



# Country Experience: Rwanda



- **Approach**

- **Community surveillance/Health facility?**

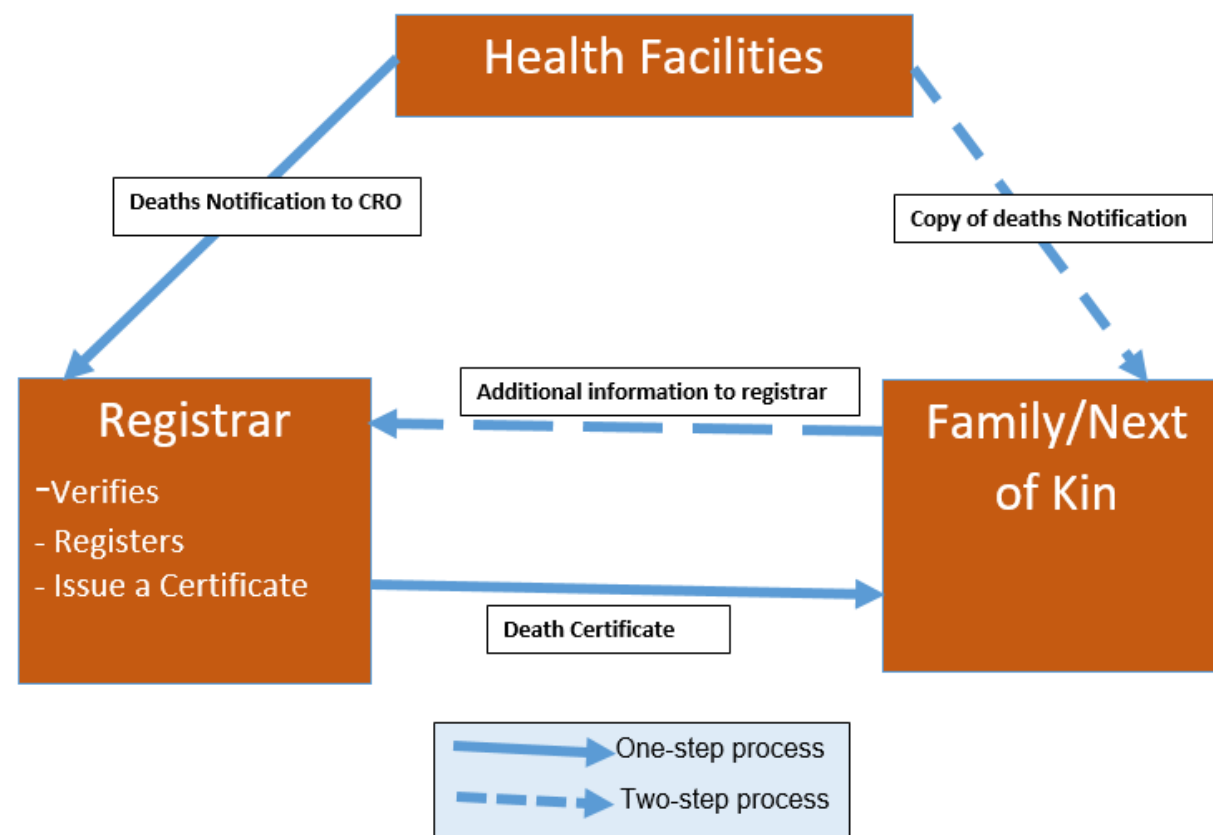
- Mapping and consultation with all key CRVS stakeholders
    - Identified existing mortality data sources ie DHIS2, CRVS, IDSR
    - National mortality technical committee tasked to coordinate all mortality activities
    - Established RMS technical team to take lead on daily monitoring of mortality reporting
    - Leverage existing mortality reporting systems to avoid duplication of data reporting
    - Oriented RMS technical team on excess mortality analysis and use

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## • Rapid Mortality Surveillance linkages to CRVS

- Health facilities are responsible for notification of deaths to CR office
- Health facility data manager notifies deaths that occurred in the facility to CR office
- Families notify deaths to CR for community deaths
- Physicians are responsible for certification of deaths and deaths report in ICD coding system

Linkages of RMS to CRVS System for Facility Deaths

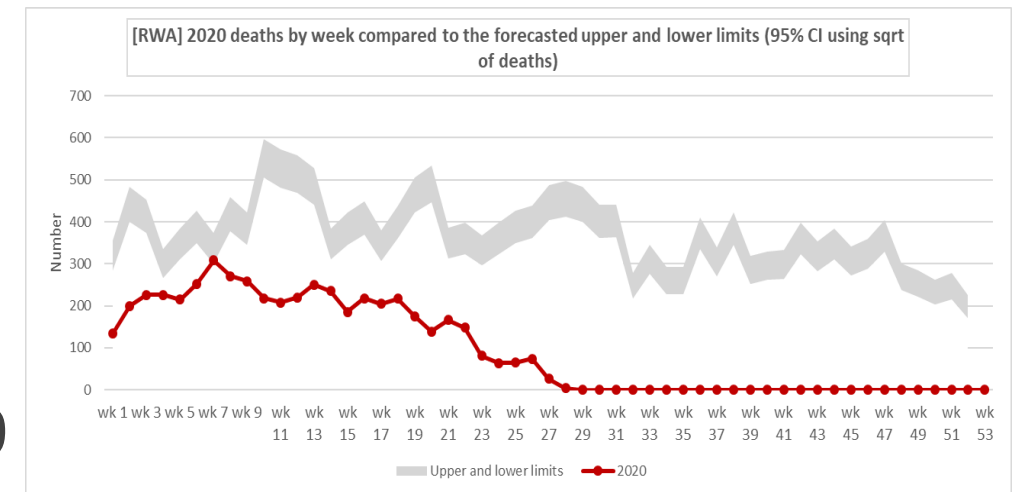
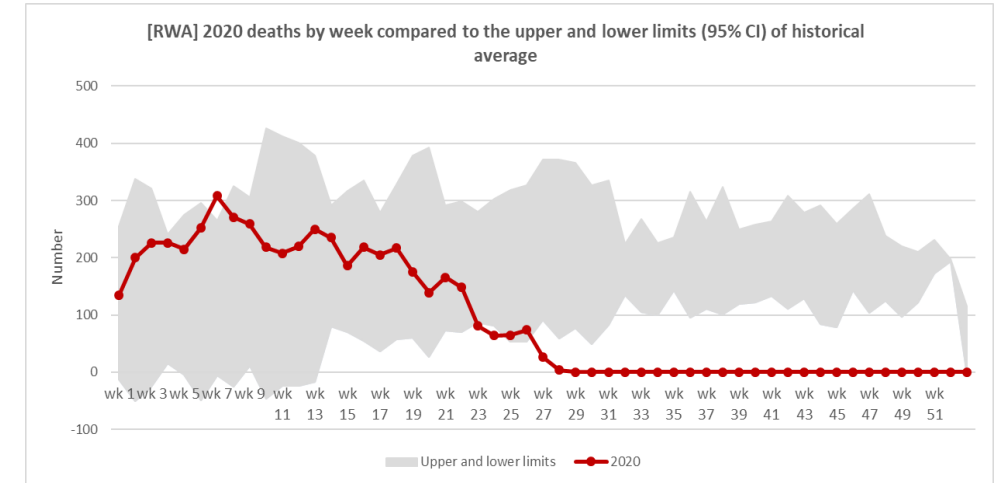


# Country Experience: Rwanda



- Progress and Results to date

- Integrated RMS into routine system in all Health facilities
- Improved DHIS2 for surveillance of deaths in health facilities: COVID-ICD codes introduced
- Improved e-IDSR system to include all-cause mortality for surveillance of deaths in the community
- Historical mortality data for 3 years populated to compute excess mortality due to COVID-19





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- **Long-term plans**
- Develop and integrate an interactive eLearning course unit into existing MCCOD e-learning course to train physicians on correct certification of COVID-19 deaths
- Orient ICD 10 mortality coders on COVID-19 deaths
- Support routine mortality data collection during epidemic
- Continue to collect baseline and historical mortality data to analyze excess mortality and use
- Registration of facility deaths will be done in the health facilities after the law was passed
- Registration of community deaths will be done at Cell level