

Civil Registration and Vital statistics Progress Report



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Uganda National Institute of Public Health
D4Health Initiative



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1.0 Executive summary

During this quarter, Data for Health Initiative supported The Ministry of Health (MoH) and the National Identification and Registration Authority (NIRA) in collaboration with its to scale up access to death notification and certification services.

NIRA has undertaken an internal review process to assess the business process for the birth and death registration, followed by training CRVS duty bearers in referral and Health Centre IVs. D4H supported the legal review of the existing laws on CRVS championed by Vital strategies. NIRA continues birth and death registration at both facility and community level with use of the local government structures in place led by their district offices and support by the subcounty level. All notifications and registrations are submitted into the Mobile Vital statistics System (MVRS). The current notifications stand at 10% (13,191/135,000) for birth and 2% (492/23,300) for death.

In collaboration with the Directorate of Curative Services at MoH, D4H has led several discussions and presentations to support improvements in Medical Certification of Cause of Death (MCCD) through the use Health Management Information Systems (HMIS) form 100 and the International Classification of Disease-11 (ICD11)/MCCD app at health facility level. D4H has engaged MoH departments engaged including the AIDS Control Program (ACP), the National TB and Leprosy Program (NTLP), community Health (CHD) and clinical services department in review of HMIS tools to improve mortality surveillance data capture and reporting. D4H team made recommendations for the revision of MoH-HMIS tools which await review and approval from the respective MoH departmental technical working groups and the senior management committee Task forces. Monthly performance results from trained District hospital and Regional referral hospitals have been disseminated to encourage and improve MCCD use and mortality reporting at health facility level. Currently MCCD and reporting is very low (6%) at RRH's and only 2% at regional level.

2.0 Current Work and Country Updates

The team has conducted the following activities;

2.1 Review of Uganda's Legal Frameworks on Civil Registration, Vital Statistics and Identification Management Systems

2.1.2 Results of the CRVSID legal review

Following the launch of the legal review in February 2020, the Global Health Advocacy Initiative (GHA) supported this 4-day long workshop aimed at presenting the results of the CRVS legal review to key stakeholders in Uganda to facilitate discussions and reach consensus on priority issues for undertaking legal reform. The workshop entailed presentations and discussions of the results of the CRVSID legal review, highlighting the following:

- Gaps and obstacles in the legal framework which prevent timely, continuous and universal registration;
- Elements where the legal framework does and does not align with international best practices;
- Clarification of the roles and responsibilities of CRVSID stakeholders to strengthen their collaboration; and
- Strategies required for strengthening the CRVSID legal framework through legal reform and administrative measures

2.1.2 Budget advocacy

A presentation and discussions were also help on budget Advocacy Inception and focusing of gaps in CRVS financing and strategy development to support domestic funding for CRVS

2.1.3 The CRVS Technical Working Group (TWG) meeting

The workshop was concluded with a CRVS technical working group meeting during which the processes and steps for development of the CRVS Policy were outlined as follows;

Step 1 – Identifying of the issues of concern

- preliminary meeting to prepare the Terms of Reference (TOR) for the Technical Working Group (TWG)
- Come up with a technical group to champion CRVS Policy formulation
- Concept note
 - Put ideas on paper so people understand the problem
 - With proposals for top management to adopt proposals
 - With nominations for technical working group

Step 2 – Regulatory Impact Assessment (RIA)

- Work with lawyers, parliamentary council
- Stakeholder assessment

Step 3 – Rresearch around this issue, situational analysis

- Agenda setting, developing documents to position ideas for resources, involves parliamentarians, etc.

Step 4 – Development of policy itself

Step 5 – Legislative process

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- Cabinet approval
- Parliamentary approval

2.2 Support Medical Certification of Cause of Death and use of the ICD11 module in DHIS2 at district level

2.2.1 Support for CDC Mortality Surveillance activities

Following a two weeks supervision of the CDC/Baylor mortality Surveillance (MS) project in Kabarole, Kyenjojo and Bunyangabu Disticts involving both facility (3 Hospitals) and Community (3 sub counties), it was found that structures in place are well instituted and functional however there is minimal reporting on mortality and use of the MCCD/ICD11 app at all health facilities. D4H

engaged the CDC-Uganda team to discuss support MoH in improving mortality surveillance systems in place to enhance data capture, storage, access and utilization through country projects and implementing partners. We continued these discussions to provide technical guidance on approaches to implementation of MS activities under Country Operational Plan (COP) for the year 22/23

2.2.2 MoH support

The team has also participated in monthly meetings with the MoH to discuss modalities to improve Health facility use of MCCD and reporting in ICD11 through review/feedback meetings and follow up support. These meetings included the MoH departments (2 with AIDS Control Program-AIC and 2 with the National Tuberculosis and Leprosy program-NTLP) to discuss uptake and use of Medical Certification of Cause of Death with HMIS form 100 for deaths reported in the programs. We have also attended 2 MoH 5-day workshops to review HMIS tools and improve on data capture for mortality surveillance at both Health facility and community level in reference to data variables and indicators for reporting at national level.

With support from the directorate of curative services, D4H guided the development and distribution of a circular endorsed by the MoH-Director General of Health services to all District Health Officers, Regional referral and general District Hospitals and Health Center IV's in-charges to facilitate implementation and improvements of MCCD/ICD11 for all deaths that occur at health facility level.

2.2.3 Support for the CRVS National Integrated Surveillance System

D4H participated in the development of the action plan for population-based surveillance and CRVS team as contribution to the National Integrated surveillance System (NISS). This involved discussions in 3 meetings with National CRVS stakeholders to conduct situation analysis and gap identification of the National civil registration and Vital statistics systems.

2.2.4 Analysis of Cause of Death training

We participated in a 3-day regional workshop held on 22-24 August in Kigali, Rwanda on Analyzing Mortality and Causes of Death (ANACoD3) hosted by Vital Strategies and the Bloomberg Philanthropies Data for Health Initiative. The training aimed to build the skills of

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Civil Registration and Vital Statistics (CRVS) staff in data management, analysis, and assessment of the quality of cause-of-death (COD) data for civil registration and vital statistics (CRVS) system improvement and the use of data for decision-making.

2.2.5 MCCD quality Improvement

D4H is also supporting with provision of guidance on MCCD/ICD11 data quality improvement at Jinja Regional Referral hospital through the Field Epidemiology Training Program (FETP). We conducted a half day training covering the following;

- Introduction on use of mortality data, overview of the MCCD form 100 and previous performance in MCCD from January- August
- Filling the MCCD and ICD11 in DHIS2 using practical examples/ scenarios

The major concerns/issues raised, the discussion and their responses were as follows;

- Who should fill in the form 100 (The ward clinical teams lead by a doctor on each ward during the ward hand over meetings on in the ward weekly review meetings).
- Who should oversee that forms are available and filled - (the ward/ departmental in-charge).
- Who should fill the MCCD in to ICD11 (the records officer or one of the trained clinicians guided by the clinical team during their ward meetings).
- Who should oversee the entire process- the hospital appointed MCCD focal person

The next steps and follow up include the following;

- Mentorship sessions (during one of their ward meetings) on ICD11 for ward clinicians by the records officer.
- Follow up on MCCD and ICD11 entries of all new deaths occurring through the ward incharges weekly by Petra
- Review of all deaths reported in DHIS2 reports in comparison to MCCD's and ICD11 entries each.

2.2.6 MCCD performance reviews

D4H team continues to support MCCD data collation, analysis and interpretation of Mortality data reported in DHIS2 and the ICD11 module. Below are the current results of the number of deaths reported in DHIS2 and those certified using MCCD/ICD11 module by health facility from January-June 2022.

Deaths reported and certified by the trained Regional referral Hospitals (July-September 2022)

Table 1: This table shows all deaths reported and certified in DHIS2 by the trained RRH's January-June, July-August and September 2022)

HMIS Data Elements used:

- 105 ES – Outpatient Emergency Unit Deaths, 105-DT01 – Outpatient Deaths,
- 108-IC03 – Inpatient Deaths, 106a-HC28 HIV Clinic Deaths,

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- 105-MA13 – Maternal deaths, 105-MA12 – Neonatal deaths (8-28 days), 105-MA11 – Newborn deaths (0-7 days)

Note the following;

- i. Only 8/14 RRH in Jul-Aug and 6/14 in September.
- ii. The proportion of certified deaths by all RRH is very low - Average 8% (Jul-Aug) and 6% (September).
- iii. There was marked improvement in Hoima RRH 60% Jul-Aug which declined to 1% in September.
- iv. Improvement by Fort portal RRH from 7% (Jul-Aug) and 46% (September)

		July-August			September		
Sn	RRH	Total IPD 108-IC03,OPD-(Matrnal, neonatal(05 MA-11, MA-12&MA-13) , 105-DT01 & ES10, 106a-HC28) OPD	Total MCCD entries in DHIS2 death module	Proportion of deaths MCCD	Total IPD 108-IC03,OPD-(Matrnal, neonatal(05 MA-11, MA-12&MA-13) , 105-DT01 & ES10, 106a-HC28) OPD	Total MCCD entries in DHIS2 death module	Proportion of deaths MCCD
1	Hoima	229	138	60%	87	1	1%
2	Fort P	544	39	7%	98	45	46%
3	Lira	277	28	10%	104	0	0%
4	Kayunga	40	2	5%	47	0	0%
5	Kawempe	244	9	4%	247	6	2%
6	Mbale	140	2	1%	219	0	0%
7	Masaka	168	1	1%	89	8	9%
8	Jinja	227	1	0%	122	3	2%
9	Arua	164	0	0%	90	0	0%
10	Soroti	81	0	0%	73	0	0%
11	Mbarara	340	0	0%	116	17	15%
12	Gulu	395	0	0%	42	0	0%
13	Entebbe	27	0	0%	10	0	0%
14	Moroto	38	0	0%	18	0	0%
	Grand Total	2914	220	8%	1362	80	6%

Table 2: This table shows all deaths reported and certified in DHIS2 by the 14 regions from January-June, July-August and September 2022.

		July-August			September		
Sn	Region	Total IPD 108-IC03,OPD-(Matrnal, neonatal(05 MA-11, MA-12&MA-13) , 105-DT01 & ES10, 106a-HC28) OPD	Total MCCD entries in DHIS2 death module	Proportion of deaths MCCD	Total IPD 108-IC03,OPD-(Matrnal, neonatal(05 MA-11, MA-12&MA-13) , 105-DT01 & ES10, 106a-HC28) OPD	Total MCCD entries in DHIS2 death module	Proportion of deaths MCCD
1	Kigezi	581	32	6%	366	9	2%
2	Bukedi	371	36	10%	121	7	6%
3	Bunyoro	1017	144	14%	675	1	0%

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4	Bugisu	899	4	0%	330	0	0%
5	Lango	834	12	1%	252	45	18%
6	Ankole	1593	30	2%	325	17	5%
7	North Central	763	43	6%	321	3	1%
8	Kampala	1550	87	6%	793	17	2%
9	West Nile	1891	19	1%	883	9	1%
10	South Central	884	4	0%	620	8	1%
11	Busoga	1028	16	2%	495	9	2%
12	Acholi	1205	33	3%	396	0	0%
13	Karamoja	359	14	4%	135	0	0%
14	Teso	626	45	7%	156	8	5%
	Grand Total	14238	540	4%	5868	133	2%

Note the following;

- i. Proportion of certified deaths by all regions is very low (highest at 14% in Jul-Aug from Bunyoro and 18% from Lango in September).
- ii. We have an MCCD average 4% (Jul-Aug) and 2% (September).

3.0 Issues of concern

- Acceptability of MCCD HMIS form 100 and ICD11 use
- Unclear roles and responsibilities at of staff at health facility, District, regional and national level
- Limited monitoring for use of MCCD, reporting and data use

4.0 Next steps/Upcoming Activities

4.1 Support functionality of DHIS2/MCCD application

- Working with the MoH-Division of Health Information (DHI) team to ensure functionality and use of the DHIS2 ICD11 module to ease data analysis and interpretation.
- Conduct support supervision and mentorship of trained regional referral Hospitals, district hospitals and health Centre IV's
- Develop and disseminate MCCD Standard operating Procedures (SOP's)
- Support mortality data validation and analysis with use of the WHO ANACOD3 tool

4.2 Strengthen NIRA function in CRVS

- Conduct the RIA
- Development and Dissemination of the National CRVS Policy

5.0 Conclusion and recommendations

There is generally very low certification of all deaths at both RRH's (5%) and regional level (3.5%) D4H wishes to continue providing of technical support to strengthen the national CRVS functions through the following;

- Facilitation of quarterly CRVS and MS TWG and relevant subcommittees to strengthen coordination and governance of all cause mortality activities across the country

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- Support linkage of HMIS-MCH death audit forms to HMIS 100 form in MCCD app/DHIS2 to enable reporting of all deaths audited at health facilities including maternal and perinatal deaths (0-28 days) deaths
- Support for digitization of the community Health Information systems to ease data collection, reporting and use of data.
- Activate mortality review meetings at facility level to improve notification, review and MCCD.
- Conduct support supervision and mentorship sessions at regional level
- Continue monthly performance review meetings at national level

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