

Beyond Data Collection: How Bangladesh is Using Mortality Data to Guide Policies

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Death Registration Minimal



1. Death registration very low and late
2. CoD recording negligible (death registration needed for inheritance, CoD not needed!)



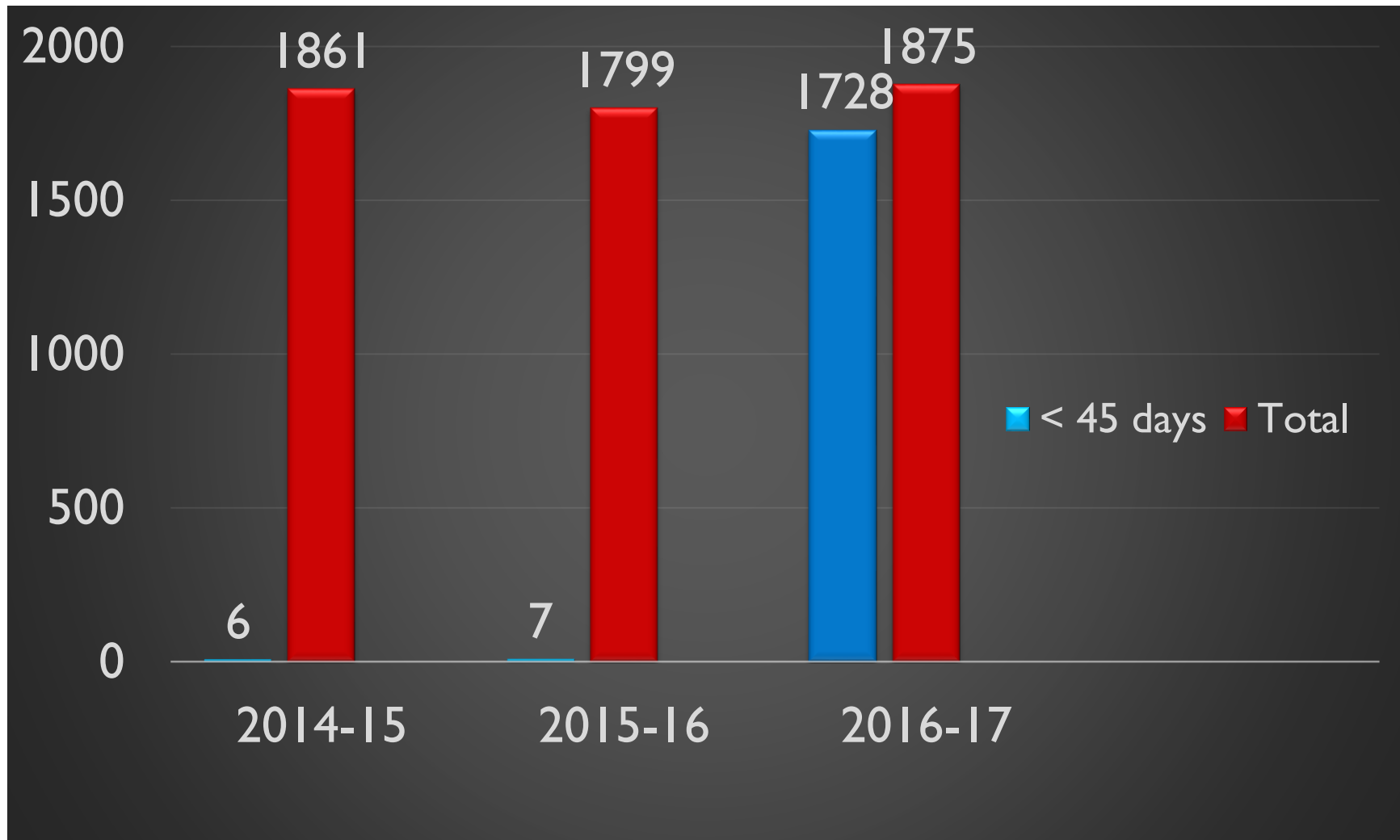
Interventions by Bloomberg D4H



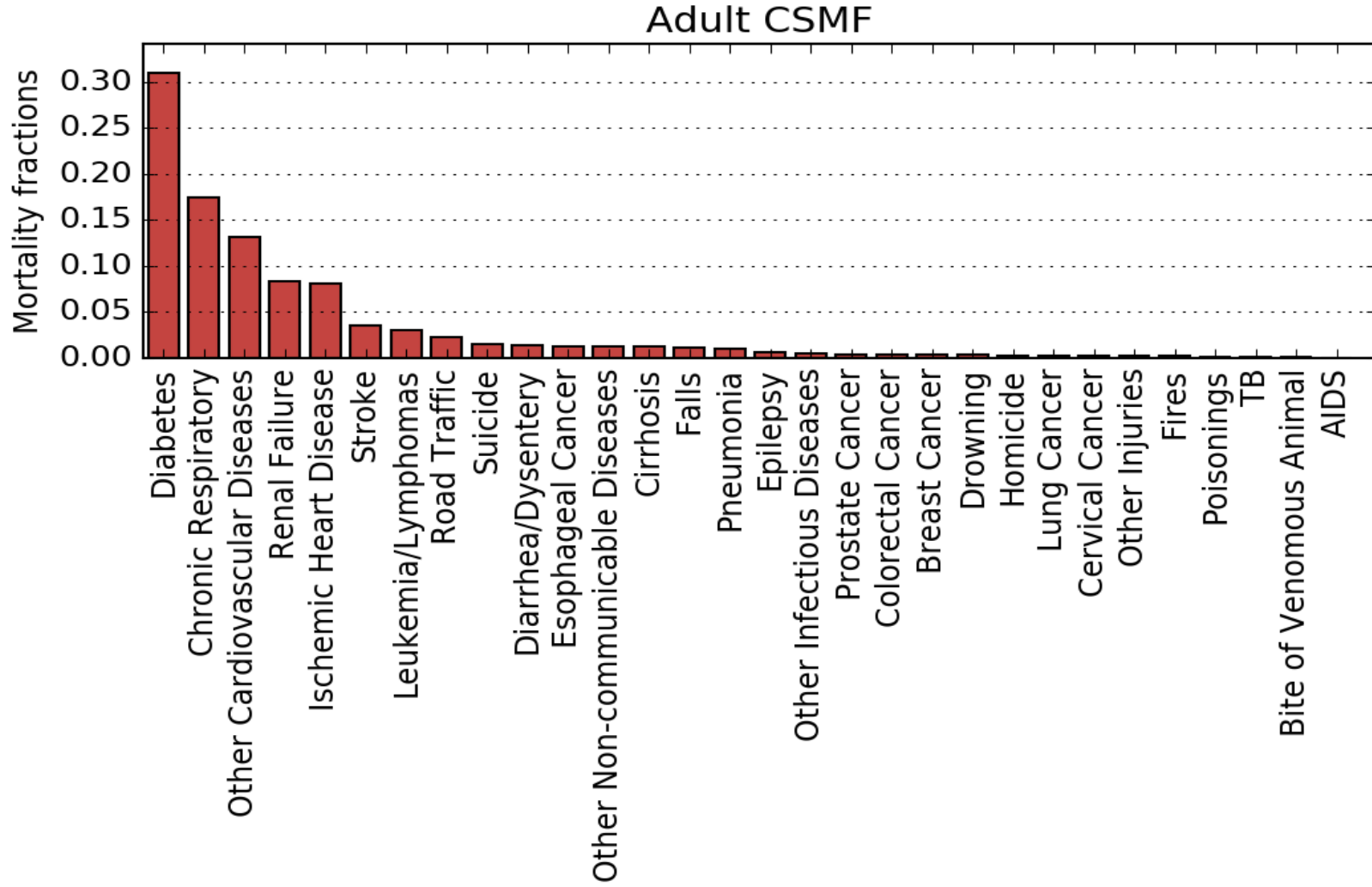
1. **Notification** by health workers sent to registrars
2. International Standard of **Medical Certificate of CoD** and improve medical certification of CoD in hospitals
3. **VA** using tablets where medical certificate is not possible
4. **Capacity development** of 1,300 physicians on MCCoD, 140 staff on VA, 10 staff on ICD-10 coding, 17 personnel on Startup Mortality List (SMoL)
5. **HR support by D4H**: 3 consultants on CR working with CRVS Secretariat at Cabinet Division and 3 on VS at DGHS
6. **Local coordination** by Upazila (sub-district) Administration
7. More actionable **data visualization**



Result: Increased **Death** Registration within 45 Days



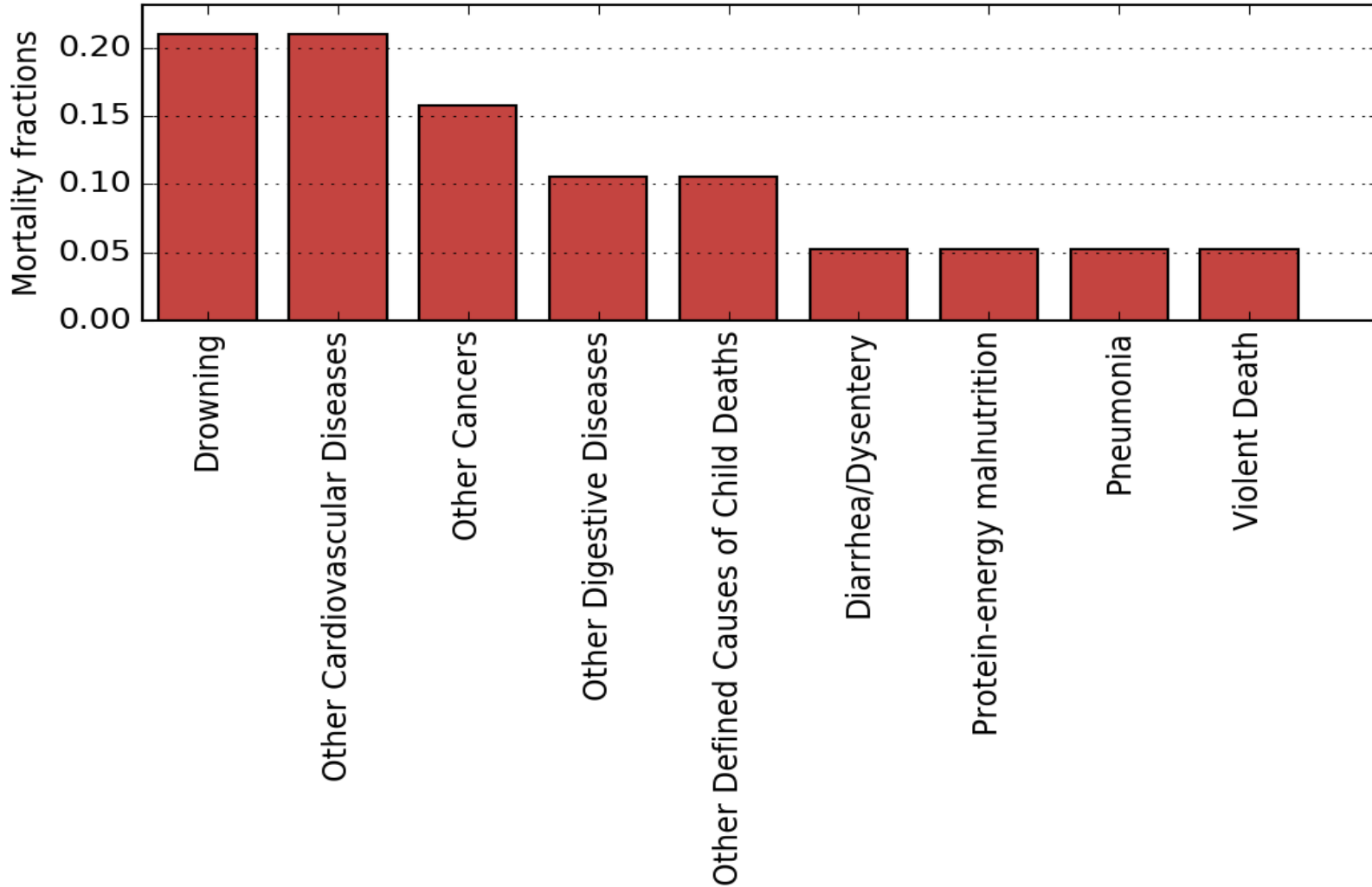
Result: Availability of Intl. Standard Underlying Cause of Death Data: Adult



Result: Availability of Intl. Standard Underlying Cause of Death Data: Child

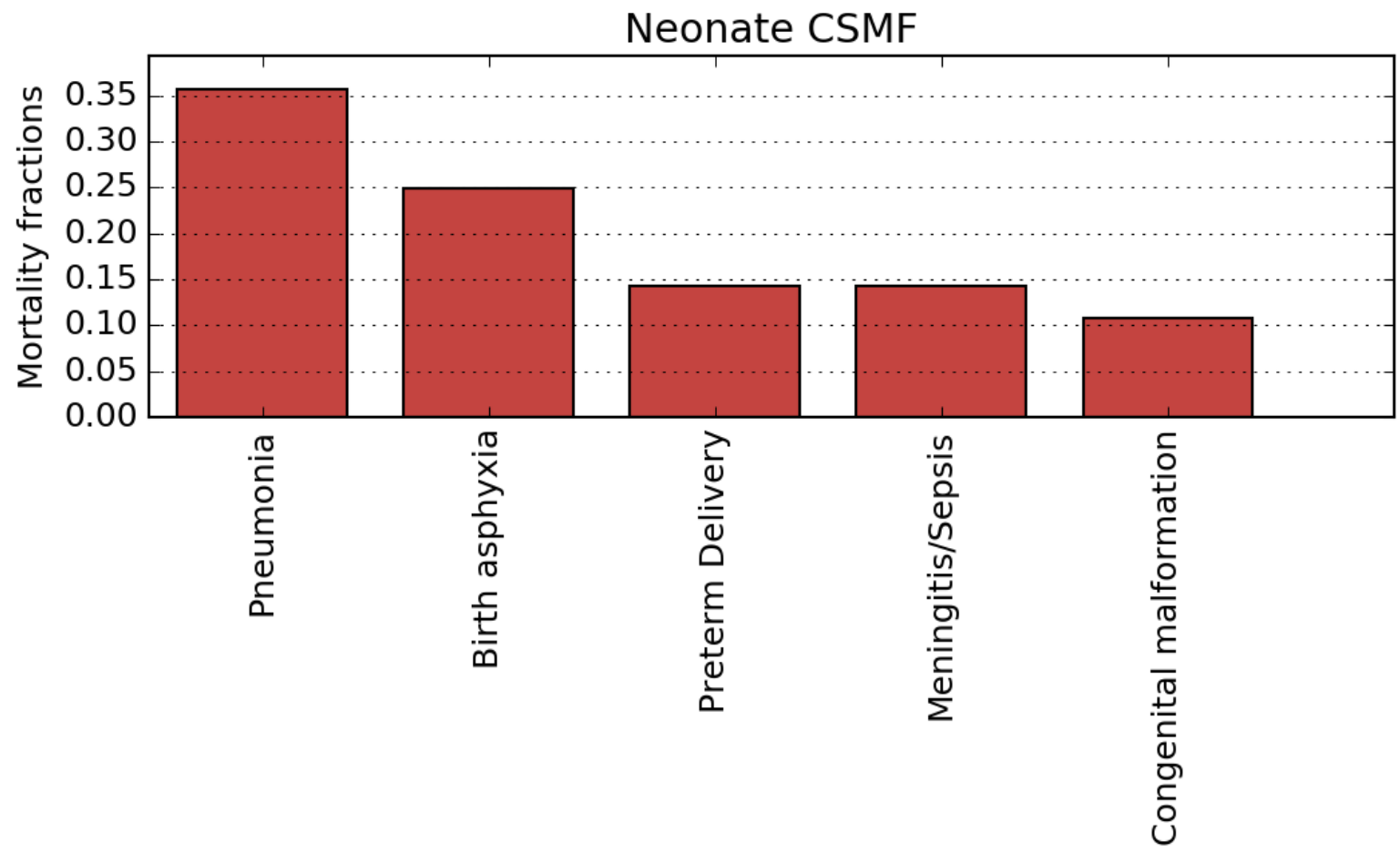


Child CSMF





Result: Availability of Intl. Standard Underlying Cause of Death Data: Neonate



Results



- ▶ In 9 months, in 4 hospitals 2,600 MCCoD issued and transferred to SMoL module in DHIS-2; a total of 2,200 VA
- ▶ Policy level recognition for ascertaining underlying CoD
- ▶ Health Ministry decided to incorporate CoD in undergraduate medical curriculum
- ▶ Creating permanent post of coders



Open Questions



1. How sustainable beyond pilot period?
 2. How scalable beyond pilot location?
 - a. Funding
 - b. Human resources capacity development
 - c. Monitoring
 - d. Incentives/time for doctors and health workers
 3. Who ensures quality of content for MCCoD in undergraduate curriculum?
 4. How to improve data visualization of CoD data for policy makers?
 5. How to create demand for death registration and CoD inclusion?
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