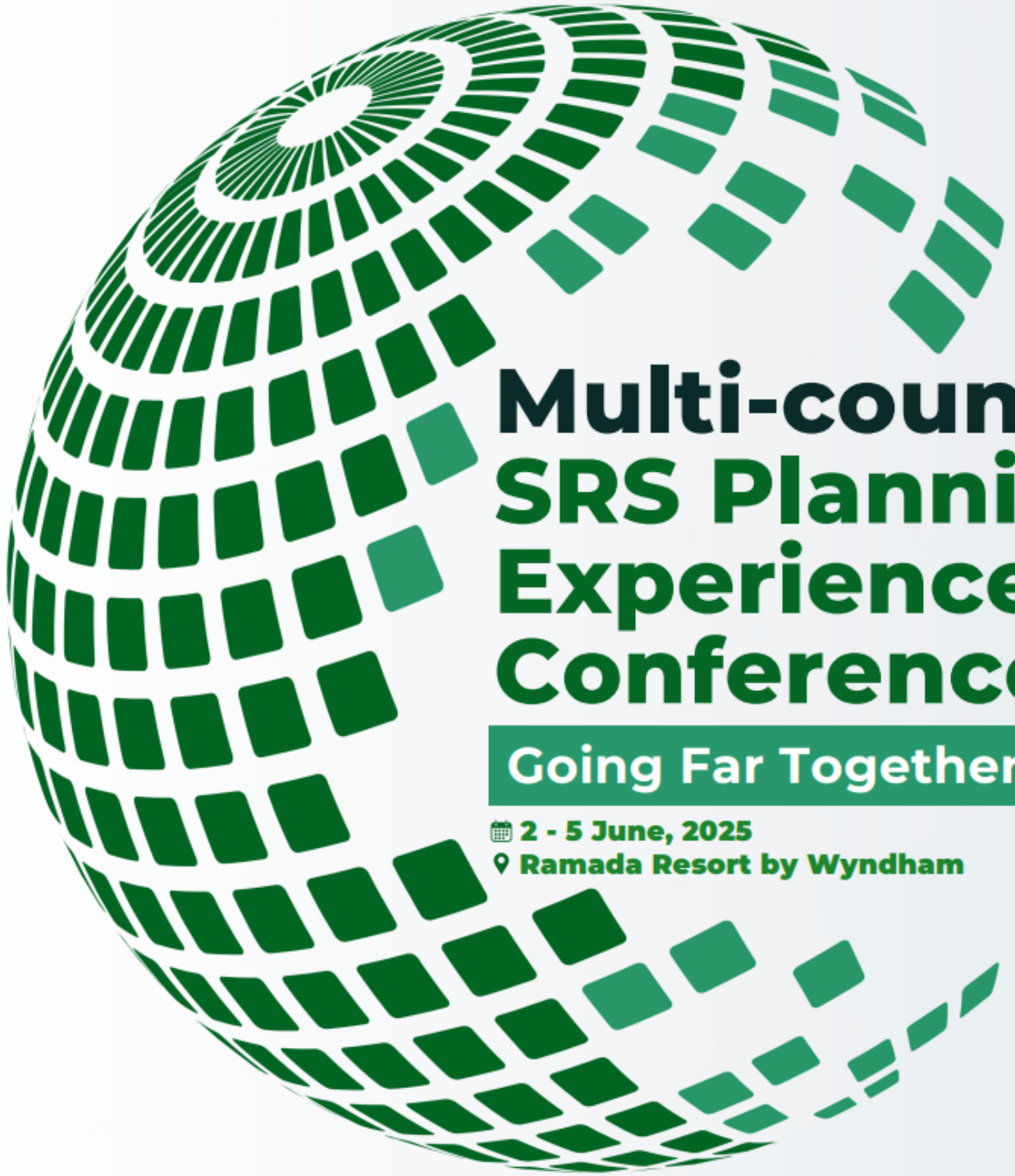


Multi-country SRS Planning and Experience-Sharing Conference

Going Far Together

2 - 5 June, 2025

Ramada Resort by Wyndham

Agenda

Day 3, June 4 – How to develop an SRS Design and Outings	
8:30am	• Optional Session: In depth discussion of VIVA digital solutions for data managers and IT teams
9-10:30am	• Topic 5: Developing a plan for defining SRS design- what comes next? Revisit situational assessment, design and implementation plan; decide what activities are needed to complete SRS design
10:30-11	• Break
11-12pm	• Situational assessment presentations and report out on learning- 3 countries, 15 min each, 15 min for questions
12-1pm	• Situational assessment presentations and report out on learnings- 3 countries, 15 min each, 15 min for questions
1-2pm	• Lunch
2-6 pm	Optional Outings • Ifakara Health Institute field site visit in Bagamoyo • Gift shopping for traditional crafts in Dar es Salaam

Topic 5: Developing a plan for defining an SRS design

Developing a plan for defining SRS design: what comes next?

Collaborative Requirements Development

Collaborative Requirements Development and the Vital Insights for Vital Action (VIVA) 12-Step Guide

Ensure Agreement Among High-Level Stakeholders

VIVA STEPS

- **1: Building support**
- **2: Situational assessment**

Define Requirements

VIVA STEPS:

- **3: Surveillance Design**
- **4: Sampling**
- **5: Development of tools**
- **10: Routine data collection and transfer**
- **11: Data analysis and dissemination**

Design System Changes

VIVA STEPS:

- **6: Digital solutions**
- **7: Equipment and supplies**
- **8: Human resources**
- **9: Baseline mapping**

VIVA Step 12: Assess, Adapt, and Sustain

Ensure Agreement Among High-Level Stakeholders

WHAT

VIVA STEP 1 Building support

The first phase of CRD process >>>

VIVA STEP 2 Situational assessment

- *Engaging inter-agency teams in assessment process can increase shared understanding of the issues and opportunities*
- *Provides information to:*
  - *Describe the processes, persona, and tasks*
  - *Inform the requirements*

HOW

Identify Key Leaders

- Representing all potential data consumers
- Representing ministries and programs with a stake
- Who have authority to enable (or block) SRS implementation
- Who define shared objectives & mutual benefits

Question to be answered:

- What information is needed by whom, and what would they do if they had this information?

Define Requirements

WHAT

VIVA STEPS 3 & 4

- Define core processes for integrated SRS, to inform requirements
- Driven by integrated vision
- Document requirements to translate design into implementation

VIVA STEPS 5 & 10

Tools implement the processes supported by DAK personas

VIVA STEP 11

Define data user needs (requirements) to inform data use plans

HOW

Identify Data Sources

- What data are needed to meet the information needs of SRS?
- Existing mortality data sources
- New data needed

Address Data Policy, Access, Needs

- Who is owner or custodian?
- What policies/governance are required to make it accessible?
- Harmonize data standards
- Data/information flow
- Timeliness requirements
- Analysis/dissemination

Design System Changes

WHAT

VIVA STEPS 6 & 9
Requirements for the processes to be implemented electronically defined in DAK

VIVA STEPS 7 & 8
Systematically documenting requirements/processes informs budget needs and list of capabilities

HOW

Systems/Platform

- Digital solution? Yes or no
- Agree on platform(s)
- Data interoperability/exchange
- Hardware/software
- Comms/networking

Operating Procedures:

- Define roles, access, security, confidentiality
- Assign responsible parties
- Operations manual

VIVA Step 12: Assess, Adapt, and Sustain through DAK data quality assessment

End of Presentation

Comments, Questions and Discussions

Topic 5: Five additional decisions for your design

1. **Formative research to inform data collection, reporting process, and linkage/integration with CRVS**
   a) Based on your data collection strategy discuss the need for a formative research
   b) Outline the scope of the formative research (broadly)
2. **Human resources: SRS management and implementation team**
   a) How will you staff the SRS?
3. **Data tools**
   a) Identify tools that will be used for various types of data
4. **Data system, digital solution and data flow**
   a) Develop a diagram for your data flow
   b) Discuss IT solution at each level and for each type of data
5. **Ethical clearance**
   a) Discuss need for ethical clearance, what would be required and how to proceed

Break

Country Presentations on Situational Assessments and Lessons Learned

Ghana

Mortality monitoring and cause of death determination in Ghana via a Sample Registration System (SRS)

A Situational Analysis

Multi - Country SRS Planning and Experience Sharing Conference
June 1-6, 2025 | Dar es Salam, Tanzania
Presented by: Ayaga A Bawah, Ghana

Ghana Technical Working Group

- Prof. Ayaga A. Bawah - Regional Institute for Population Studies, University of Ghana
- Dr. Wisdom Atiwoto - Ministry of Health, Ghana
- Dr. Lawrence Lartey - Ghana Health Service
- Dr. Adam Zakaria - Ghana Health Service, Public Health Division
- Mad. Sarah Woode - Ghana Statistical Service
- Mr. Kingsley Kwakye - Births and Deaths Registry, Ghana
- Mr. Daniel Azongo - Navrongo Health Research Centre, Ghana
- Williams Kwarah - Vital Strategies

Country setting

- A lower-middle economy (World Bank) located in West Africa.
- It is divided into 16 regions and 261 districts, with approximately 32 million population, 57% living in urban locations.
- The life expectancy at birth is approximately 66 years.
- The completeness of death registration remains low at 39% as at 2023. CDR of 7/1,000 population.
- Recent amendments in law allows the decentralization of births and deaths registration mandated by the BDR to run the CRVS.

Significance of an SRS

- Health and wellbeing of a country is measured by mortality indicators.
- Accurate and timely data on the number and causes of death critical for determining burden of diseases.
- It is essential for identifying and detecting emerging health threats and adopt mitigation measures to address such threats.
- Helps to evaluate impact of interventions and provide evidence for priority-setting, policy-making, and monitoring of impact of scaled health programs and policies.
- Measure the effectiveness and impact of its health sector and disease control programs.

The Challenge

- Existing systems do not adequately permit government to reliably and continuously collect and use mortality data in a timely manner at national and subnational levels.
- Death registration in the current form is limited in coverage – registration is below 40 percent in most cases.
- Routine data from health facilities is unrepresentative because it is only limited to deaths that occur in health facilities.
- Surveys and censuses do not produce data on a routine bases and often limited in scope.
- SRS could help harmonize existing systems and provide nationally representative data for planning.

Vision Statement for an SRS

To establish a nationally representative data collection system that accurately captures quality mortality data, enabling the estimation of mortality rates across all ages, cause of death and all-cause mortality based on precise demographic denominators for public health action by 2030.

Objectives of Situational Analysis

- To assess current situation in mortality data collection, reporting and actions in Ghana and identify existing gaps.
- SWOT analysis to assess existing systems, their strengths and weaknesses and how these could be leveraged as building blocks for SRS.
- Determine the specific requirements for the SRS implementation.
- Assess the funding landscape for the SRS implementation
- Develop recommendations for the SRS in Ghana.

Methodology

- A mixed-methods approach
- Identification of relevant stakeholders and institutions.
- Desk review to gather relevant institutional reports and documents essential for assessing existing data systems and identifying critical gaps.
- Scoping review to systematically identify and analyze published literature on mortality data to deepen understanding of Ghana's readiness to implement an SRS.
- Interviews with selected stakeholders to gain insights into the current operational systems for generating mortality statistics.
- Areas assessed included
  - Governance and stakeholders
  - Current death registration systems and other sources of mortality data
  - Information systems
  - Funding landscape

Methodology

- Descriptive statistics used to summarize key findings; results presented in tables and charts.
- Network analysis done to visualize the flow of mortality data among stakeholders and identify potential linkages for enhancing coordination and integration within the existing system.
- Conducted SWOT analysis to assess internal factors that may support or hinder the integration of an SRS within the current mortality data capturing framework.
- Funding landscape analysis was conducted to understand available funding opportunities and mechanisms.

Findings - Governance and stakeholders

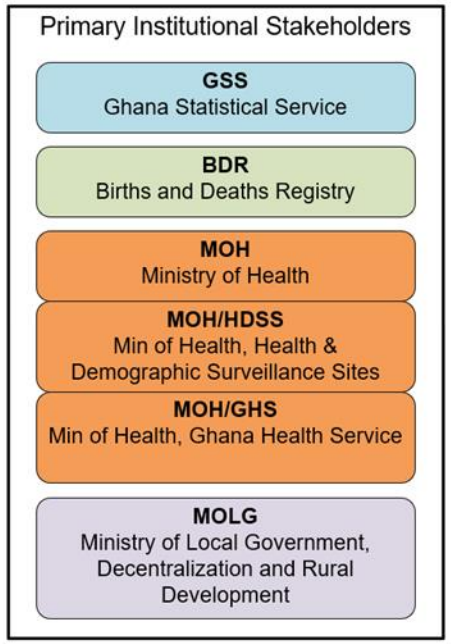
- Legal framework exists (*The Burials Ordinance of 1912 (Births, Deaths, and Burials Ordinance*); revised **Registration of Births and Deaths Act, 2020 (Act 1027)**
  - ✓Act mandates registration of deaths within 10 days of occurrence with a Medical Certificate of Cause of Death (MCCD)
  - ✓Challenges with enforcement, due to religious, cultural, and financial constraints.
  - ✓Although the MCCD is legally free, lack of clarity around its issuance often results in informal charges levied on bereaved families.
  - ✓Shortage of medically trained pathologists, leading to delays in completion of death certification well beyond the mandated 10-day free registration window

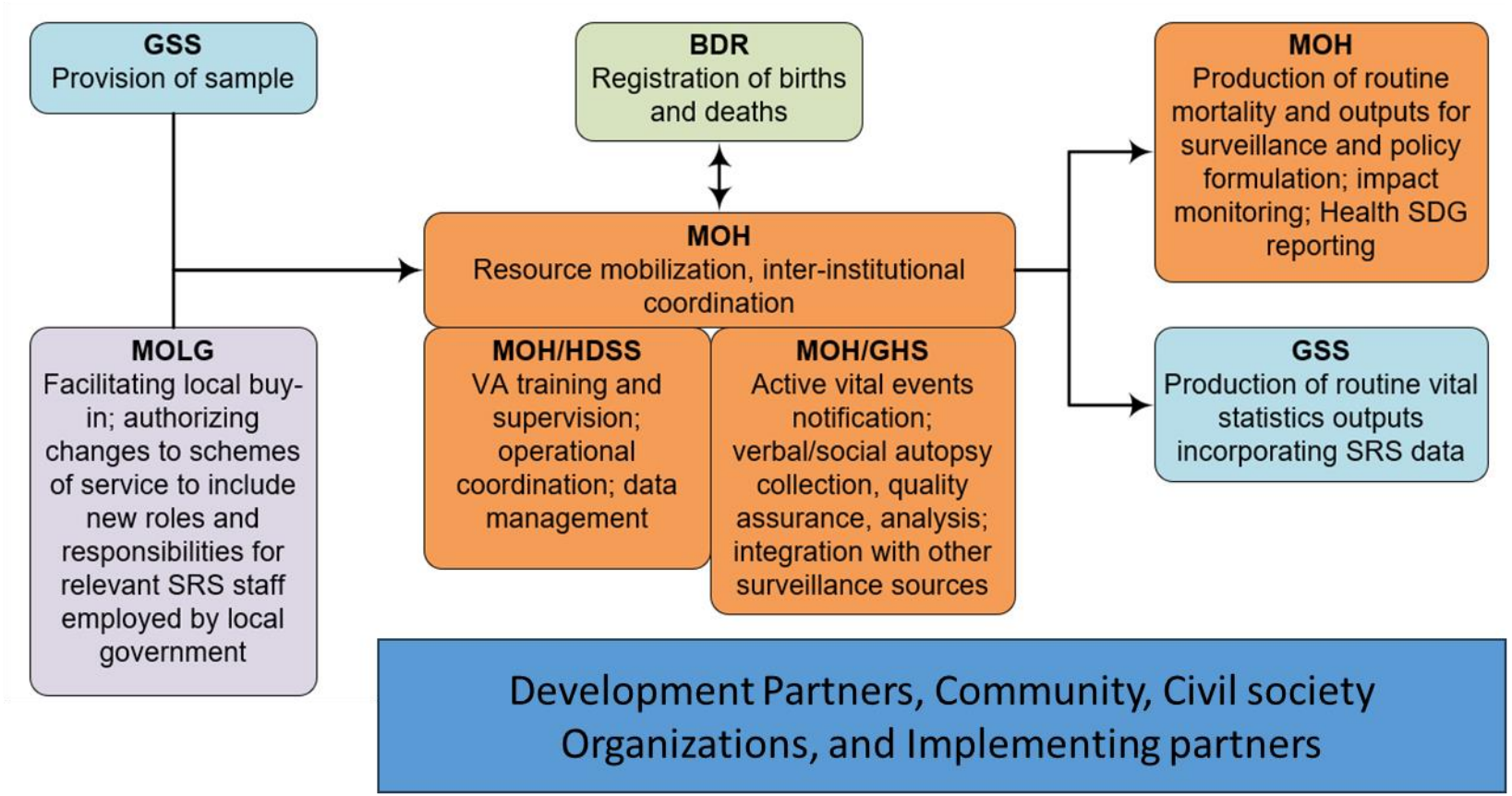
Key improvements include the **decentralization of the Births and Deaths Registry and digitisation of registration processes**

Findings - Stakeholders

Several stakeholders identified as key actors who play crucial roles in the implementation of SRS in Ghana

Primary Stakeholders and Institutional Relationships





Findings - Stakeholder analysis

Stakeholder matrix to help us understand the level of coordination among the stakeholders

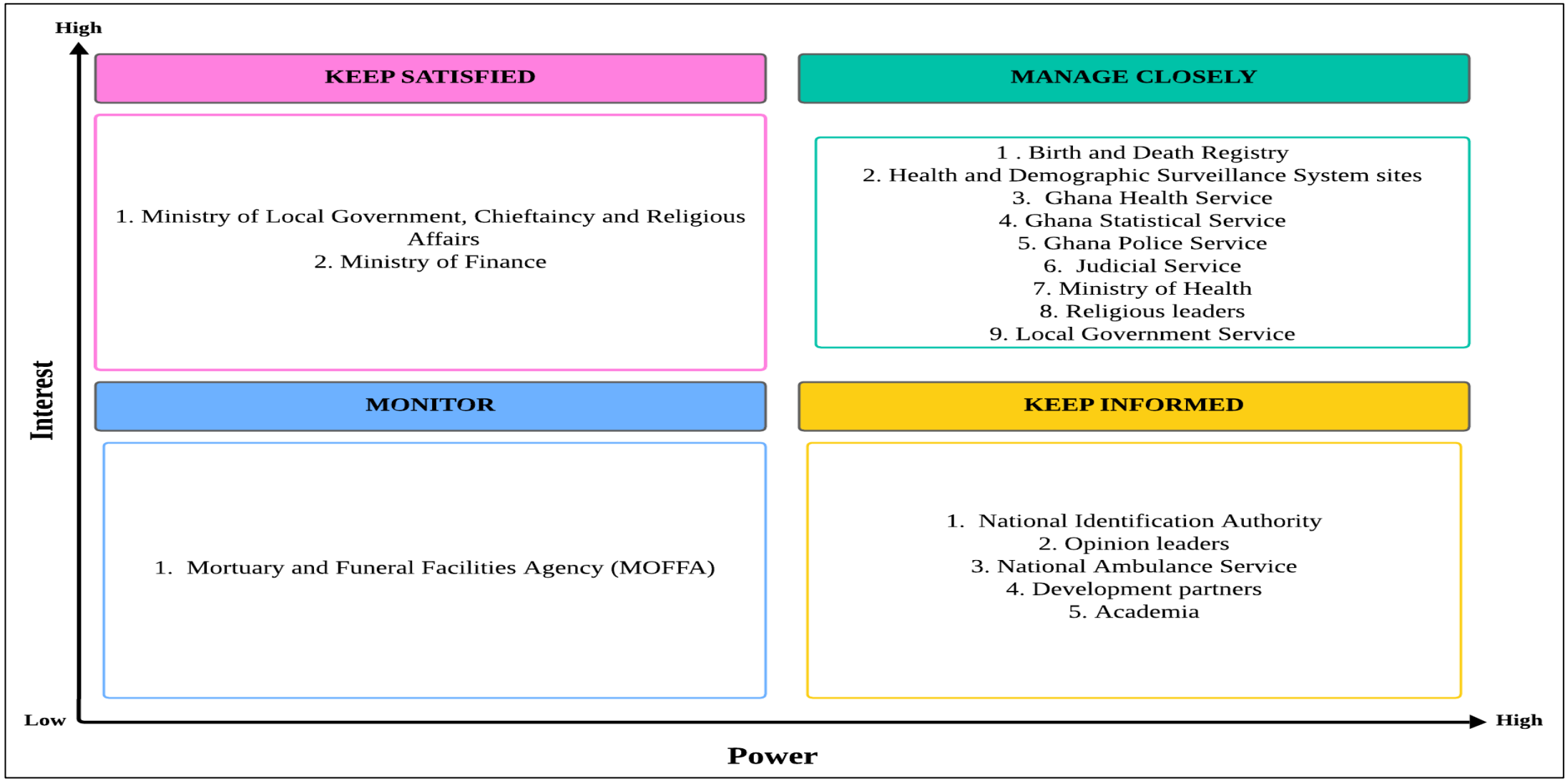
Stakeholder coordination matrix

Stakeholders	BDR	HDSS	GHS	MoH	GSS	GPS	NAS	NIA	LGS	MLGCRA	JS	MoF	RLs	OLs	DPs	MOFFA	AC
Births and Deaths Registry (BDR)																	
Health and Demographic Surveillance Systems (HDSS)	1																
Ghana Health Service (GHS)	2	3															
Ministry of Health (MoH)	2	3	3														
Ghana Statistical Service (GSS)	3	2	3	3													
Ghana Police Service (GPS)	2	1	1	1	1												
National Ambulance Service (NAS)	1	1	3	3	1	2											
National Identification Authority (NIA)	1	0	0	0	2	1	1										
Local Government Service (LGS)	1	0	0	0	0	0	0	0									
Ministry of Local Government, Chieftaincy and Religious Affairs (MLGCRA)	3	1	2	2	2	1	2	0	0								
Judicial Service (JS)	1	0	1	1	1	1	1	1	0	1							
Ministry of Finance (MoF)	2	0	3	3	3	1	2	0	0	3	1						
Religious leaders (RLs)	1	2	1	1	1	1	1	0	0	3	1	0					
Opinion leaders (OLs)	1	2	3	3	1	1	1	1	0	3	1	0	0				
Development partners (DPs)	3	3	3	3	3	0	2	2	0	2	1	0	0	1			
Mortuary and Funeral Facilities Agency (MOFFA)	2	0	1	1	1	1	1	1	0	2	1	0	1	0	0		
Academia (AC)	1	3	2	2	3	1	2	2	0	1	1	1	0	1	3	0	

3-High coordination, 2-Medium coordination, 1-Low coordination, 0-No coordination

Findings - Stakeholder Power Interest Matrix

To further understand the influence and involvement of various stakeholders in the integration of an SRS, a power-interest matrix was developed to determine their level of power (ability to influence the SRS process) and their level of interest .



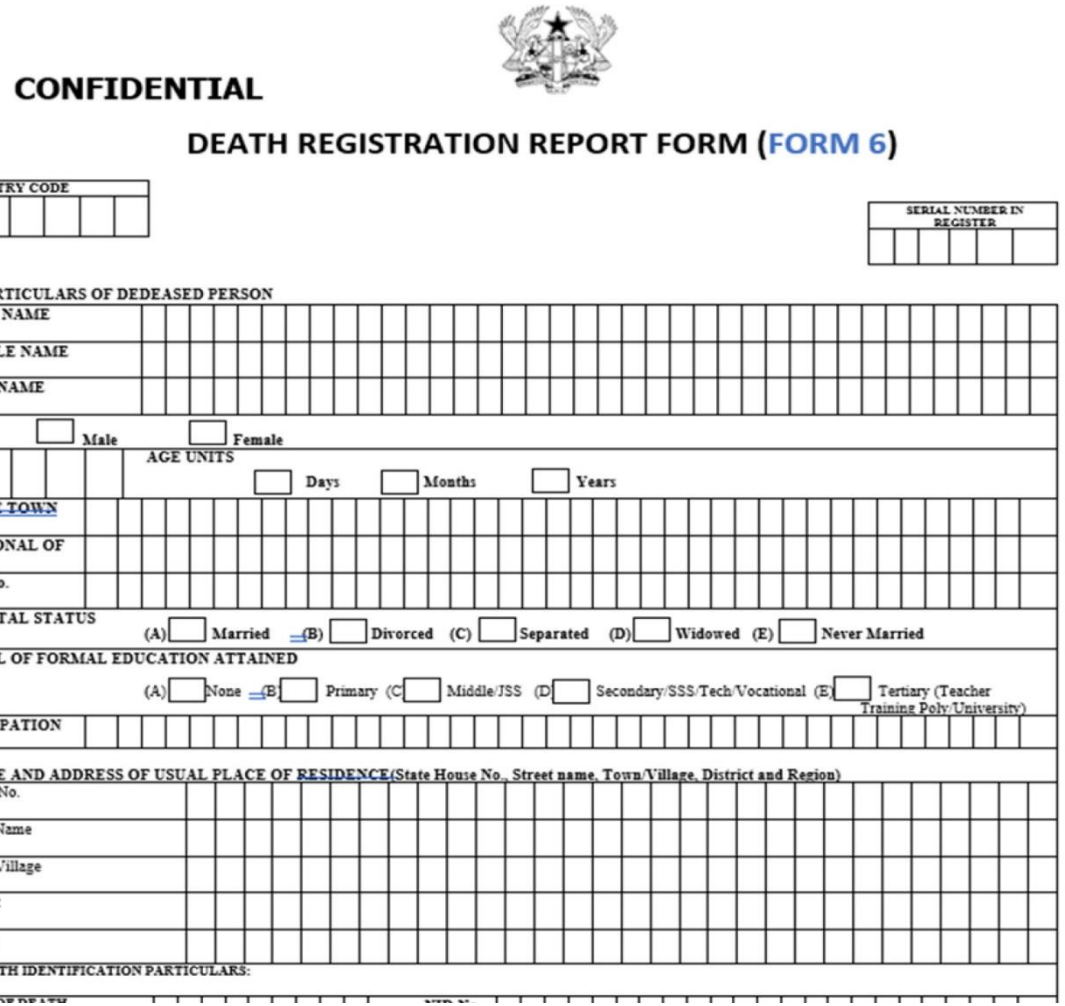
Findings - current death registration systems and other mortality data sources

Births and Deaths Registry

- Collects data on registered deaths and compiles statistical reports to inform national planning and policy decisions.
- Collaborates with Ghana Statistical Service and Ghana Health Service to ensure accurate reporting of these vital statistics.
- Has a decentralized electronic registration system where deaths are reported to the District Registrar to initiate the process and data synced to a national database.
- Lack of functional notification system due to fragmented mortality data systems leading to under-registration of deaths and limited cause of death information

Findings - current death registration systems and other mortality data sources

Deaths Registration Report Form



CONFIDENTIAL

DEATH REGISTRATION REPORT FORM (FORM 6)

REGISTRY CODE

SERIAL NUMBER IN REGISTER

A. PARTICULARS OF DEDEASED PERSON

1a. FIRST NAME

b. MIDDLE NAME

c. LAST NAME

2 SEX (Male) (Female)

3 AGE AGE UNITS (Days) (Months) (Years)

4 HOME TOWN

5 NATIONAL OF

6 NID No.

7 MARITAL STATUS (A) Married (B) Divorced (C) Separated (D) Widowed (E) Never Married

8 LEVEL OF FORMAL EDUCATION ATTAINED (A) None (B) Primary (C) Middle/JSS (D) Secondary/SSS/Tech/Vocational (E) Tertiary (Teacher Training Poly/University)

9 OCCUPATION

10 PLACE AND ADDRESS OF USUAL PLACE OF RESIDENCE(State House No., Street name, Town/Village, District and Region)

a House No.

b Street Name

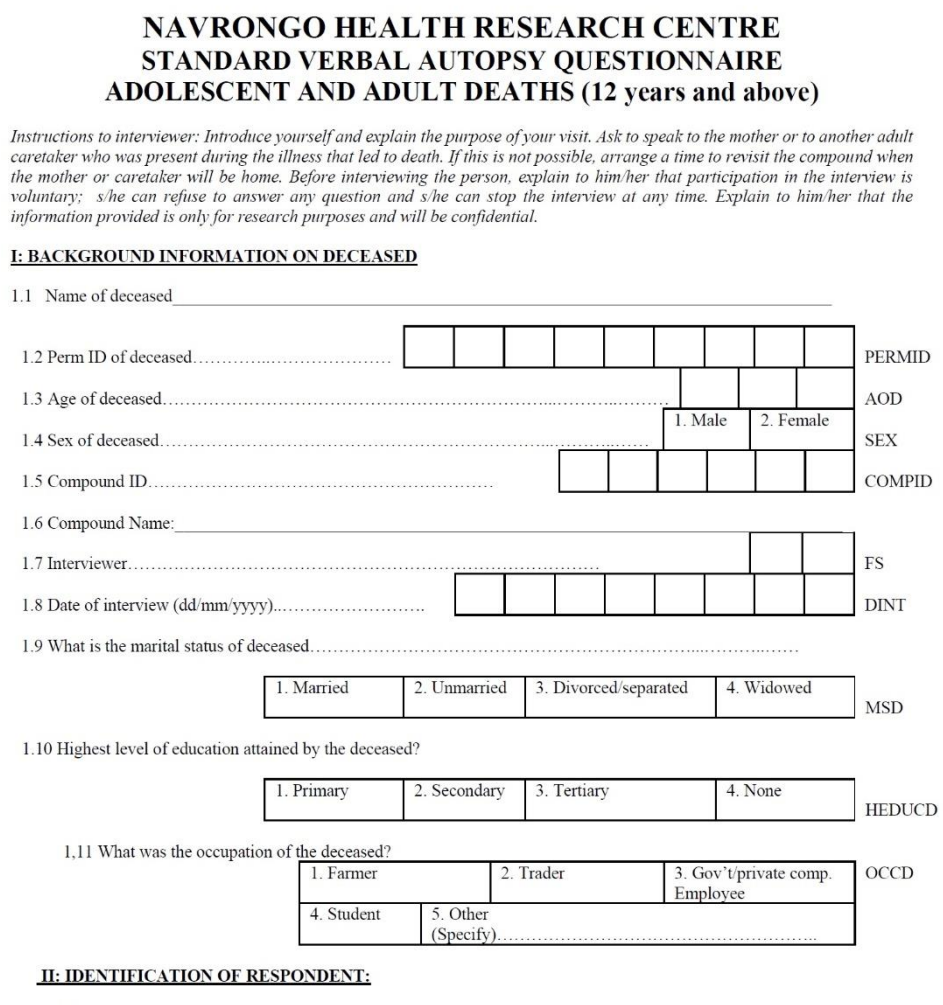
c Town/Village

d District

e Region

B. DEATH IDENTIFICATION PARTICULARS:

Verbal Auptosy Form used by HDSS



NAVRONGO HEALTH RESEARCH CENTRE
STANDARD VERBAL AUTOPSY QUESTIONNAIRE
ADOLESCENT AND ADULT DEATHS (12 years and above)

Instructions to interviewer: Introduce yourself and explain the purpose of your visit. Ask to speak to the mother or to another adult caretaker who was present during the illness that led to death. If this is not possible, arrange a time to revisit the compound when the mother or caretaker will be home. Before interviewing the person, explain to him/her that participation in the interview is voluntary; s/he can refuse to answer any question and s/he can stop the interview at any time. Explain to him/her that the information provided is only for research purposes and will be confidential.

I: BACKGROUND INFORMATION ON DECEASED

1.1 Name of deceased

1.2 Perm ID of deceased..... PERMID

1.3 Age of deceased..... AOD

1.4 Sex of deceased..... 1. Male 2. Female SEX

1.5 Compound ID..... COMPID

1.6 Compound Name:

1.7 Interviewer..... FS

1.8 Date of interview (dd/mm/yyyy)..... DINT

1.9 What is the marital status of deceased.....

1. Married	2. Unmarried	3. Divorced/separated	4. Widowed	MSD

1.10 Highest level of education attained by the deceased?

1. Primary	2. Secondary	3. Tertiary	4. None	HEDUCD

1,11 What was the occupation of the deceased?

1. Farmer	2. Trader	3. Gov't/private comp. Employee	OCCD
4. Student	5. Other (Specify).....		

II: IDENTIFICATION OF RESPONDENT:

2.1 Name of respondent:

Findings - current death registration systems and other mortality data sources

Ghana Health Service

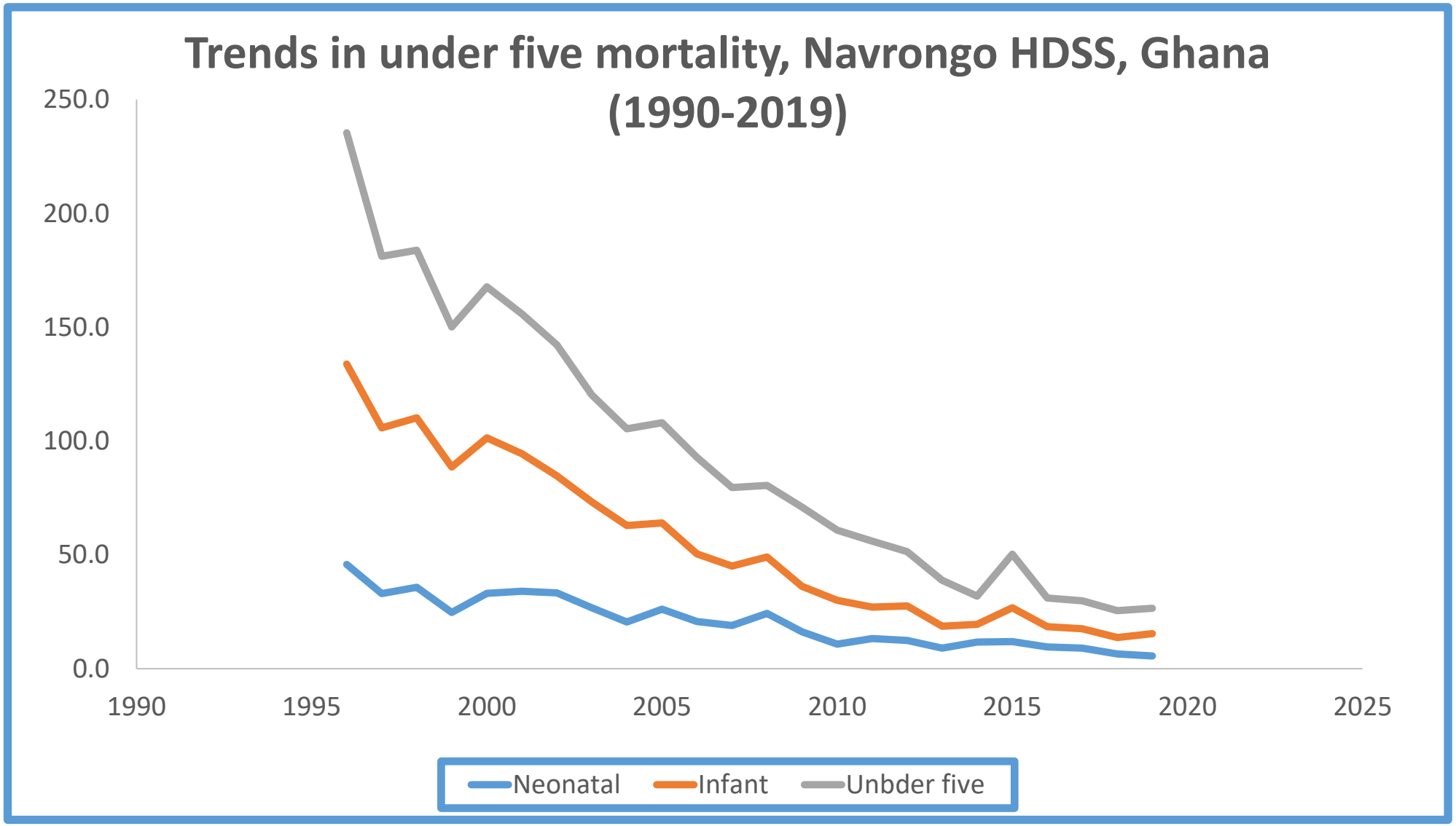
- Deaths registered in health facility are certified by a Doctor who assesses, completes and issues the medical certificate of cause of death.
- Where the cause of death is uncertain or sudden, further investigations may be required. This could involve:
  - ✓ Clinical audits to review the patient's medical records.
  - ✓ Post-mortem examinations (autopsies), especially if the death is unexplained or suspected to be due to unnatural causes.
  - ✓ Laboratory tests to confirm infections, toxicology reports, or underlying conditions.
- Hospitals report mortality data to the GHS DHIMS2 and COD platforms , which compiles institutional mortality statistics.
- Challenges such as incomplete death registration and limited autopsy practices can affect the accuracy of cause-of-death reporting.

Findings - current death registration systems and other mortality data sources

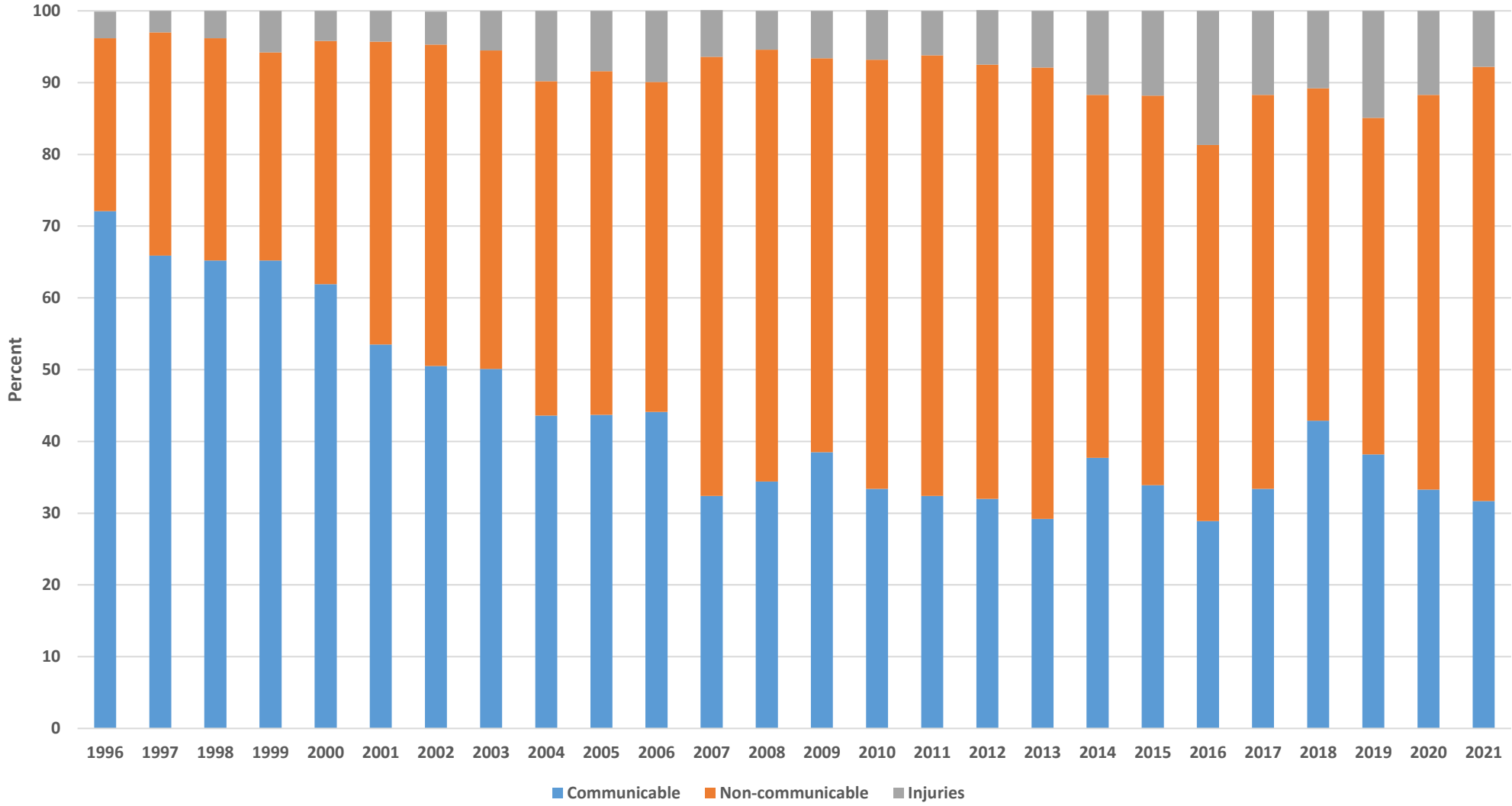
Health and Demographic Surveillance Systems (HDSS)

- Currently, there are three HDSS sites in Ghana – northern, middle, and southern belts.
- All deaths recorded in the HDSS are followed up and a verbal autopsy (VA) is conducted to ascertain the possible cause of death. Kintampo HDSS is piloting MITS and collecting mortality data.
- The VA involves interviewing relatives, caregivers who were closely associated with the deceased person during the period leading to death.
- Different systems exist for coding or determining the cause of Death from the VA.
- There have been a transition from physician coding to automated systems of coding **(InterVA**, InSilicoVA and SmartVA).
- The VA tools currently used are the 2016 and 2022 WHO Verbal Autopsy tools.

Findings - current death registration systems and other mortality data sources



Findings - current death registration systems and other mortality data sources



Findings - current death registration systems and other mortality data sources

Ghana Statistical Service (GSS)

- The GSS records death statistics mainly through national censuses, household surveys, and administrative records.
- A key sources is the Maternal Health Survey, which gathers mortality data by assessing household deaths, causes of death, and pregnancy-related mortality.
- GSS collaborates with the Births and Deaths Registry to compile official death registration statistics which provides insights into demographic trends, regional variations, and mortality rates across the country.
- GSS also works with health institutions and international partners to improve the accuracy and completeness of mortality data.

Findings - current death registration systems and other mortality data sources

Non-traditional sources: Several non-traditional sources of mortality data exist.

- ***Community-Based Reporting***: community leaders, religious institutions, and funeral homes often keep informal records of deaths within communities.
- ***Police and coroner reports through road traffic accidents and suicides/homicides****:* Public reports of deaths, especially in cases of accidents, epidemics, or disasters, can provide real-time insights into mortality trends.
- ***Mortuaries and Funeral Homes or Facilities***: these death records are recorded mainly for operational purposes, therefore are not standardized and not integrated into national mortality databases.
- ***Academic and Research Institutions***: these institutions other than the HDSS sites conduct studies on mortality patterns, through surveys and verbal autopsy methods. data collected do not often make their way into official statistics.

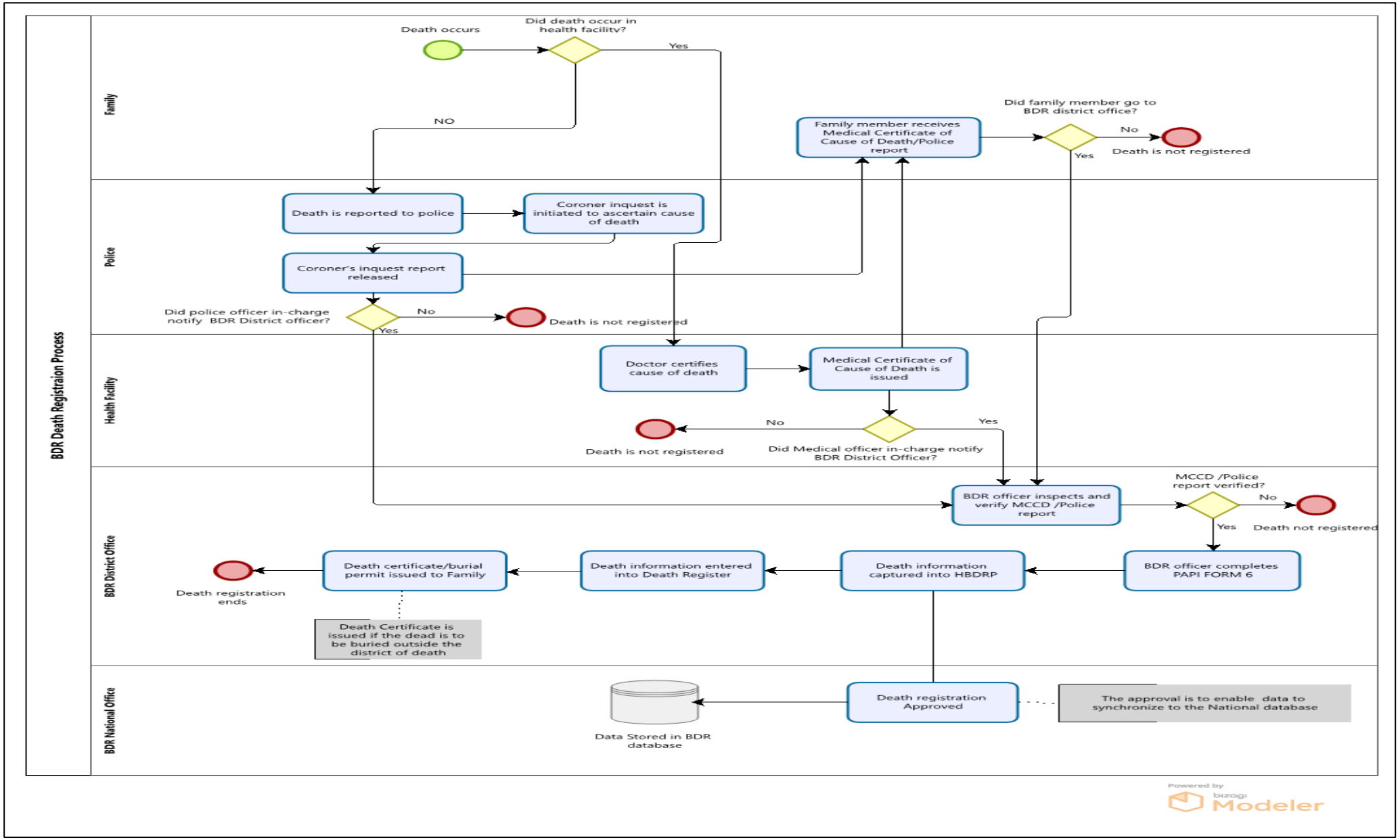
Strengthening institutional coordination can help incorporate these non-traditional data sources into a more comprehensive mortality tracking framework.

Findings - Information system

- Death registration is passive in Ghana.
  - Persons and institutions expected to notify the BDR.
- The system identifies two streams of events:-

1. Community deaths and facility-based deaths.
   - Community deaths reporting initiated by relative or informant of deceased.
   - Police or coroner reports written and possible cause of death determined.
   - BDR registers death.
2. Facility death reporting
   - A doctor certifies the cause of death and issues a Medical Certificate of Cause of Death (MCCD).
   - MCCD is sent to the BDR to complete death registration.

Findings - Current Registration process flow map at BDR



Findings - Funding landscape assessment

- Ghana's readiness to implement an SRS is hinged on understanding the funding landscape that can support its development, operationalization, and long-term sustainability.

- Ghana potentially has mixed sources of funding for an SRS implementation where resources can be leverage both internally and externally.

- There is a strong possibility of pooling resources from domestic and external sources using various funding mechanisms especially co-funding models.

Findings - Funding landscape

Key stakeholders

Key government bodies involved include:

- Ministry of Health
- Ministry of Finance
- Ministry of Local Government, Chieftaincy and Religious Affairs

Development partners and donors:

- The World Bank,
- World Health Organization (WHO),
- United Nations Children's Fund (UNICEF),
- The Global Fund,
- USG (USAID, CDC through PEPFAR and Global Health Security),
- CIDA/Global Affairs Canada,
- Global Financial Facility (GFF),
- UNAIDS,
- UNFA,
- UNDP,
- Bloomberg Philanthropies, and
- Bill and Melinda Gates Foundation (BMGF)

Current and potential funding sources

Domestic

- Leverage respective ministries budgetary allocations for surveillance activities and strengthening CRVS system.

External sources

- Engage development partners to expand support for surveillance activities to include mortality surveillance
- .Engage partners who historically supported Demographic and Health Surveys (e.g. UN agencies, World bank, US government).
- Other bilateral, multilateral and foundations including WHO, CIDA/Global Affairs Canada, Bill & Melinda Gates Foundation, and Bloomberg Philanthropies D4H. and US Government Global Health Security, PEPFAR and PMI activities.

Findings: Funding landscape

Strategic priorities and alignment

- SRS supports the goals of the National Health Sector Strategy, which emphasizes the importance of digital transformation, real-time data availability, and improved mortality surveillance.
  - Ghana included mortality surveillance into the Medium-Term Development Plan.
- SRS supports Sustainable Development Goal (SDG) target 16.9, which promotes legal identity for all, including birth registration.
- Many development partners are strategically aligned with these SDGs in Ghana.

Funding gaps and opportunities

- Technology infrastructure – mobile and computer systems, and data storage infrastructure.
- Staff capacity building low.
- Community engagement is underfunded despite being essential for improving awareness and uptake of civil registration services.
- Opportunities to pool resources through effective coordination; and ensuring SRS complements and strengthen other digital health systems and CRVS modernization programs.

Findings: SWOT Analysis

Strengths

- Favorable Legal Policy Environment
- Existence of Institutions mandated to register deaths
- HDSS Sites providing leadership and technical support.
- Availability of diverse mortality data sources.
- Nationwide coverage of BDR offices.
- Expertise exists in country

Weakness

- Overdependence on development Partner/Donor Funding
- Poor death registration coverage, currently at about 39%.
- Lack of integration of parallel data collection systems, weak notification systems, heavily paper-based systems.
- Public apathy to register deaths, especially in rural areas.
- Cultural and physical barriers.
- Institutional bottlenecks – limited MCCD, penalties for late death registration, weak enforcement of burial laws.

Opportunities

- Existence of National Identification System.
- High mobile phone and internet penetration presents opportunities for death notifications.
- Political commitment to achieving 80% coverage of death registration under SDG 17.19.2.
- Ghana's Development Partners' strong commitment towards the CRVS and data use for decision making.
- Existence of data exchange platform.
- Existence of functional health information platforms like DHIMS and LHIMS.

Threats

- Political will and funding volatility due to shifts in political priorities and change I government.
- Diminishing donor support in the midst of competing priorities.
- Low demand creation especially in rural areas.
- Some communities do not report child deaths due to stigma or cultural norms.
- Pockets of conflicts in some geographical areas could pose a threat to registration.
- Low internet connectivity in rural communities could negatively affect digital operating systems for registration.

System design considerations

1. Start with a linkage to CRVS with the ultimate aim of full integration. Full integration would require

- Legislative instrument to establish the required legal requires.
- This will be costly and time constraints.
- Existing legislation for data sharing which will be leveraged on.

2. Smallest geographic units: Enumeration Area

- Existence of a geographic unit which is the enumeration areas
- The EA is what is used for both census and other surveys in the country.
- There is experience and skill in using the EA
- Use of a two-level stratification, that is at national and regional to give estimates at these levels
- *GSS is planning to move to grid system so we may explore that option also

System design considerations

3. Statistical domains relevant for Ghana

- The statistical domain or unit of analysis will be national and subnational (regional)
- We will sample clusters (EAs) at the regional levels
- Allows for political commitment and appreciation of problems and information disseminated
- Actions are mostly administered through administrative structures and this allows ease of implementation

4. Minimum data

- Births and pregnancies
- Deaths by age
- Cause of death
- Population by age and sex
- Rural/urban considerations
- SES

System design considerations

5. Data collection strategy

- Leverage on existing community health nurses and volunteers working in communities for notification and registration.
- Use CHO/CHN to conduct VA interviews.
- Collaborate with local government authorities to leverage other existing structures.
- This allows to facilitate active search of deaths for verbal autopsies to be conducted.

6. Assessment for complete

- To undertake surveys every two years.
- To compare data with HDSS site

7. Phased Implementation

- Due to operational and iinitial cost implications, the phased approach has been recommended to learn lessons for expansion to include all regions.
- Initial pilot to test protocol, tools, and digital platforms.
- Phase 1 implemented in 6 northern regions and Western North (USAID survey clusters).
- Phase 2 nationwide scale-up.

System design considerations

8. Governance Structure

- Ghana to consider the Adoption of ACDC mortality surveillance governance recommended structure.
- Steering committee at national level to offer oversight(relevant stakeholders).
- Technical working group to offer technical assistance.
- Administrative governance levels from district to national.

Conclusions

- Ghana has the capacity and potential to successfully implement an SRS.
- Though challenges exist, effective and efficient stakeholder coordination, collaboration and ensuring clear roles and responsibilities are important success factors.
- Leverage technology and transition paper-based systems to electronic platforms.
- Religious and cultural factors need collective and sustained efforts at community through to the national level.
- Government needs to improve and sustain human resource capacity and address logistical needs.
- Sustained domestic resource mobilization and priority setting must be seen as a continuous effort throughout SRS implementation.

Next Steps

- Meeting to brief relevant stakeholders.
- Identify stakeholders for the governance structure setup(steering committee, administrative structure set up).
- Hold TWG meetings to develop working plans for the development of design protocols.
- Development of design protocols.
- Stakeholder meeting to review developed design protocol.

Acknowledgement

BILL & MELINDA GATES foundation

Vital Strategies


Thank you

Kenya

Mortality Surveillance Situational Assessment Report: Kenya

4th June 2025

Administrative Profile

Republic, with national and devolved (County) governance structure – Constitution of Kenya 2010.

The National Government performs most governance functions (Security, Education, Health Policy, Level 6); while Devolved units, Composed of 47 counties, perform functions of local governance.

The counties are further subdivided into 389 sub-counties, 993 divisions, 4,032 locations, and 9,128 sub-locations as of 2024.

Health Service Delivery Structure

Tier 1: Community Health Services

- Services at the household/village level via Community Units (CUs)

- 1 CHP supports 20 households supervised by CHA

Tier 2: Primary Care Services

- Level II (Dispensaries): Basic care, immunizations, antenatal, first-aid

- Level III (Health Centers): Diagnostics, common illness treatment, maternal & child health

Tier 3: County Referral Services

- Level IV & V facilities: Specialized services, surgeries, complex illness management

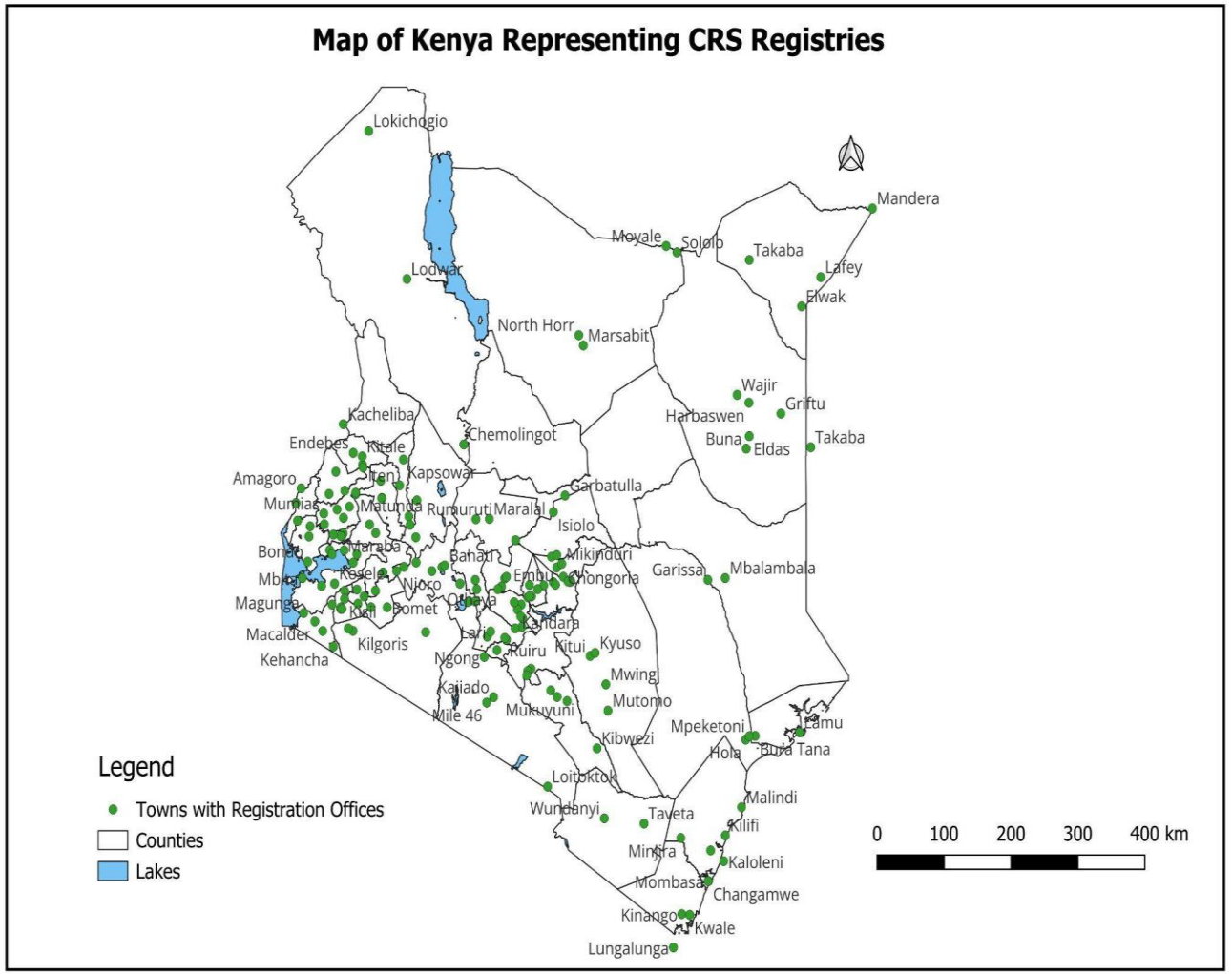
Tier 4: National Referral Services

- Level VI facilities: Tertiary care by sub-specialists for highly complex conditions

Civil Registration Services

- CRVS registers, analyses and disseminates data on vital statistics
- The civil registration services in Kenya is present in all counties
- There are 167 operational sub-county CRS offices
- Birth registration completeness - 77%
- Death registration completeness - 45%

(KVSR, 2023)



Mortality surveillance systems: KHIS

- Monthly aggregate death data
- IDSR: Weekly cause-specific mortality data
  - Published in weekly epidemiological bulletins
- KHIS tracker – morbidity and mortality data

Electronic Community Health Information System (e-CHIS)

- Community-level data collection tool
- Tracks service delivery, follow-up
- Supports supervision and reporting
- Utilised by the community health promoters (CHPs)
  - Household Registration
  - Household member registration
  - Muting and Death Reporting
  - Event-based surveillance

Civil Registration Services System

- There exists a CRVS System - Digitalisation is ongoing
- The birth certification module is complete
  - Now assigning UPI numbers as it is integrated with the National Registration Bureau and IPRS databases
  - Currently implemented at Nairobi CRS offices
- Death registration module – Establishment ongoing

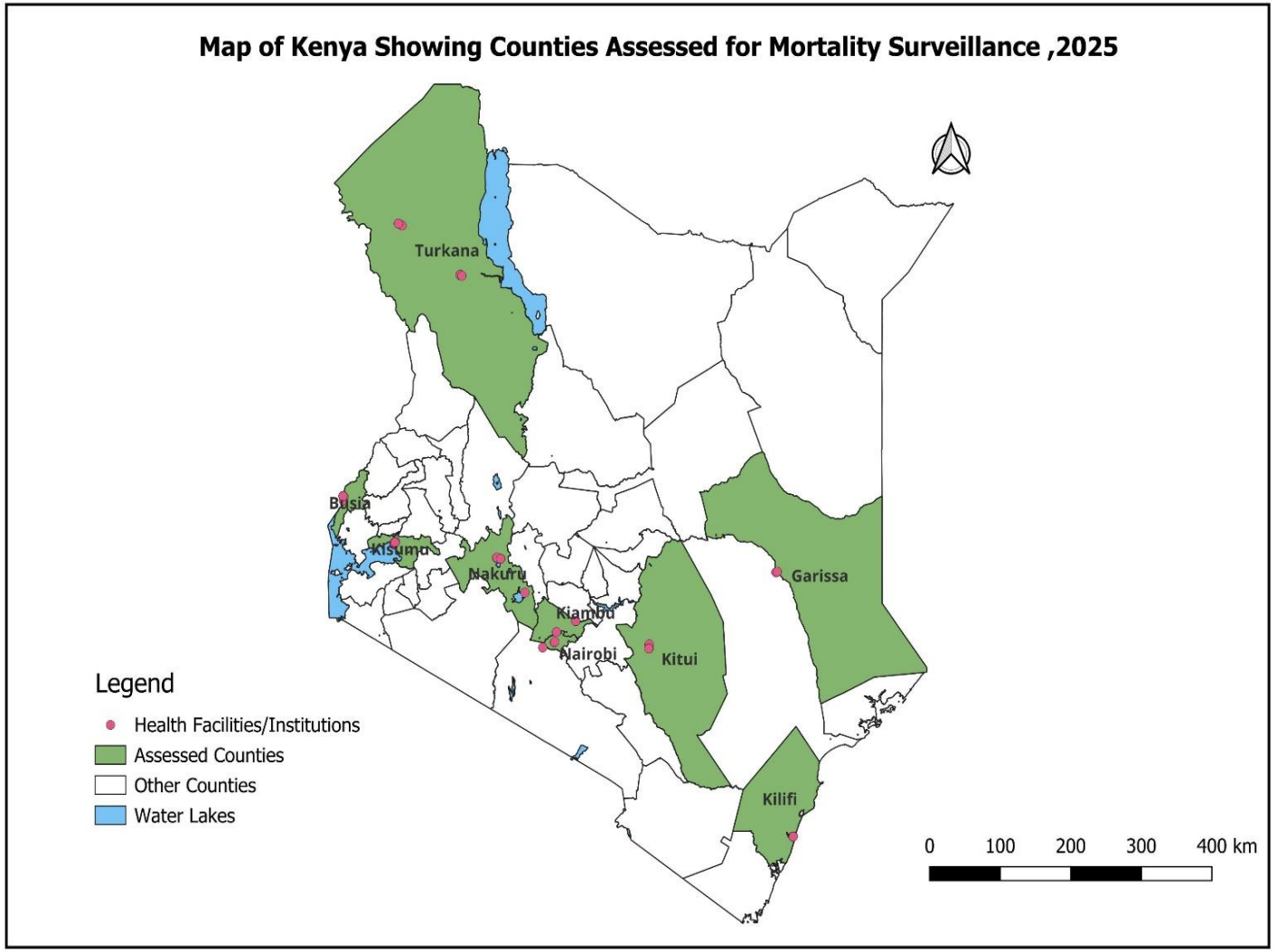
Situational assessment

Methodology of the Assessment

- Desk Review
  - Policies, frameworks, and business process mapping
- Stakeholder consultations
- Field Visits
  - On-site evaluation of mortality surveillance practices
- Tools
  - Semi-structured interview guides on KOBO Collect
  - Interviews were recorded using tablets
  - Key data collection forms catalogued through photographs

Field visits: Selected Counties

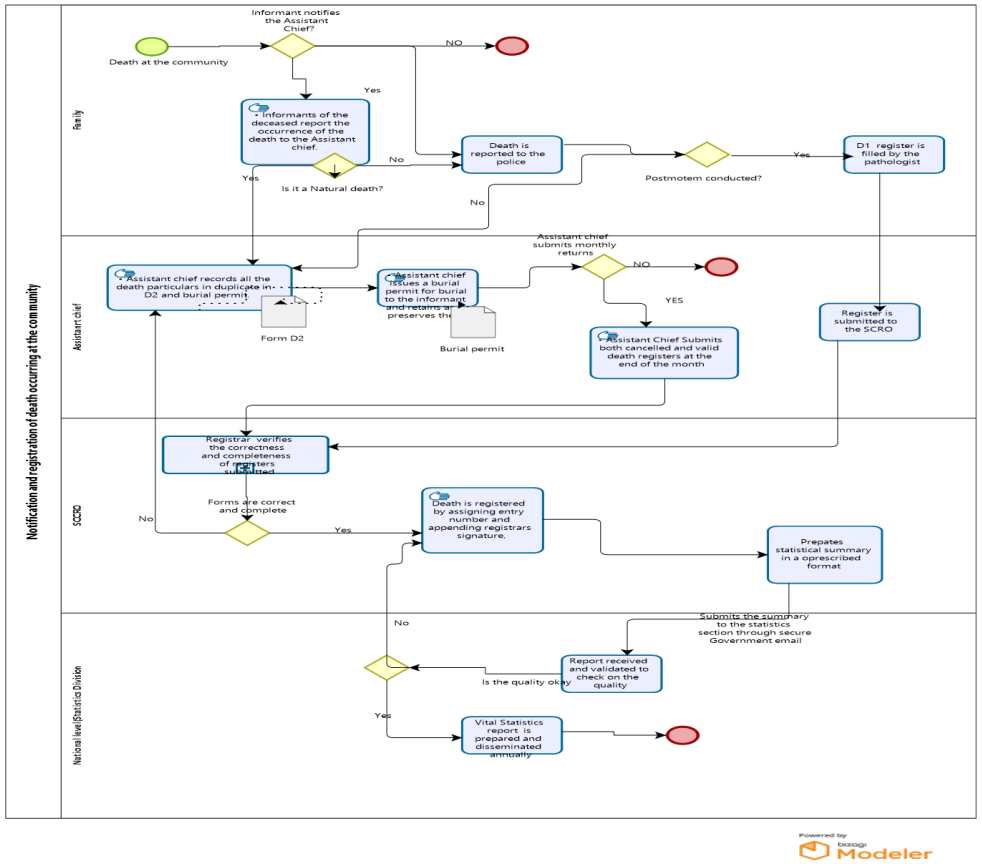
County	Rationale
Turkana	ASAL, Refugee population (Kakuma Refugee Camp)
Nakuru	Urban population, Rift Valley region
Busia	Cross-border population
Kisumu	Experience with CHAMPS/HDSS
Garissa	ASAL, Islamic population
Kitui	ASAL, Eastern region, rural population, VA pilot site
Kilifi	Experience with mortality surveillance/HDSS
Kiambu	Part of Nairobi metropolitan, urban population
Nairobi	Urban population, burial site (Langata cemetery)



Legal & Policy Framework for Mortality Surveillance & SRS

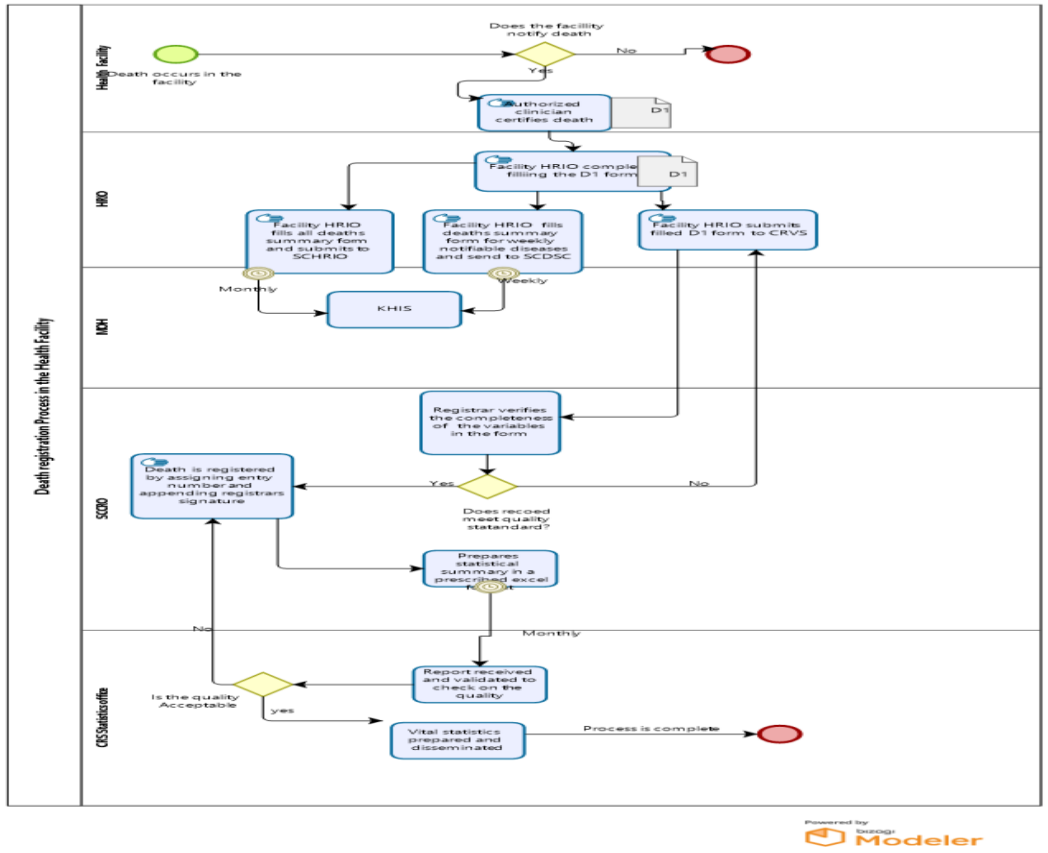
Category	Framework/Act	Purpose	Relevance to SRS
Global & Regional	SDG 3.1, Africa CDC Mortality Surveillance Framework	Improve health outcomes, reduce maternal mortality	Outlines global/regional mandates and offering technical support
National	Birth & Death Registration Act, Digital Health Act (2023)	Birth and death registration, support data systems	Statutory backing for mortality data collection
Health Sector Policies	Kenya Community Health Policy (2020-2030)	Guide on provision of community health services for UHC	Leveraging on the community health service providers to capture vital events

Civil registration for community deaths



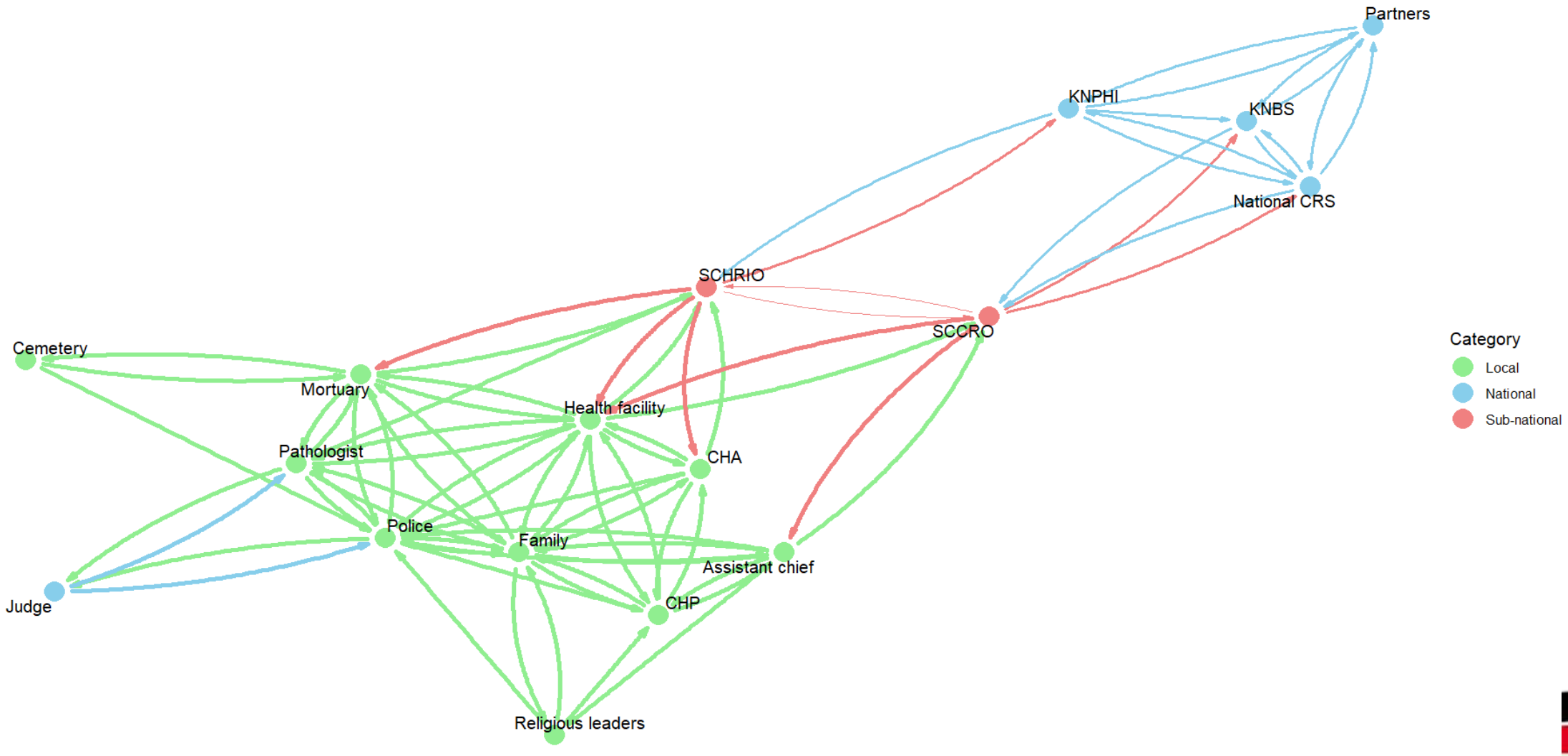
- Family is the starting point for the registration process
- Assistant chief as registration assistants
- Lay reporting of CoD
- Form D2 used for notification of death(paper-based)
- Submitted to CRVS office for completion of registration

Civil registration for facility deaths



- Death ascertainment done by medical officer of health
- Form D1 filled by HRIO
- Submitted to sub-county civil registrar for completion of registration
- Copy sent to the national CRVS office

Information network analysis



Case study- Turkana county(Refugee population)

- Kakuma Refugee camp- served by unit heads and reporting to the area chief (in the host community)
- Socio-cultural factors hindering the reporting of community deaths(fear of death, no benefit from death registr)
- Burials are done at an established cemetery within the camp
- **Best practice-** Bi-weekly mortality audits for all deaths at Lodwar County Referral Hospital

Summary

System fragmentation

- Mortality data is fragmented across several institutions
- Parallel systems with limited integration

Death Registration Coverage

- Coverage remains low in some regions e.g. in ASAL areas
- Infrastructural challenges hence delayed reporting

Ct….

Cause of Death Data

- Limited implementation of verbal autopsy
- Low-quality MCCoD data

Funding and resource allocation

- Mortality surveillance not prioritized at all levels across institutions
- No sustainability plan for Mortality Surveillance

Policy and legal frameworks

- Existing policies and laws governing collection of mortality eg CAP 149
- Limited enforcement

Lessons learnt

Situational Assessment

- Need for a government-led initiative for ownership and sustainability
- Interoperability of mortality systems is important for surveillance
- Value of multi-sectoral collaboration

SRS Conference

- Need for integration of mortality surveillance systems
- SRS and MOH are viable structures for improving CRS data completeness
- Governance structures for SRS should be properly instituted, and roles clearly outlined

Next Steps

- Review SRS governance structure
- Develop SRS samples
- Define SRS system requirements
- Develop a costed strategic action plan

Action photos

Stakeholder engagement meeting in Naivasha

Situational Assessment team at Nakuru County Civil Registrar’s office

Acknowledgement

Gates Foundation

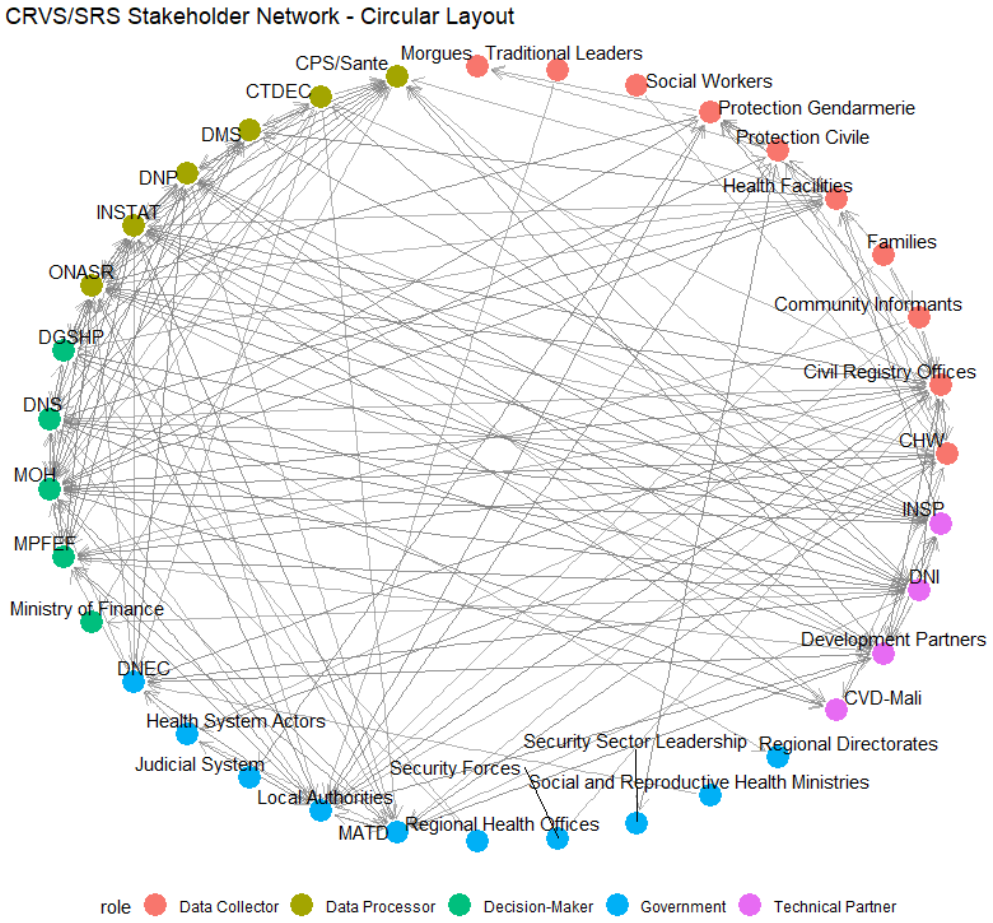
Thank You!

Mali

Toward Integrated Mortality Surveillance: Lessons from Mali's SRS Planning Initiative

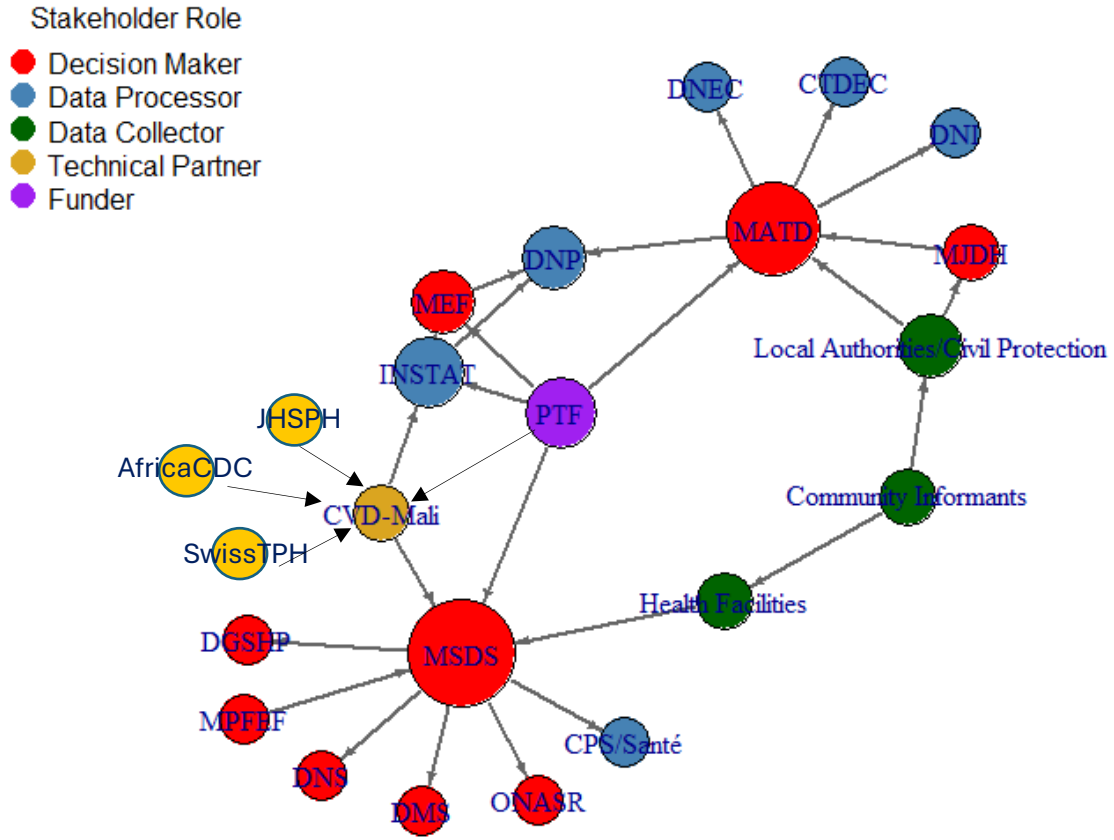
Vers une surveillance intégrée de la mortalité : enseignements de l'initiative de planification du SRS au Mali

Stakeholder Mapping Exercise, (first draft)



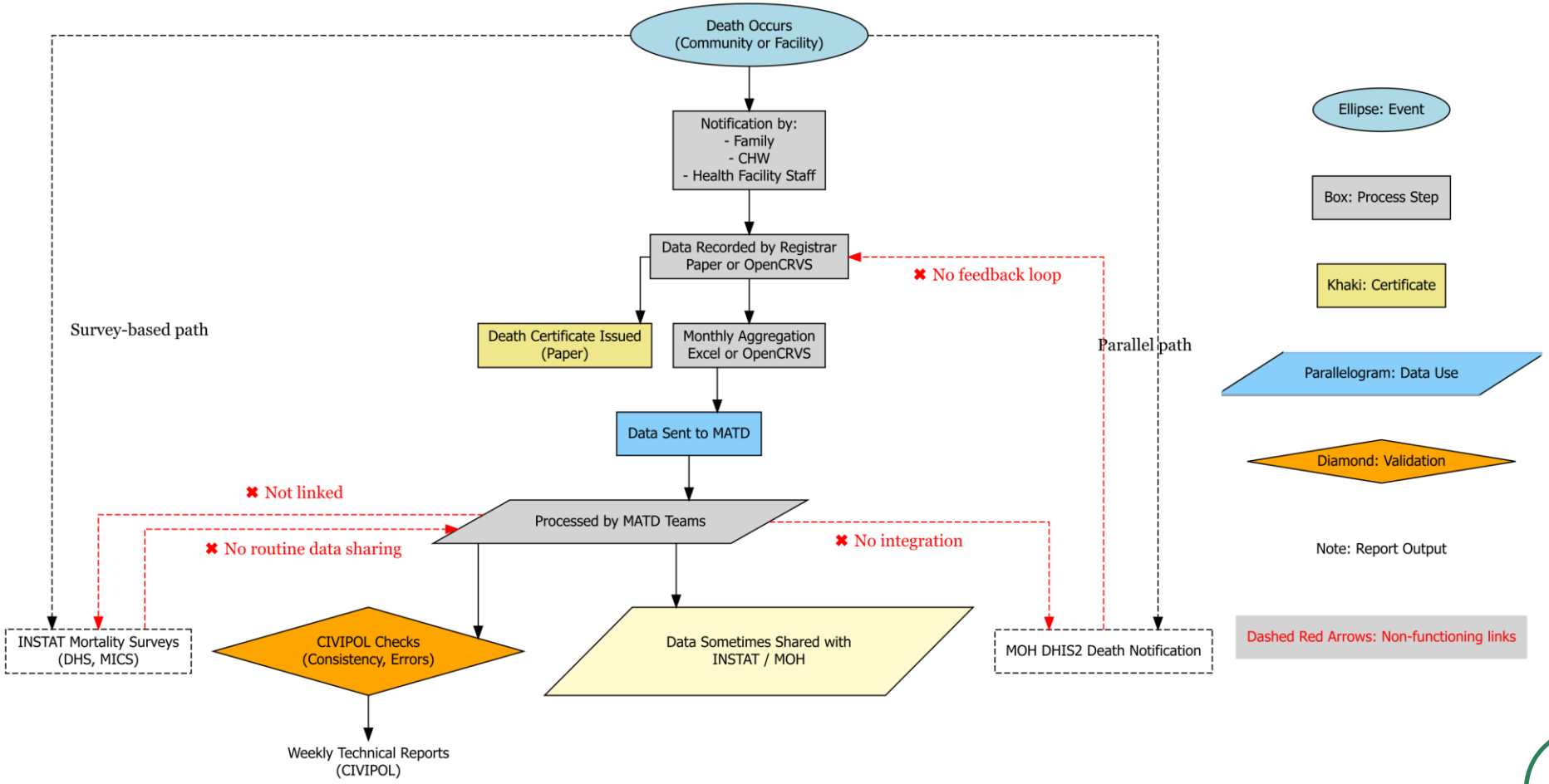
MALI SRS
Système Représentatif de Statistiques civiles du Mali

Stakeholder Mapping Exercise, (getting there)



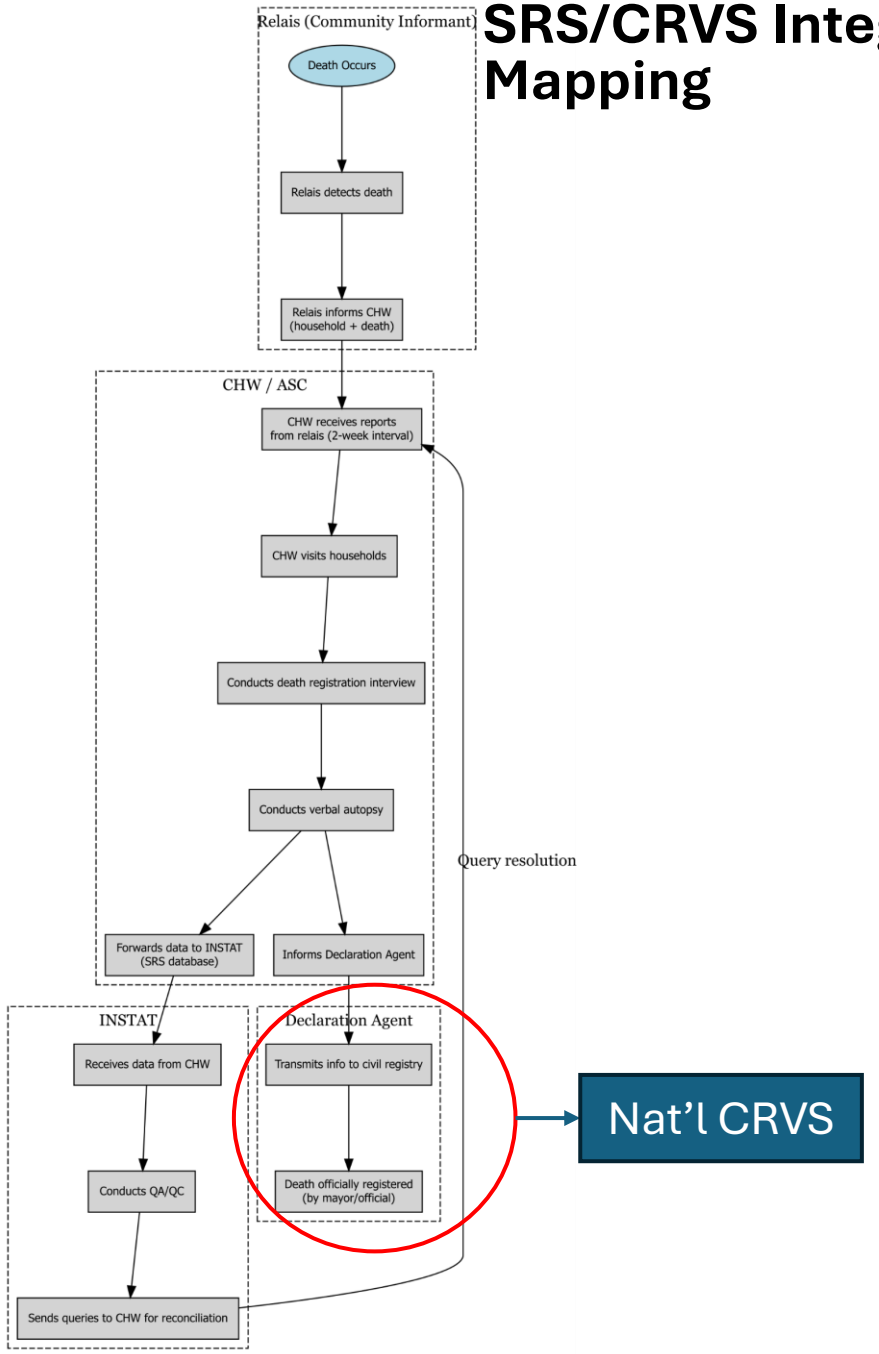
MALI SRS
Système Représentatif de Statistiques civiles du Mali

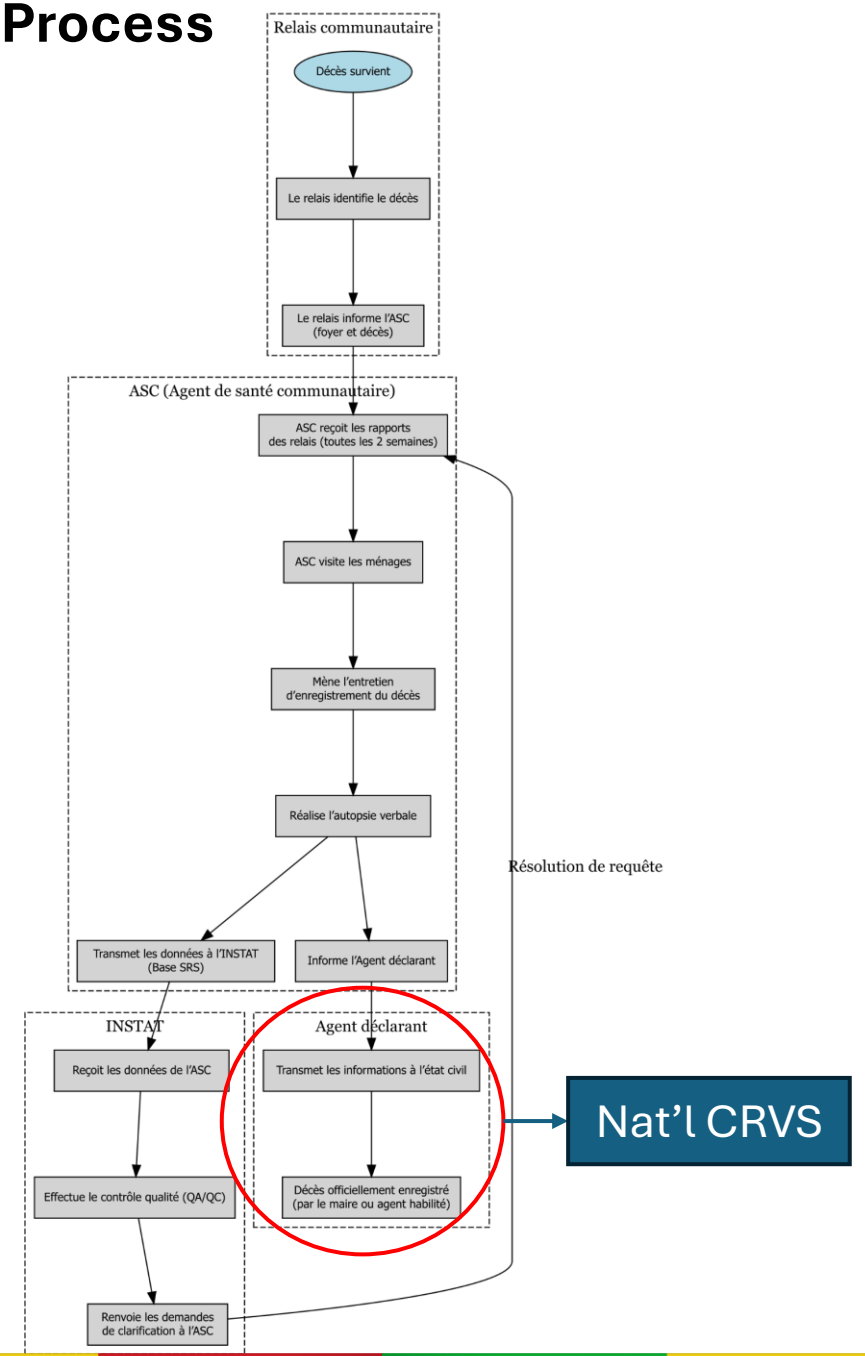
Process Mapping Exercise



MALI SRS
Système Représentatif de Statistiques civiles du Mali

SRS/CRVS Integration Process Mapping





MALI SRS
Système Représentatif de Statistiques civiles du Mali

What are we going to do when we go home?

- Distill all information and exercises into reference documents
- Decide the high-level KEY stakeholders to invite to decide additional items on SRS mortality registration tool
- Calculate workload for reporting structure actors
- Plan in-person meeting in Bamako to have discussions on protocol

Que va-t-on faire quand on rentrera à la maison ?

- Distiller toutes les informations et exercices dans des documents de référence
- Déterminer les parties prenantes CLÉS de haut niveau à inviter pour décider des éléments supplémentaires de l'outil d'enregistrement des décès dans le cadre du SRS.
- Calculer la charge de travail des acteurs de la structure de rapportage
- Planifier une réunion en présentiel à Bamako pour discuter du protocole

MALI SRS
Système Représentatif de Statistiques civiles du Mali

Additional remarks
Commentaires additionnels

SRS Vision

The Sample Registration System (SRS) in Mali aims to deliver high-quality, **timely**, and **actionable** all-cause and cause-specific mortality data for **all ages** at national and subnational levels by **2030**. Designed to be **digital**, **interoperable**, and **linked with the CRVS** and other national health systems, the SRS will be **locally owned** and resilient, enabling **early detection** of public health threats and **informing effective policy and planning**. The target users of the SRS system in Mali include government entities, particularly the Ministry of Health and Social Development, including national and local health authorities, policy makers, planners, and other relevant stakeholders. Data generated by the SRS will **drive evidence-based interventions to reduce mortality** and improve the health and welfare of all Malians.

Vision du Système d'Enregistrement par Sondage (SRS)

Le Système d'Enregistrement par Sondage (SRS) au Mali vise à fournir, d'ici **2030**, des données de mortalité toutes causes confondues et par cause spécifiques, de haute qualité, **en temps opportun** et **exploitables**, pour **tous les âges**, aux niveaux national et infranational. Conçu pour être **numérique**, **interopérable** et **connecté à l'état civil (CRVS)** ainsi qu'aux autres systèmes de santé nationaux, le SRS sera **localement géré** et résilient, permettant la **détection précoce** des menaces pour la santé publique et éclairant **l'élaboration de politiques et de plans efficaces.**

Les utilisateurs cibles du système SRS au Mali incluent les entités gouvernementales, en particulier le Ministère de la Santé et du Développement Social, y compris les autorités sanitaires nationales et locales, les décideurs politiques, les planificateurs et d'autres parties prenantes concernées. Les données générées par le SRS permettront de **guider des interventions fondées sur des preuves pour réduire la mortalité** et améliorer la santé et le bien-être de tous les Maliens.

Merci!

Pakistan

SRS -Situational Assessment- Pakistan

Dr Faiza Bashir

Research Director NIH

Country Context

Indicator	Value
Population	Male: 124,324,406 Female: 117,154,694 Total: 241,479,100
WHO Region	Eastern Mediterranean
World Bank Income Group	Lower-middle income
Administrative Structure (# provinces, # districts)	4 Provinces, 2 Autonomous territories (AJK & GB), 1 federal territory, 158 districts
Life Expectancy at Birth	Male: 64 years Female: 66 years Avg: 65 years
Crude Death Rate	6.8/1000 population
Completeness of Death Registration	**~58%**

Why SRS-Pakistan?

Population & Mandates

5th most populous
deaths outside healthcare
limited community buy-in
overlapping mandates

SDG Goals

100% birth and 80% death registration;

currently at 58% Vs Census with no timelines

Way Forward

SRS is a practical interim solution for enhancing registration and CoD

System Gaps

coordination between systems,
low coverage,
under-reporting,
inadequate legal framework

Reform Efforts

CRVS policy (2020),
Digital Birth Registration
Verbal Autopsy pilots

Planning phase objectives

Phase 1: Stakeholder Engagement & Situational Assessment

Phase 2: Process Mapping & Proof of Concept (PoC)

Phase 3: Costed Implementation Plan

METHODOLOGY

Mixed-Methods Approach: Desk review + 6 months of stakeholder interviews

National Coverage: Interviews in all 4 provinces and 3 territories

Structured Tools: Used standardized interview guides (Forms 1.1, 1.2, 1.3)

Diverse Respondents: Federal ministries, health departments, local authorities, graveyards, CRVS

Field Visits: LHWs, and graveyards, union council administrations

DESK REVIEW

1 **Ongoing Efforts**

A lot of data points
Many partner organizations
Systematic approach missing
Many pilots

2 **Disintegrated Data**

facility-based, focusing on counts and are disconnected
Mortality analytics are missing

3 **Capacity**

Multiple digital platforms
trained HR available

4 **Legal framework**

.Ineffective ambiguous and voluntary

Overall Impression

Death and Cause of death reporting is limited

- Deaths outside the facilities especially in rural areas & go unregistered uncertified by medical professionals
- Even within hospitals; limited training on standardized reporting protocols like ICD often results in non-specific diagnoses
- Cultural stigma surrounding certain conditions, such as HIV/AIDS or maternal mortality, discourages accurate reporting
- Limited community compliance
- Regions affected by conflict or political instability face frequent disruptions
- Multiple digital platforms and trained HR available
- System readiness and sensitization for establishing mortality surveillance was there

Stakeholders

Health

Director General health

Diseases Surveillance Units

Provincial LHW prog lead

Healthcare commissions

MNCH Coordinators

Information systems

Other agencies/ Administration

CRVS/ NADRA

Bureau of Statistics

Graveyards

Ambulatory services

Cantonments

Religious affairs

Minorities councils

Partner organizations

Integral Global

WHO

UKHSA

UNICEF

World bank

Others

Legal Framework

Foundational Law

- The **Births, Deaths and Marriages Registration Act of 1886** still governs registration
- Allows **voluntary registration**; lacks enforcement

Federal Legislation

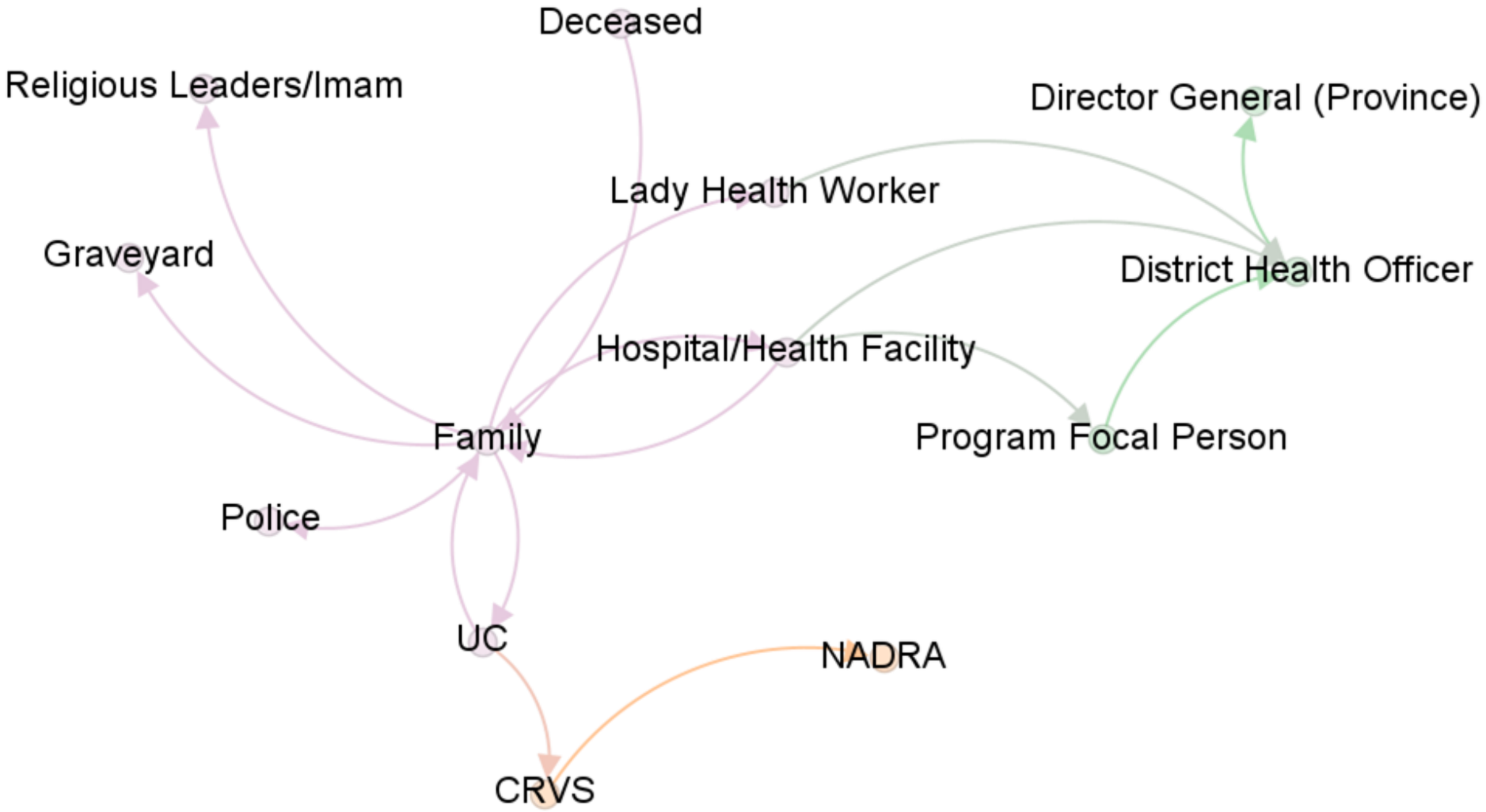
- **NADRA Ordinance (2000)**: Assigns civil registration to NADRA and creates the Civil Registration Management System (CRMS).
- **General Statistics (Reorganization) Act (2011)**: Assigns Pakistan Bureau of Statistics (PBS) responsibility for national vital statistics.

Provincial Legislation

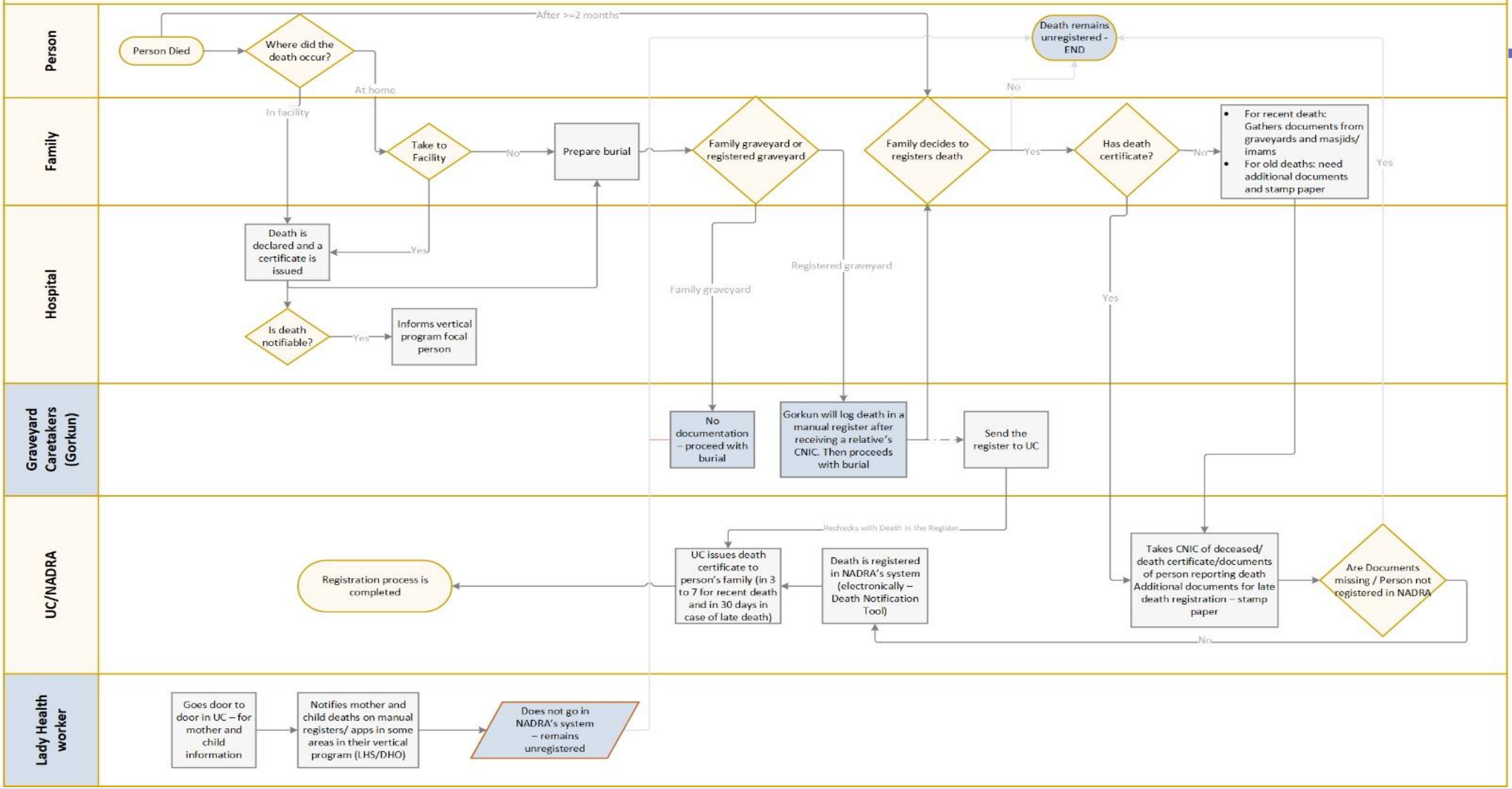
- **Inconsistencies** in legal scope, enforcement, and procedures exist across provinces

Information system	Data Type	CoD data	Completeness
NADRA CRVS	Aggregate	Limited	**31%-58%**
HMIS/ RMNCH/ IDSRS/ EMR/ One Patient One ID	Aggregate	No	Mortality data captured but incomplete/missingness/ but no analytics for mortality
Provincial Disease Surveillance Response Unit	Aggregate	Partial	Pools data from multiple systems (IDSRS, Vertical Disease Programs, etc.)
Graveyard Records	-	No	Incomplete, paper-based and not aggregated at any level
Vertical Programs	Aggregate	No	Captured only for target diseases

NETWORK ANALYSIS



Current Death Registration Process



SWOT ANALYSIS

Strengths

- Established digital frameworks CRMS, IDSRS
- Existing provincial surveillance platforms (e.g., IDSR, DDSRU)
- 70%LHW coverage and polio is an add on
- Political willingness to enhance mortality data

Weaknesses

- Multiple standalone data systems
- Underreporting
- Weak legal frameworks
- Funding
- Uncovered areas

Opportunities

- Leveraging NADRA's digitization
- Integration with existing Health information systems
- Trained VA experts
- Linkages with academia
- International donor support

Threats

- Socio-cultural barriers
- Competing initiatives
- Logistical constraints
- Financial sustainability
- Weak enforcement of mandatory reporting

INTEREST-POWER GRID

Interest		
	High interest; Low power *(Stakeholders to inform and involve in advocacy efforts.)* • Program managers/implementers (DHIS2/EMR/IDSRS) • Physicians • Community • Public and academic institutions • Research community • Donors	**High interest; High power** *("Key players"* *Keep closely involved throughout the system development and implementation to ensure support)* • NADRA • Health ministry/departments • Media • Ministry of Planning
	Low interest; Low power *(Monitor and engage minimally)* • Religious communities • NGOs	**Low interest; High power** *(Not main targets but could oppose the system: keep them informed and acknowledge their views)* • Local government (UC level) • Police • Politicians • Healthcare commissions • Cantonments • Religious scholars
	Power	

Funding landscape analysis

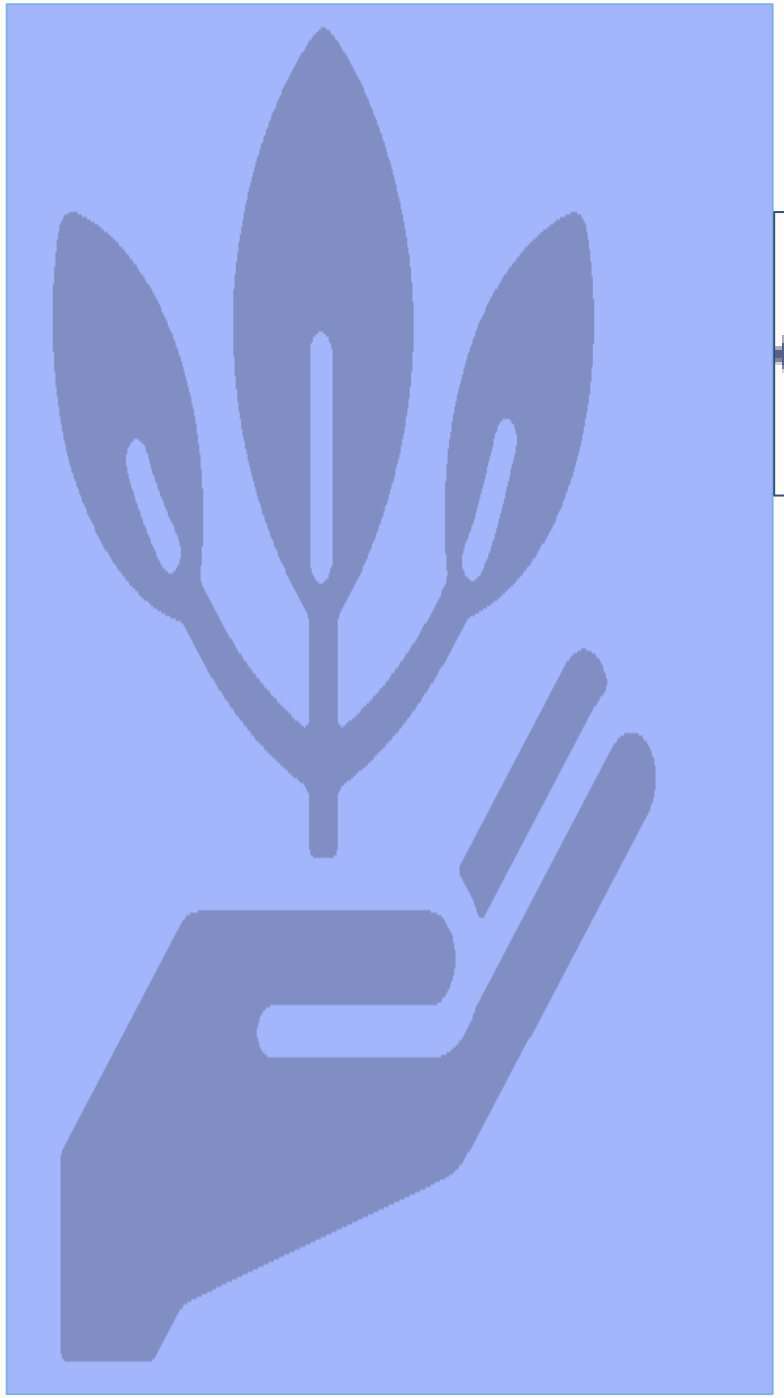
Sustainable SRS implementation requires a diversified funding base, leveraging both domestic and international support

Available hubs:

1. Domestic budgets:
    - Federal government (PBS, NHSR&C):
    - Provincial governments
2. Bilateral donors (Grants, Technical Assistance)
3. Multilateral agencies (Loans, Grants)
4. Private foundations

Key Resource Gaps:

- **Operations:** Consistent funding for staff, data processing, & quality control
- **Infrastructure:** Modern data collection tools, secure storage, efficient reporting
- **Human Resources:** Continuous training for enumerators, supervisors, & data analysts
- **Logistics:** Support for transport (especially remote), field communication, & activities
- **Cause of Death (Verbal Autopsy):** Funding for VA training, tools, & quality assurance



Vision

Establish a strong, nationally representative SRS that delivers timely and accurate data on births, deaths, and causes of death to guide policy, and promote inclusive development across Pakistan.

We envision an equitable, sustainable, and interoperable SRS - expanding population coverage and fully linked with CRVS, health systems, and local governments - to track progress toward the SDGs over next 5 years.

Acknowledgments

- Prof Zainab and Her team at AKU
- SRS Core team at NIH
- Partners like CRVS NADRA
- Pakistan Bureau of Statistics
- Ministry of planning
- Dr Chalapati Rao

Thank you

Senegal

VISION

By 2050, Senegal will have a secure, continuous, real-time, sustainable national digital surveillance system for data on births, deaths and their causes by age group and gender, in a collaborative, integrated approach that improves existing systems and enables decision-makers to develop public health policies and interventions tailored to communities.

Republic of Senegal
One People - One Goal - One Faith

Ministry of Health
and Social Action

Situational Assessment for Integrating SRS into Existing Health Data Management Systems in Senegal

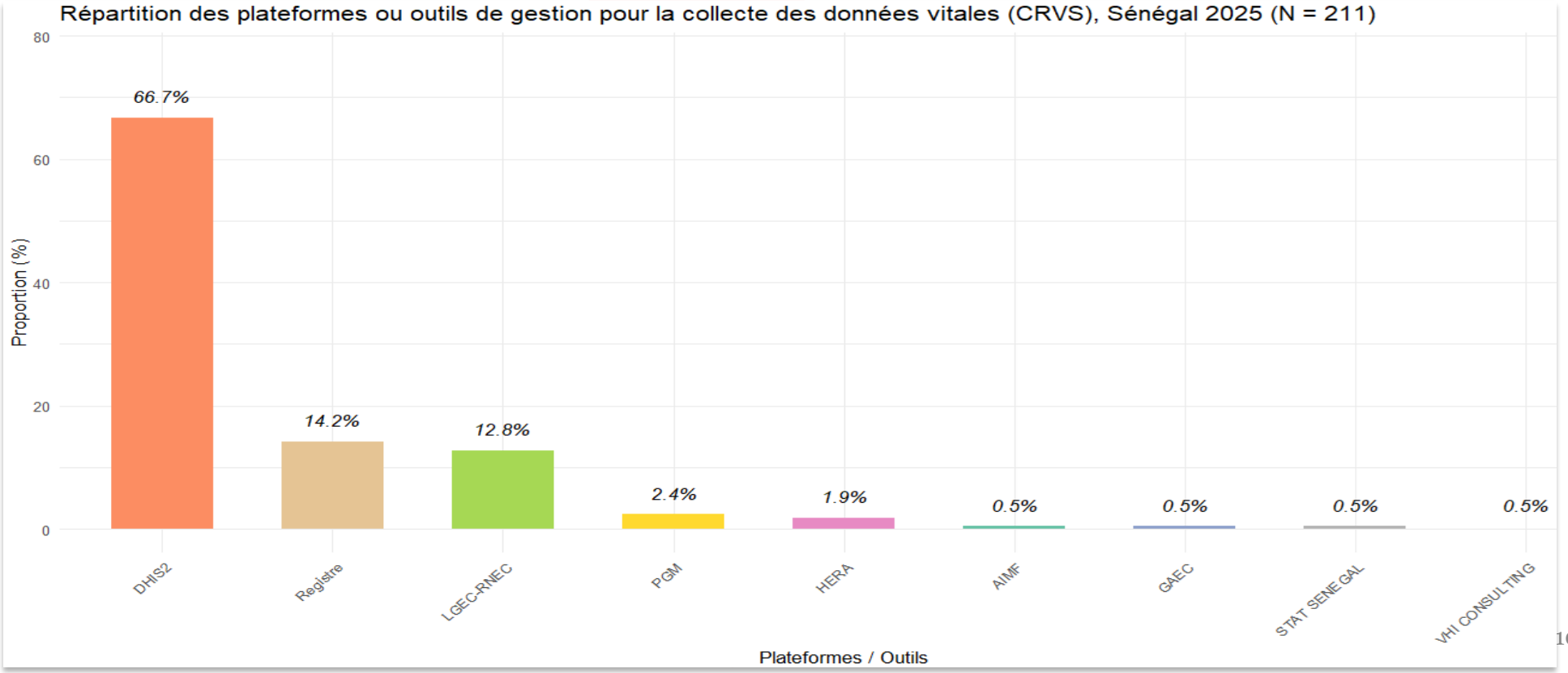
Team:

- Pr Ibrahima SECK
- Dr Boly DIOP
- Dr Malick ANNE
- M. Atoumane FALL
- Dr Adia Mah Diamaro DIANÉ
- Dr Tidiane GADIAGA

Dar Es Salam, Tanzania June 04 2025

KEY RESULTS (1/4)

R1: Existence of Platforms and Management Tools for Collecting Vital Event Data (DHIS2, RGEC, LGEC.....)



KEY RESULTS (2/4)

R2: Existence of Vital Data Collected (deaths, births, pregnancies, causes of death, population counts, etc.).

Types and approaches to data collection	Collected data	
Data types	**Accomplished**	**Proportion %**
Deaths	198	93,8
Birth	192	91,0
Pregnancies	145	68,7
Causes of death	128	60,7
Population census	103	48,8
Approaches used		
Civil registration	128	60,7
Census	45	21,3
Surveys	48	22,7
Health information system/routine data	146	69,7

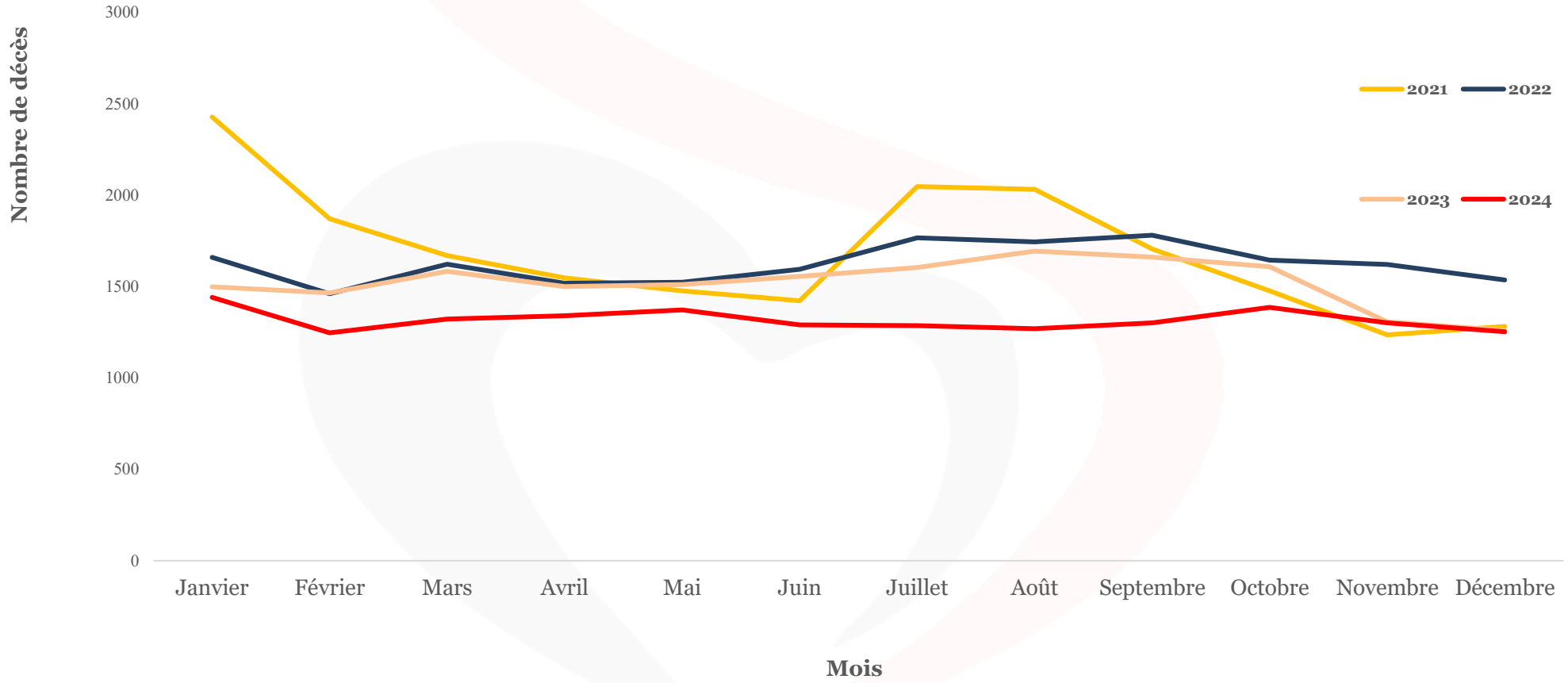
KEY RESULTS (3/4)

- R3: Use of Monitoring Systems to Collect Mortality Data

Approaches used to collect data	Collecting data	
	Yes	
	Accomplished	%
Verbal Autopsy	27	56,3
Surveillance of maternal, perinatal deaths, and response (SDMPR)	113	86,3
Integrated disease surveillance and response (SIMR)	105	80,2
Population Observatory / Health and demographic monitoring system (HDSS)/CHAMPS	32	24,4
Civil Registration System and Vital Statistics (CRVS) / Community surveillance	36	27,5
Cemetery surveillance	1	0,8

KEY RESULTS (4/4)

- R4: Availability of Monthly Changes in the Number of Deaths from 2021 to 2024



LESSONS LEARNED

- Setting up an SRS is a gradual process.
- The SRS does not replace other existing systems, but complements them.
- Different models for integrating the SRS into the CRVS.

CHALLENGES AND OPPORTUNITIES (1/2)

Gaps	Opportunities with SRS
• Multiple, compartmentalized subsystems for recording vital events.	• Establishing communication between these subsystems through interoperability.
• Incompleteness and incompleteness of vital data reported by recording systems.	• Improving the completeness and exhaustiveness of vital data.
• Failure to digitize death notification procedures in the health sector.	• Full digitization of death notification procedures.

CHALLENGES AND OPPORTUNITIES (2/2)

Gaps	Opportunities with SRS
• Failure to involve community players in mortality monitoring.	• Use of community players in monitoring vital events (deaths and births) at community level.
• Lack of training for healthcare providers and agents in other sectors on death management and birth registration procedures.	• Capacity-building for healthcare providers and agents from other sectors on death management and birth registration procedures.

NEXT STEPS

	February 2025	March 2025	April 2025	May/June 2025
Drafting the protocol				
Submission to CNERS				
Recruitment of interviewers				
Interviewer training				
Field data collection				
Data processing				
Data analysis				
Report preparation				
Report sharing				

- **June - September 2025:**
  - ✓ Finalization of the situational analysis report.
  - ✓ Workshop to share the situational analysis with BSS stakeholders.
  - ✓ Drawing up a national plan to implement the SRS in Senegal.
  - ✓ Plan budgeting.
  - ✓ Plan validation.
- **October 2025 - September 2029: Implementation of SRS**

THANK YOU

UNIVERSITE GASTON BERGER
L'excellence au service du développement

ANSD

BILL & MELINDA GATES foundation

Bloomberg Philanthropies

DATA FOR HEALTH INITIATIVE

Vital Strategies

Tanzania

T2-PSL-v19.0

ISO 9001:2015 certified

IFAKARA HEALTH INSTITUTE

research | training | services

Sample Registration System (SRS) Planning Grant - Tanzania

Mortality Data Systems Assessment

Presenter: Gisbert Msigwa

Ramada Hotel – Dar es Salaam

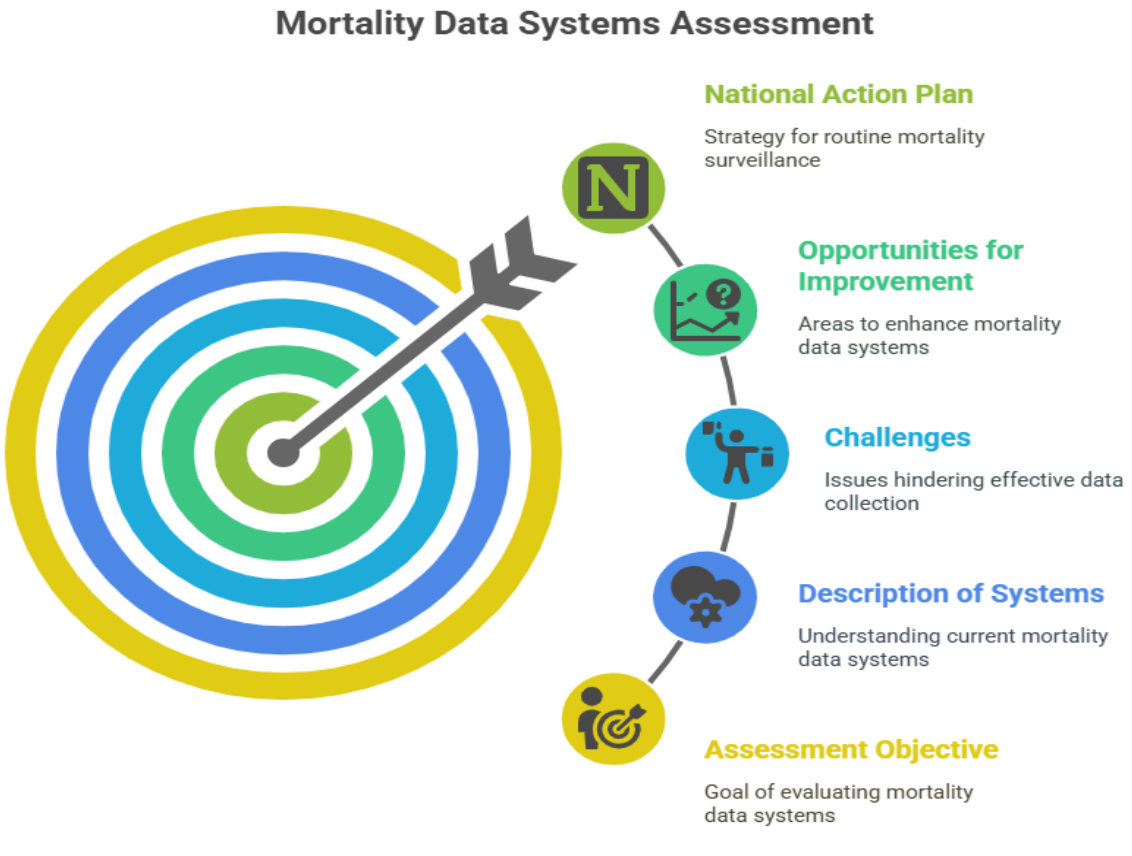
4th June 2025

ISO 9001:2015 certified

IFAKARA HEALTH INSTITUTE

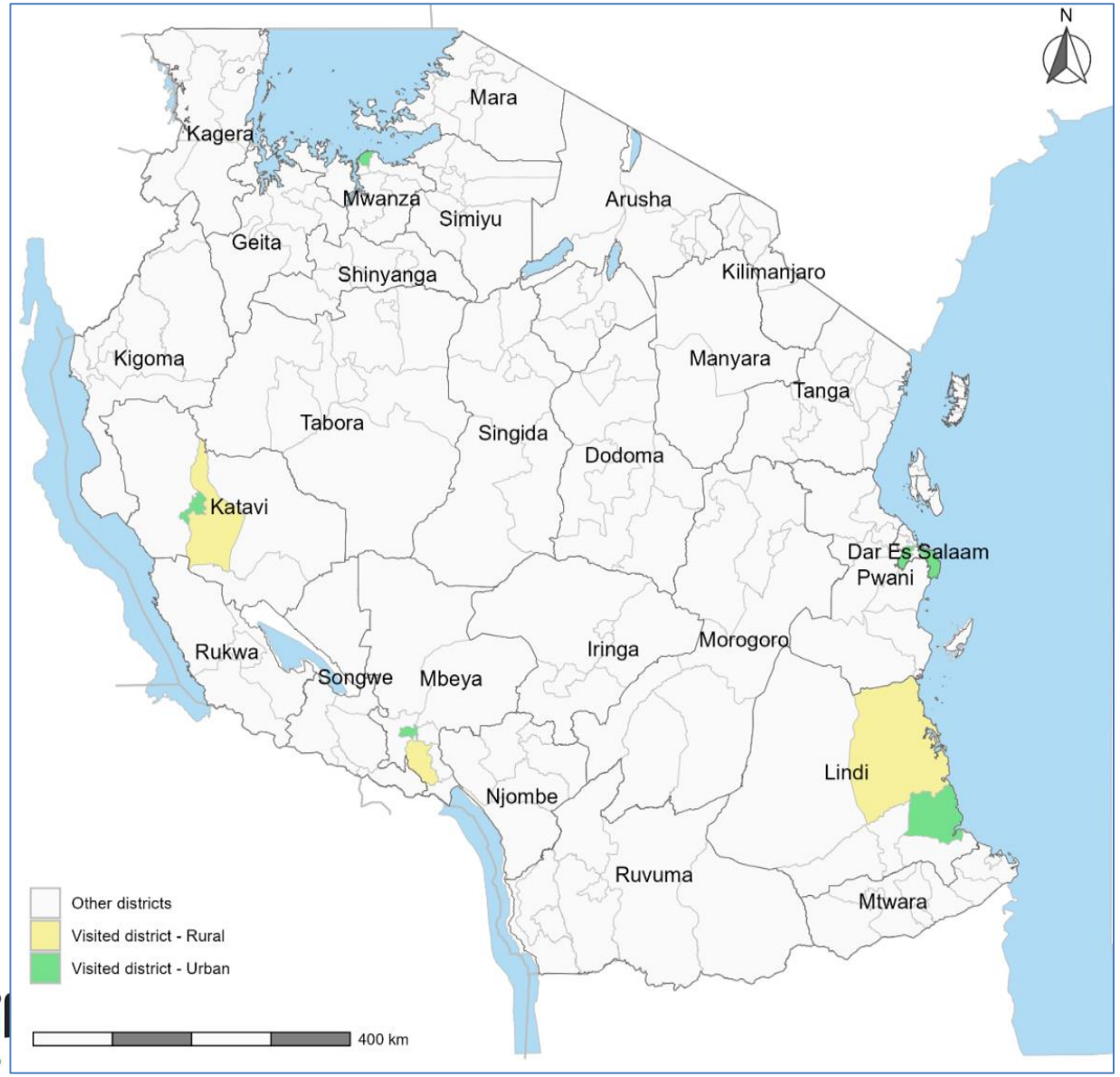
research | training | services

Objective of this assessment



- The assessment sought to identify and describe the current state, and challenges of existing mortality data systems.
- It also aimed to identify opportunities to improve the state of mortality data in Tanzania and support the formulation of a national action plan for a routine mortality surveillance program through SRS implementation.

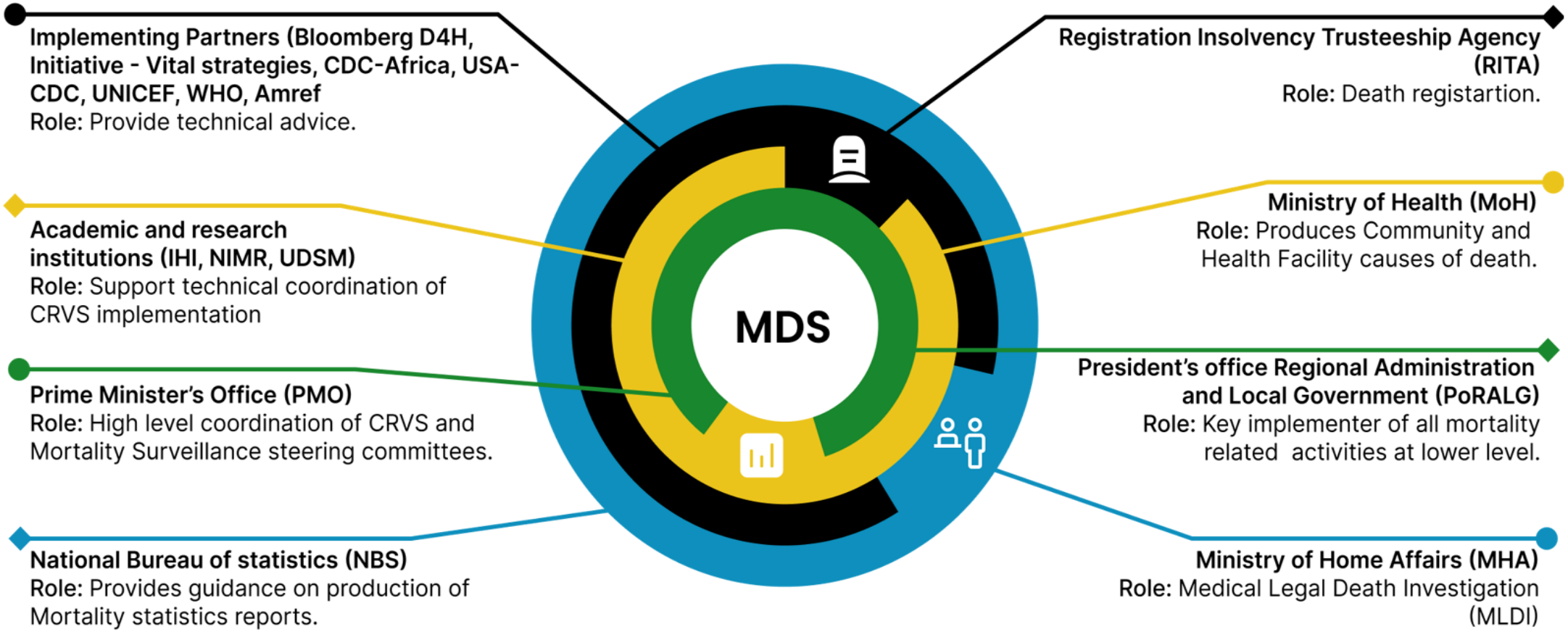
Study Proposal, Sites and Respondents



- The study was preceded by the ethical clearance provided by NIMR.
- Individuals working at the national, regional, district, facility, and community levels were participated in the study.
- Data was collected by trained field interviewers using electronic data collection tools embedded in Tablets.
- Study sites included 5 Regions. Two districts (Urban and Rural) were purposively selected in each region.

Results from the assessment

Mortality data systems' stakeholders in Tanzania



To have active technical working groups meet as per ToRS, SRS will technically be led by IHI, will be coordinated by MoH while having desk officers from each of the key institutions (NBS, PoRALG, RITA, MoHA etc)

Mortality data and information systems

SN	Mortality data platform	Managing institution	Geographic Scope	Type of mortality data	Level of data collection
01	CRVS	MoCLA	National	Individual	Health facility and Community
02	DHIS2	Ministry of Health	National	Individual and aggregate	Health Facility
03	MPDSR	Ministry of Health	National	Individual	Health facility and Community
04	IDSR	Ministry of Health	National	Individual and aggregate	Health facility and Community
05	CRVS Decentralized	MoCLA	Regional	Individual and aggregate	Health facility and Community
06	CRVS VA	Ministry of Health	Nationally representative sample	Individual and aggregate	Community deaths only
07	MLDI	Ministry of Home Affairs	National	Individual	Health facility and Community
08	HDSS	National Institute for Medical Research	District	Individual	Community deaths

- 8 systems were identified and assessed, same information being collected multiple times, projections are used as denominators.

SRS will use enumeration to have active denominators.

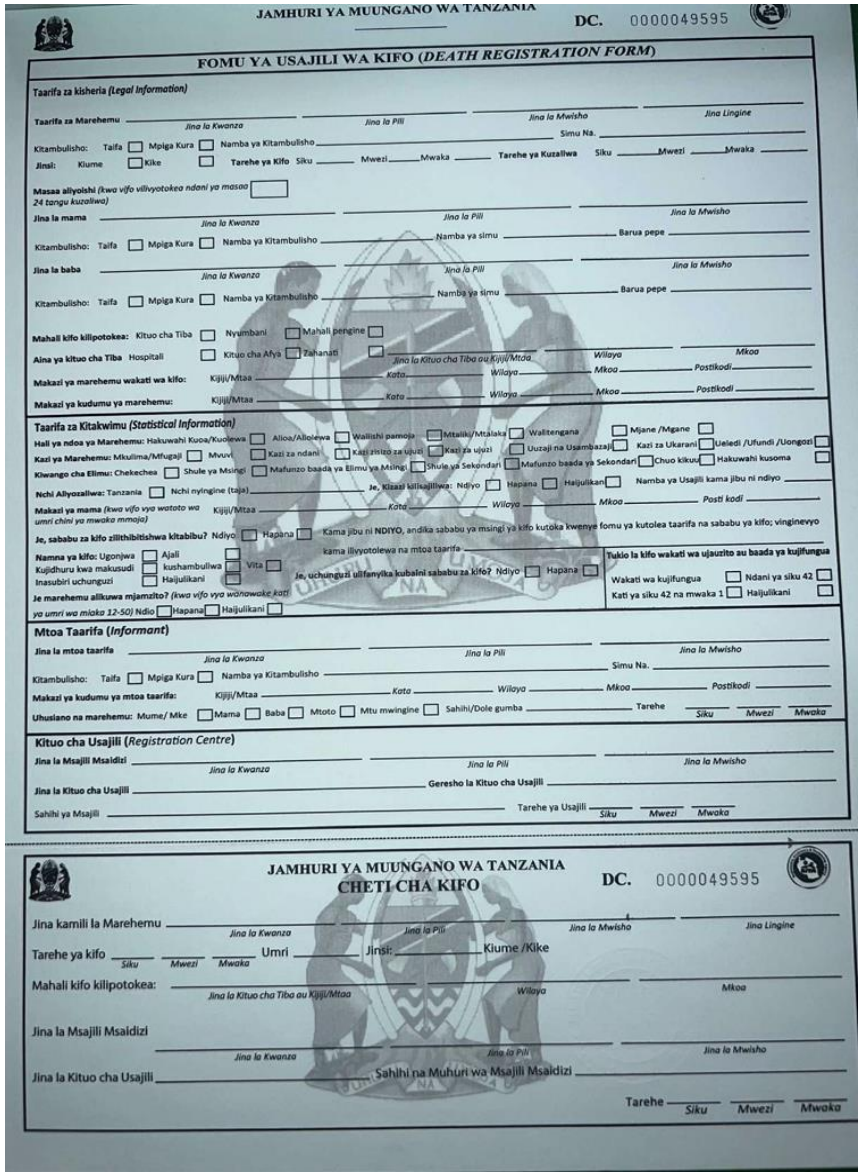
Through SRS information will be collected once and used multiple times

Data Capture forms

- We have identified 20 forms that are used for mortality system related data capture by different institutions that were assessed.
- Majority of forms were paper based at a point of data collection and transmission was electronic (hybrid systems)
- Cadres identified to be involved in production of mortality data included nurses, vital events registrar, mortuary attendants, police, community health workers, clinicians and local leaders.

Digitize the data collection forms

Use community CHWs in data collection, they are now government employees and curricula include data collection


JAMHURI YA MUUNGANO WA TANZANIA

DC. 0000049595

FOMU YA USAJILI WA KIFO (*DEATH REGISTRATION FORM*)

Taarifa za kisheria (*Legal Information*)

Taarifa za Marehemu — Jina la Kwanza — Jina la Pili — Jina la Mwisho — Jina Lingine

Kitambulisho: Taifa ☐ Mpiga Kura ☐ Namba ya Kitambulisho — Simu Na.

Jinsi: Kiume ☐ Kike ☐ Tarehe ya Kifo Siku Mwezi Mwaka — Tarehe ya Kuzaliwa Siku Mwezi Mwaka

Masaa aliyoishi (*kwa vifo vilivyotokea ndani ya masaa 24 tangu kuzaliwa*)

Jina la mama — Jina la Kwanza — Jina la Pili — Jina la Mwisho

Kitambulisho: Taifa ☐ Mpiga Kura ☐ Namba ya Kitambulisho — Namba ya simu — Barua pepe

Jina la baba — Jina la Kwanza — Jina la Pili — Jina la Mwisho

Kitambulisho: Taifa ☐ Mpiga Kura ☐ Namba ya Kitambulisho — Namba ya simu — Barua pepe

Mahali kifo kilipotokea: Kituo cha Tiba ☐ Nyumbani ☐ Mahali pengine ☐

Aina ya kituo cha Tiba: Hospitali ☐ Kituo cha Afya ☐ Zahanati ☐ — Jina la Kituo cha Tiba au Kijiji/Mtaa — Wilaya — Mkoa

Makazi ya marehemu wakati wa kifo: Kijiji/Mtaa — Kata — Wilaya — Mkoa — Postikodi

Makazi ya kudumu ya marehemu: Kijiji/Mtaa — Kata — Wilaya — Mkoa — Postikodi

Taarifa za Kitakwimu (*Statistical Information*)

Hali ya ndoa ya Marehemu: Hakuwahi Kuoa/Kuolewa ☐ Alioa/Aliolewa ☐ Walishi pamoja ☐ Mtalaki/Mtalaka ☐ Walitengana ☐ Mjane /Mgane ☐

Kazi ya Marehemu: Mkulima/Mfugaji ☐ Mvuvi ☐ Kazi za ndani ☐ Kazi zisizo za ujuzi ☐ Kazi za ujuzi ☐ Uuzaji na Usambazaji ☐ Kazi za Ukarani ☐ Ueledi /Ufundi /Uongozi ☐

Kiwango cha Elimu: Chekechea ☐ Shule ya Msingi ☐ Mafunzo baada ya Elimu ya Msingi ☐ Shule ya Sekondari ☐ Mafunzo baada ya Sekondari ☐ Chuo kikuu ☐ Hakuwahi kusoma ☐

Nchi Alyozaliwa: Tanzania ☐ Nchi nyingine (taja) — Je, Kizazi kilikajiliwa: Ndiyo ☐ Hapana ☐ Haijulikani ☐ Namba ya Usajili kama jibu ni ndiyo

Makazi ya mama (*kwa vifo vya watoto wa umri chini ya mwaka mmoja*) — Kijiji/Mtaa — Kata — Wilaya — Mkoa — Posti kodi

Je, sababu za kifo zilithibitishwa kitabibu? Ndiyo ☐ Hapana ☐ Kama jibu ni NDIYO, andika sababu ya msingi ya kifo kutoka kwenye fomu ya kutolea taarifa na sababu ya kifo; vinginevyo kama iliyvyotolewa na mtoa taarifa

Namna ya kifo: Ugonjwa ☐ Ajali ☐ Kujidhuru kwa makusudi ☐ kushambuliwa ☐ Inasubiri uchunguzi ☐ Haijulikani ☐ Vita ☐

Je, uchunguzi ulifanyika kubaini sababu za kifo? Ndiyo ☐ Hapana ☐

Je marehemu alikuwa mjamzito? (*kwa vifo vya wanowake kati ya umri wa miaka 12-50*) Ndio ☐ Hapana ☐ Haijulikani ☐

Tukio la kifo wakati wa ujauzito au baada ya kujifungua

Wakati wa kujifungua ☐ Ndani ya siku 42 ☐

Kati ya siku 42 na mwaka 1 ☐ Haijulikani ☐

Mtoa Taarifa (*Informant*)

Jina la mtoa taarifa — Jina la Kwanza — Jina la Pili — Jina la Mwisho

Kitambulisho: Taifa ☐ Mpiga Kura ☐ Namba ya Kitambulisho — Simu Na.

Makazi ya kudumu ya mtoa taarifa: Kijiji/Mtaa — Kata — Wilaya — Mkoa — Postikodi

Uhusiano na marehemu: Mume/ Mke ☐ Mama ☐ Baba ☐ Mtoto ☐ Mtu mwingine ☐ Sahihi/Dole gumba ☐ Tarehe Siku Mwezi Mwaka

Kituo cha Usajili (*Registration Centre*)

Jina la Msajili Msaidizi — Jina la Kwanza — Jina la Pili — Jina la Mwisho

Jina la Kituo cha Usajili — Geresho la Kituo cha Usajili

Sahihi ya Msajili — Tarehe ya Usajili Siku Mwezi Mwaka

JAMHURI YA MUUNGANO WA TANZANIA

CHETI CHA KIFO

DC. 0000049595

Jina kamili la Marehemu — Jina la Kwanza — Jina la Pili — Jina la Mwisho — Jina Lingine

Tarehe ya kifo Siku Mwezi Mwaka — Umri — Jinsi: Kiume /Kike

Mahali kifo kilipotokea: — Jina la Kituo cha Tiba au Kijiji/Mtaa — Wilaya — Mkoa

Jina la Msajili Msaidizi — Jina la Kwanza — Jina la Pili — Jina la Mwisho

Jina la Kituo cha Usajili — Sahihi na Muhuri wa Msajili Msaidizi

Tarehe Siku Mwezi Mwaka

Features of interoperability between the existing ICT systems used for Mortality Surveillance in Tanzania

- All systems do not routinely exchange data.
- All systems assessed were found to have an ongoing data integration status with the next step being finalization, testing, and rollout.
- All assessed systems had individual and aggregated data, which creates a conducive environment for data users.

We will use data systems integration to facilitate data exchange between SRS and CRVS

Vision of Tanzania SRS

To establish functioning and efficient vital events' registration system that supports effective decision making

- The vision will be 5 years to align with RITA's vision and complement on Tanzania Developent Vision 2050.
- The SRS will produce timely and accurate agreed data sets.

Considerations for integrated SRS in Tanzania

1. Socio-demographic Data collection in SRS Sample – enumeration. Phase wise approach

2. Continuous update of Births, Deaths, CoD and pregnancy tracking by CHWs who also complete all relevant notification forms.

3. Birth and Deaths notification forms sent to CR to facilitate Vital Events registration.

4. **Mortality Surveillance**
   - Follow-up deaths with verbal autopsy to ascertain CoD
   - VA supervisor visit households to conduct VA interview
   - System's data linkage between CRVS, DHIS2, EMR systems, eIDSR and SRS.

5. **Dissemination and use of SRS Data**
   - Region will be our sub-national level.
   - Government and other stakeholders use SRS indicators for decision making, informing interventions, public health programs and for national and international reporting (eg; tracking SDGs)

6. Provision of platform for supporting special surveys and other nested studies (eg. maternal and child health, immunization, clinical trias etc).

Next steps

- Finalize the assessment report to incorporate the missing contents.
- Design the SRS (agree on sampling strategy).
- Costing the SRS implementation.

Thank you for listening

Lunch

Outings

IHI site visit to Bagamoyo
Gift shopping

Closing