



Recording and monitoring deaths during heatwaves: a scoping review of mortality attribution and surveillance systems

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ABSTRACT

Background: Heatwaves are a significant public health concern linked to substantial excess mortality worldwide. Most deaths during heatwaves arise from the exacerbation of underlying chronic conditions rather than direct heat-related causes, making individual attribution challenging. Improving how heatwave-associated deaths are recorded and monitored is essential for enhancing data quality, comparability, and public health response.

Objective: To map and synthesise global practices for recording and monitoring heatwave-related mortality, including attribution methods, ICD coding, and integration of real-time surveillance.

Methods: A scoping review was conducted following Joanna Briggs Institute methodology and the Population–Concept–Context framework. Searches were performed in PubMed, Scopus, CINAHL, Embase, and Web of Science from inception. Two reviewers independently screened and extracted data on mortality attribution, ICD coding, recording systems, managing agencies, surveillance approaches, heatwave definitions, limitations, and recommendations. Findings were synthesized using tables, figures, conceptual maps, and narrative summaries. The protocol was registered in the Open Science Framework (OSF) <https://doi.org/10.17605/OSF.IO/5AX4T>.

Results: A total of 176 studies from 41 countries were included. Only 8.5% of the included studies used heat-specific ICD codes to identify direct heat-related death; real-time mortality monitoring systems were limited, fragmented, and inconsistent across jurisdictions.

Conclusions: Heatwave-associated deaths are rarely coded as direct heat-related, reflecting the indirect and multifactorial pathways linking heat to mortality. Significant gaps in global mortality recording and surveillance systems highlight the need for improved attribution practices, standardised coding, integrated systems, and stronger institutional coordination to support public health preparedness in a warming climate.

1. Background

Heatwaves are a growing public health concern worldwide (Xu et al., 2016). Extreme heat can cause direct thermal illnesses such as heat exhaustion and heat stroke (Bouchama and Knochel, 2002), but most deaths occurring during heatwaves arise indirectly through the exacerbation of pre-existing chronic conditions (Thompson et al., 2024a). Elevated temperatures can narrow physiological and therapeutic safety

margins, triggering or accelerating events related to respiratory and cardiovascular diseases, acute kidney injury, mental health conditions, and other comorbidities (Åström et al., 2011). As a result, the mortality burden associated with heatwaves is largely population-level and probabilistic and is not individually identifiable through a single direct cause of death (Zhao et al., 2024).

A recent global modelling study estimated that heatwaves contributed to more than 153,000 cases of excess mortality between 1990 and

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2019, with substantial regional and temporal variations (Zhao et al., 2024). In Australia, heatwaves cause more deaths than all other natural disasters combined, including floods, bushfires, storms, and cyclones (Dey and Lewis, 2021). Between 2000 and 2018, 473 deaths were reported as heat-related (Coates et al., 2022). However, this figure reflects only cases explicitly identified as heat-related in coronial records and may not represent the broader mortality patterns observed during heatwave periods (Coates et al., 2014).

Measuring the true mortality burden of heatwaves remains challenging (Coates et al., 2014). Death certificates record the proximate clinical cause of death, typically a cardiovascular, respiratory, or renal event, and heat is rarely certified as a direct cause except in cases of heat stroke (Longden et al., 2020; Longden, 2025). ICD codes mainly capture direct cases of heat illness, and are not designed to quantify for fully measuring population-level excess mortality (Longden, 2025). Most heat-attributable deaths are detectable only through population-level excess mortality analysis, comparing observed against expected deaths during heatwave periods rather than through individual-level coding (Vicedo-Cabrera et al., 2021). This structural gap between clinical death certification and epidemiological surveillance contributes to persistent inconsistency in heatwave mortality data globally (Gasparrini et al., 2015).

Current approaches to monitoring deaths during heatwaves include national mortality datasets, excess mortality estimation, state-based surveillance systems, hospital and emergency department data, and coronial investigation (Coates et al., 2014; Williams et al., 2018a; Hatvani-Kovacs et al., 2016). Effective surveillance systems are essential for timely public health action, resource allocation, and targeted interventions such as early warning alerts, community outreach, and infrastructure support (Michelozzi et al., 2010a; Sheridan et al., 2011; McGregor, 2024a; Nitschke et al., 2016). However, considerable variability exists in data sources, heatwave definitions, and recording practices, complicating both comparison and quantification globally (Coates et al., 2014; Longden, 2025).

To date, no comprehensive synthesis has been conducted to map the various methods and systems used globally to monitor heatwave-related mortality. This scoping review addresses the research question: How are mortality recording and surveillance systems structured and implemented to monitor deaths occurring during heatwaves globally? The findings will highlight inconsistencies and strengths in current approaches and inform the development of more reliable early warning systems, predictive models, and public health policy.

2. Methods

2.1. Scoping review design

This scoping review followed the methodological framework proposed by Arksey and O'Malley (Arksey and O'malley, 2005), incorporating the enhancements of Levac et al. (2010) and the methodological recommendations of Peters et al., 2020, 2022 to ensure rigor and transparency. Reporting adhered to the PRISMA-ScR (Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews) guidelines (Tricco et al., 2018), supplemented by elements of the STORIES statement (Gordon and Gibbs, 2014) and the BEME collaboration guidance (Hammick et al., 2010). The protocol was registered with the Open Science Framework (OSF) to support methodological rigor (<https://doi.org/10.17605/OSF.IO/5AX4T>).

The review followed the standard five-stage process:

- Stage 1: Identifying the research question (as stated above)
- Stage 2: Identifying relevant studies
- Stage 3: Study selection
- Stage 4: Charting the data
- Stage 5: Collating, summarizing, and reporting the findings

The optional consultation stage was not undertaken, as expertise within the author team (Professor Peng Bi) fulfilled this role.

2.2. Identifying relevant studies

A comprehensive search was conducted on August 18th, 2025, across five major databases: PubMed, Scopus, CINAHL, Embase, and Web of Science (1950 to 2025). The search strategy combined Medical Subject Headings (MeSH) and free-text keywords related to three core concepts: heatwaves and heat exposure, mortality records, and surveillance and monitoring systems. Backward and forward citation tracking was used to identify additional relevant literature. A sample PubMed search strategy is provided in Supplementary File S1.

2.3. Study selection

Two reviewers (TYA and YTD) independently screened titles, abstracts, and full texts. Discrepancies were resolved by consensus. Inclusion was informed by the JBI PCC framework (Peters et al., 2015):

- **Population:** Human populations or communities exposed to heatwaves
- **Concept:** Mortality recording, attribution, surveillance systems, or reporting mechanisms
- **Context:** Any geographic setting where heatwave-related mortality monitoring has been implemented or evaluated

2.4. Inclusion and exclusion criteria

The review included studies employing quantitative, qualitative, or mixed-method approaches that examined heatwave-related mortality, data recording practices, or surveillance systems. Eligible studies were those that analysed mortality associated with heatwaves, including investigations of how heatwave related deaths are detected, recorded, and monitored within mortality recording or surveillance systems. Publications in English from 1950 through 2025 were included, without restriction on country or region.

Studies were excluded if they did not examine heatwave-related mortality, data recording, or surveillance systems, or if they did not include mortality or meteorological data to assess heat impacts. Non-English publications, non-empirical publications, conference abstracts lacking full data, duplicate reports, and studies without sufficient methodological detail were excluded.

2.5. Charting the data

The two reviewers independently extracted data using a standardised JBI-aligned form (Aromataris et al., 2022), piloted on a subset of studies to ensure consistency. The extraction form captured the following key variables including study identification, study characteristics, heatwave definition and exposure metrics, mortality variables and attribution methods, data sources (death certificates, health department records, emergency medical services, and coronial data), ICD cause-of-death codes, details of the surveillance system and managing agency (Table 1).

2.6. Collating, summarizing, and reporting findings

Mortality attribution approaches were categorised into three methodological groups (Xu et al., 2016): direct attribution using heat-specific ICD codes recorded on death certificates (Bouchama and Knoche, 2002); population-level excess mortality estimation comparing observed and expected deaths; and (Thompson et al., 2024a) hybrid or descriptive approaches that integrate multiple data sources or classification methods.

Heatwave definitions and exposure metrics were also extracted,

Table 1
Key variables included in the scoping review.

Subcategory	Key variables
Study identification	Author (s) name, publication year, and country
Study characteristics	Study design, data source type (e.g., report, peer-reviewed paper), study period, and geographic scope (local, national, or global)
Heatwave variables	Heatwave definitions used, temperature indices applied, thresholds, and duration of heatwaves.
Mortality variables	Mortality classification (all causes, cause-specific, or excess deaths), data sources (death certificates, health department records, emergency medical services)
Statistical methods used	Attribution methods used (e.g., descriptive analysis, generalized linear model, generalized additive model, or Distributed lag non-linear model).
ICD cause-of death codes	Heat-specific (e.g., X30, T67, E900) and heat-sensitive ICD codes (i.e., codes for cardiovascular, respiratory, renal, mental, neurologic, diabetes mellitus, pre-term birth, and occupational injuries related mortality), integration with meteorological datasets or real-time reporting systems, and population subgroups analysed (age, sex, socioeconomic status, indigenous or minority groups)
System and governance variables	Surveillance system and managing agency (e.g., national health institute, meteorological bureau), limitations, and recommendations
Equity and policy considerations	Inclusion of vulnerable populations and policy relevance and use of data for heat-health warning or response systems.

including advanced indices such as the Excess Heat Factor (Nairn and Fawcett, 2011), Heatwave Magnitude Index (Dosio et al., 2018), Heat Index (Steadman, 1979), Heat-Health Watch Warning System thresholds (McGregor et al., 2015), absolute temperature cut-offs (Anderson and Bell, 2009), and percentile-based temperature definitions (Gasparrini et al., 2015).

Findings were synthesized using both quantitative (descriptive) and qualitative (thematic) approaches. Data were organized and presented through tables, figures, and concept maps, supported by a narrative synthesis. To ensure conceptual coherence particularly regarding different approaches to defining and attributing mortality during heatwaves the synthesis was structured around the following analytical dimensions.

3. Results

A total of 11,498 records were initially identified through database searches. After removing 1748 duplicates, 9750 records remained for screening. Of these, 9349 were excluded based on title and abstract review. Full-text assessment was conducted for 402 articles, with 225 excluded for reasons including being non-heatwave studies (n = 90), wrong exposure or outcome (n = 34), non-English language (Spanish, German, Japanese, Korean, Mandarin, and Portuguese) (n = 11), conference abstracts (n = 8), methodological or policy-focused papers (n = 18), incomplete or unavailable texts (n = 19), and other ineligible study types. Ultimately, 176 studies met the inclusion criteria and were included in the final scoping review ((Aboubakri et al., 2019; Aghababaeian et al., 2023; Ahmadnezhad et al., 2013; Analitis et al., 2014; Anderson and Bell, 2011; Astrom et al., 2020; Azhar et al., 2014; Baker and Sturm, 2024; Basagana et al., 2011; Benmarhnia et al., 2017; Bernal et al., 2022; Błażejczyk et al., 2022; Bobb et al., 2011; Bogdanovic et al., 2013; Bridger et al., 1976; Can et al., 2019; Canoui-Poitaine et al., 2006; Chaston et al., 2022; Cheng et al., 2024; Cheng et al., 2018; Chesini et al., 2022; Chien et al., 2016; Choi et al., 2024; Culqui et al., 2014; D'Ippoliti et al., 2010a; Dang et al., 2019; de Bont et al., 2024; DeCastro et al., 2011; Díaz et al., 2018; Dimitriadou and Zerefos, 2023; Diniz et al., 2020; Dong et al., 2016; Ellis and Nelson, 1978; Ellis et al., 1975; Ellis et al., 1980; Fouillet et al., 2006; Fouillet et al., 2008; Franklin et al., 2023; Gao et al., 2015; Gao et al.,

2025; Garssen et al., 2005; Gasparrini and Armstrong, 2011; Geirinhas et al., 2019; Ghumman and Horney, 2016; Gosling et al., 2007; Graczyk et al., 2022; Green et al., 2012; Guo et al., 2017a; Guo et al., 2018; Hagen and Weihs, 2023; Hanzlíková et al., 2015; Heaviside et al., 2016a; Heo et al., 2019; Hertel et al., 2009; Heudorf and Schade, 2014; Hoffmann et al., 2008; Hoshiko et al., 2010; Hu et al., 2025; Hünová et al., 2017; Hutter et al., 2007; Johnson et al., 2005; Johnson et al., 2016; Kaiser et al., 2007; Kaiser et al., 2001; Kang et al., 2020; Khatana et al., 2022; Kim et al., 2019; Kim et al., 2016), (Kollanus et al., 2021; Kumar and Singh, 2021; Kyselý, 2004; Kyselý and Kim, 2009; Kyselý and Kríž, 2008; Le Tertre et al., 2006; Lee et al., 2018a, 2018b, 2024; Leonardi et al., 2006; Li et al., 2019; Lim et al., 2019; Linares et al., 2015a, 2015b; Liu et al., 2025; Lo et al., 2022; López-Bueno et al., 2020, 2021; Lv et al., 2025; Ma et al., 2015; Madrigano et al., 2015; Martinez-Austria and Bandala, 2017; Mathes et al., 2017; Matte et al., 2016; Mazdiyasnani et al., 2017; Michelozzi et al., 2005, 2010b; Miron et al., 2015; Monteiro et al., 2013; Muthers et al., 2010, 2017; Nguyen et al., 2023; Nitschke et al., 2007, 2011; Niu et al., 2023; Nori-Sarma et al., 2019; Oray et al., 2018; Ostro et al., 2009; Ozturk et al., 2023; Paravantis et al., 2017; Paredes-Fortuny et al., 2024; Perkins-Kirkpatrick et al., 2025; Pham et al., 2019; Pyrgou and Santamouris, 2018; Revich and Shaposhnikov, 2008; Rey et al., 2007, 2008; Rezaee et al., 2023; Rooney et al., 1998; Royé et al., 2020), (Ruiz-Páez et al., 2023; Saleem et al., 2017; Schaffer et al., 2012; Schifano et al., 2009; Seposo et al., 2017; Shartova et al., 2018; Sheridan and Lin, 2014; Silveira et al., 2023a, 2023b; Singh et al., 2019; Son et al., 2012, 2014, 2016; Song et al., 2024; Stanojević et al., 2014; Steul et al., 2018; Sun et al., 2014, 2021; Tan et al., 2007; Tao et al., 2025; Thompson et al., 2022, 2024b; Tian et al., 2013; Tong et al., 2010, 2012, 2014; Trigo et al., 2009; Urban et al., 2017, 2019; Vandentorren et al., 2006; Vautard et al., 2020; Vyberci et al., 2015; Wang, 2023; Wang et al., 2012, 2018; Weisskopf et al., 2002; Williams et al., 2012, 2018b; Xi et al., 2024; Xie et al., 2014; Xu et al., 2013, 2023; Xu and Tong, 2017; Yan et al., 2022, 2023; Yang et al., 2013, 2019; Yin and Wang, 2017; Yu et al., 2025a, 2025b; Zaninović and Matzarakis, 2014; Zeng et al., 2014; Zhang et al., 2015a, 2015b, 2016, 2017, 2018, 2021; Zou et al., 2025)) (Fig. 1).

3.1. Characteristics of included studies

The included studies span 41 countries, with the highest representation from China (n = 31), the United States of America (n = 27), and Australia (n = 19). Contributions were also drawn from diverse regions, including Europe, North America, South Asia, and Latin America, reflecting broad international engagement with heat-health research across varied climatic and demographic contexts (Fig. 2).

Over 90% of included studies employed retrospective time-series or case-crossover designs, focusing primarily on all-cause mortality as well as cardiovascular and respiratory mortality outcomes. Across studies, older adults, individuals with chronic conditions, and urban populations emerged as the most frequently studied population groups. There was a progressive rise in research activity, with minimal output (6 studies) from 1950 to 1999, steady growth in the 2000s (62 studies from 2000 to 2014), and a marked surge of 98 studies within the last 10 years (S3).

3.2. Attribution methods

Included studies compared observed deaths with an expected baseline during heatwave periods to identify statistical excess mortality. It operates at the population level and is not constrained by individual-level causal attribution.

A wide range of regression-based frameworks were applied, often in combination rather than as mutually exclusive approaches. Approximately 65% of studies used a generalized linear modelling (GLM) framework, including Poisson, Quasi-Poisson, negative binomial, and logistic regression models for count and binary outcomes. Within this

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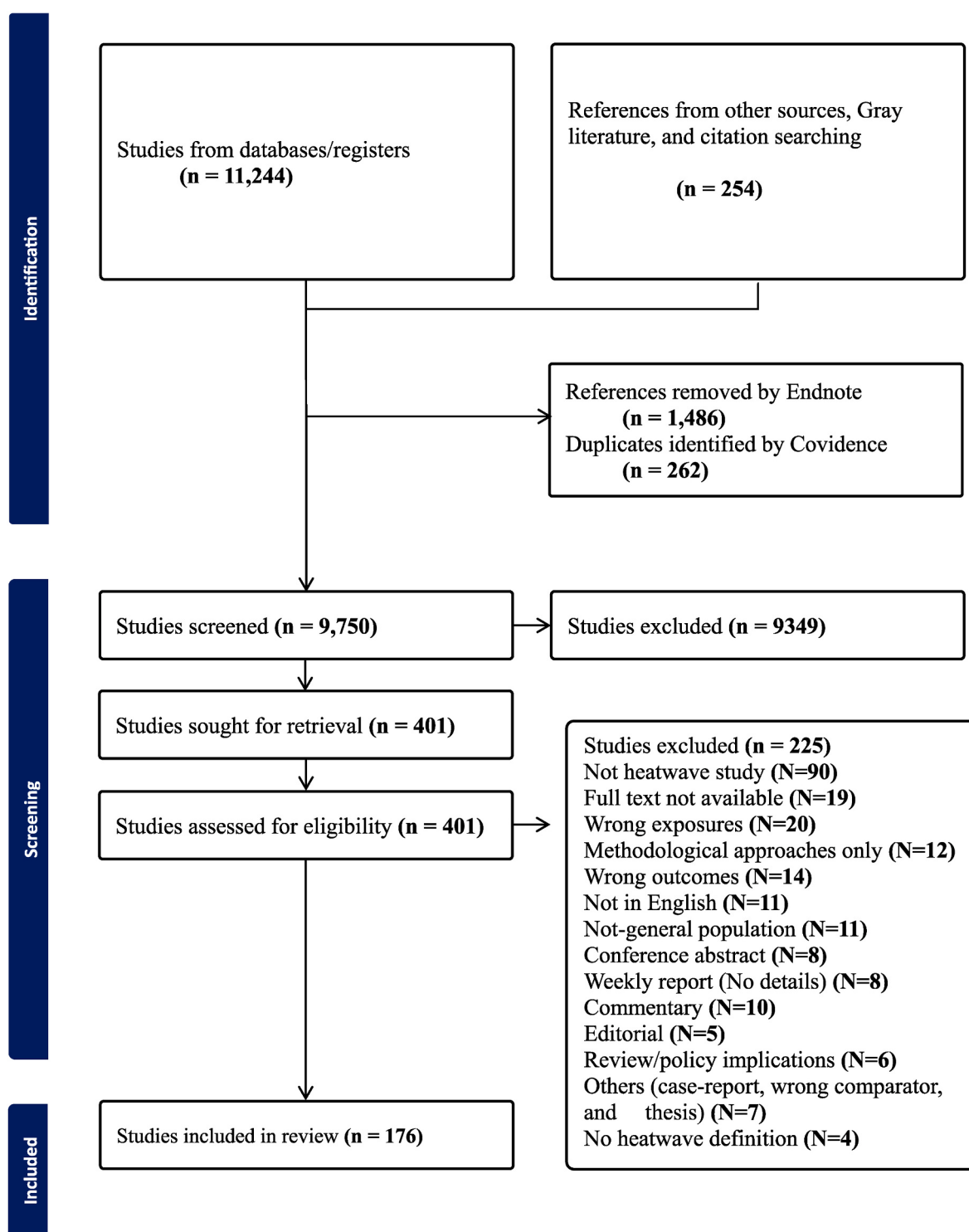


Fig. 1. Study flow chart.

broad framework, distributed lag non-linear models (DLNM) were used in 41 studies (23.3%) to assess delayed and non-linear temperature-mortality relationships, while generalized additive models (GAM) were applied in 21 studies (11.9%) to incorporate smoothing functions for temporal and seasonal variation. Cox proportional hazards models, used mainly in cohort studies, were identified in 5 studies (3%).

Because many studies combined these techniques such as GLM structures with DLNM or GAM elements these categories overlap and

should be interpreted as interrelated analytical components within a shared regression framework rather than distinct methodological types. Overall, most studies integrated GLM-based regression structures, frequently incorporating DLNM or GAM extensions to capture non-linear and lagged associations between heat exposure and mortality. Methodological heterogeneity reflected evolution from simple regression (pre-2000) to sophisticated lag-nonlinear modelling (post-2010), with increasing adoption of DLNM and machine learning approaches

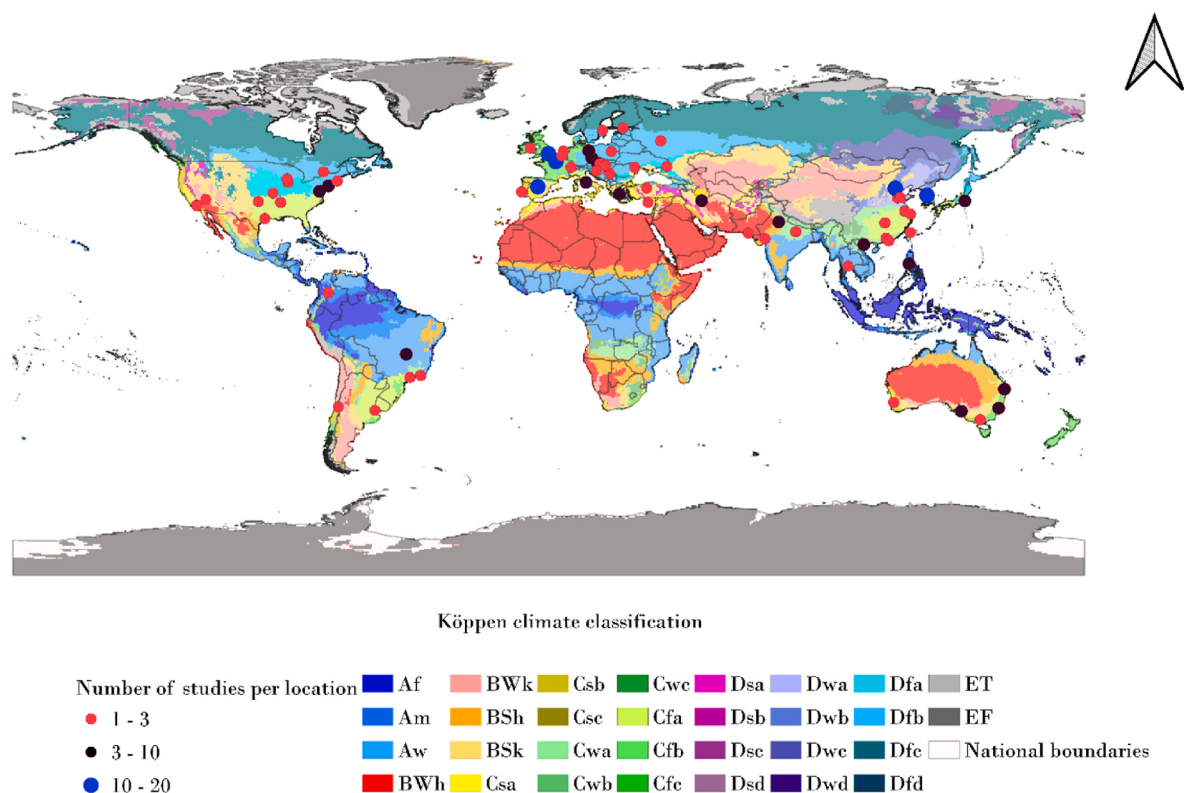


Fig. 2. Geographic spread of included studies based on Köppen-Geiger climate zone classification across continents. Köppen-Geiger climate zone abbreviations are described in the [supplementary material \(S2\)](#).

post-2015 in three studies (Kim et al., 2016, 2019; Heaviside et al., 2016b) (S3).

3.3. Heatwave definition and measurement approaches

All 176 studies provided heatwave definitions. Duration criteria appeared in 78.4% studies ($n = 138$), with minimum consecutive day requirements ranging from 2 to 5 days, followed by percentile-based definitions (e.g., ≥ 95 th percentile for ≥ 2 days) in 96 studies (54.5%) and absolute temperature thresholds were applied in 65 studies (36.9%).

More sophisticated approaches such as the Excess Heat Factor (EHF) ($n = 4$) (Franklin et al., 2023; Lee et al., 2018a; Royé et al., 2020; Williams et al., 2018b), the Heat Wave Magnitude Index (HWMi) ($n = 1$) (Wang, 2023), and the Heat Index (HI) ($n = 8$) (Hoffmann et al., 2008; Kysely and Kim, 2009; Kysely and Kriz, 2008; Madrigano et al., 2015; Mathes et al., 2017; Matte et al., 2016; Monteiro et al., 2013; Weisskopf et al., 2002), as well as operational definitions like the Heat-Health Watch Warning System (HHWWS) ($n = 2$) (Michelozzi et al., 2005; Schifano et al., 2009) appeared in a small proportion of studies. These indices are summarized in supplementary file (S4).

3.4. Temperature data reporting and meteorological data sources

Temperature was reported in 166 studies (94.3% completeness). Average temperature was reported in 58.5% ($n = 103$), maximum temperature in 46.6% ($n = 82$), and minimum temperature in 59.1% ($n = 104$).

Meteorological data sources were reported in 167 studies (94.4%). Ground-based observation systems were most frequently employed (26.7%, $n = 47$), with national meteorological services contributed data in 25 studies (14.1%), while 17 studies (9.4%) utilized gridded or reanalysis. A further 42 studies (23.5%) integrated multiple sources, and one study (0.5%) reported inadequate meteorological data. Explicit

efforts to address spatial heterogeneity through gridded data were limited, appearing in just 17 studies (9.4%) (S4).

3.5. Surveillance system approach

Surveillance systems were varied widely among the included studies, with most relying on routine administrative health data rather than dedicated or real-time heat-health surveillance platforms. Public health surveillance systems were used in 30.1% of studies ($n = 53$). Hospital-based or emergency department syndromic surveillance systems were used in only 8.0% of studies ($n = 14$). Death surveillance or mortality registration points, and other municipal mortality reporting portals accounted for 18.2% ($n = 32$). Fewer studies used structured early warning or heat-alert monitoring systems coordinated jointly by meteorological and public health agencies, representing only 6.8% ($n = 12$). Notably, 39.8% ($n = 70$) did not describe a specific surveillance system, instead relying on static death certificate registries or retrospective compilations of mortality data (S4).

3.6. Mortality data sources and institutional coordination

Across the 176 studies reviewed, mortality data were primarily obtained from routine administrative systems. National public health agencies or registries and related surveillance systems were the dominant source, reported in 67.6% of studies ($n = 119$). Institutional coordination typically involved data linkages between meteorological agencies, health authorities, and statistical offices. Overall, mortality monitoring depended largely on existing administrative datasets, with coordination achieved through inter-agency data sharing rather than fully integrated operational early-warning systems (Fig. 3 and S4).

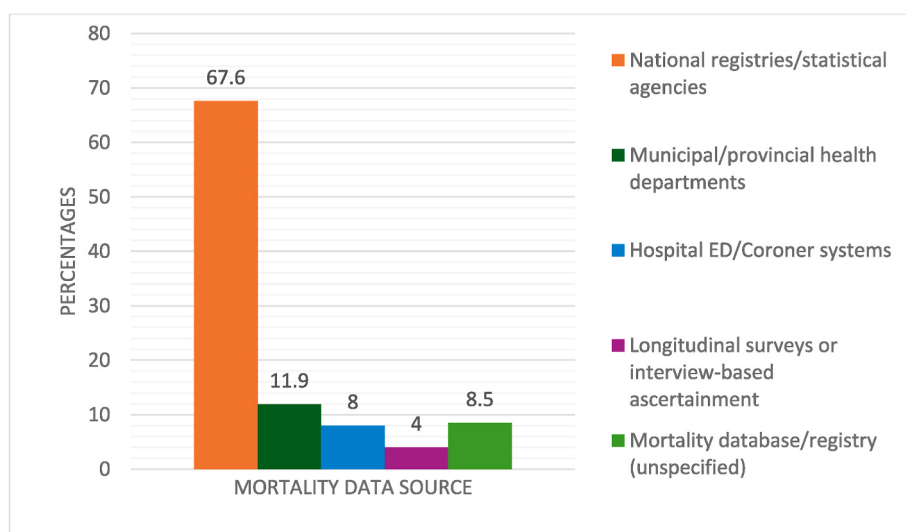


Fig. 3. Sources of mortality data among included studies in the scoping review.

3.7. Mortality assessment and ICD coding practices

All-cause mortality dominated mortality types, at 81.8% ($n = 144$) of included studies, reflecting easier accessibility and reduced misclassification. Cause-specific mortality appeared in 38.1% ($n = 67$) of studies. Among those implementing heat codes, ICD-10 was applied in 48.3% ($n = 85$) of studies and ICD-9 in 15.3% studies ($n = 27$). Approximately 55.7% ($n = 98$) of studies did not report specific ICD codes.

Only 8.5% of the 176 studies explicitly used heat-specific ICD codes (X30, T67, E900) to identify deaths directly attributed to heat. Among studies examining all-cause mortality, 36.9% ($n = 65$) reported cardiovascular disease (CVD) codes (I00–I99), and 23.3% ($n = 41$) reported respiratory codes (J00–J99) (S4 and Fig. 4).

Of included studies, 55.7% ($n = 98$) did not report any ICD codes. Among studies using ICD-10, the most frequently applied heat-specific codes were X30 and T67, while studies using ICD-9 most used E900 to classify heat-specific mortality. A smaller proportion (11.4%, $n = 20$) reported using both ICD-9 and ICD-10 (S4).

3.8. Reported limitations by published studies

Analysis of the reported limitations across all 176 studies revealed several recurring methodological and data-related challenges. The most frequently cited issue was confounding (30.7%, $n = 54$), primarily from unmeasured or inadequately controlled variables. Exposure misclassification was also common (17.0%, $n = 30$), as many studies were unable to capture individual-level heat exposure accurately. An equal proportion of studies also (17.0%, $n = 30$) identified air pollution confounding. Generalizability concerns were noted in 12.5% ($n = 22$) of studies and a smaller proportion (6.8%, $n = 12$) focused on single-city or geographically narrow analyses, reducing external validity. Furthermore, 10.2% ($n = 18$) of studies mentioned that lag-effect was not considered, limiting the understanding of delayed mortality responses to heat exposure. Finally, sample size limitations (4.5%, $n = 8$) were reported, particularly where subgroup or stratified analyses were constrained by insufficient data.

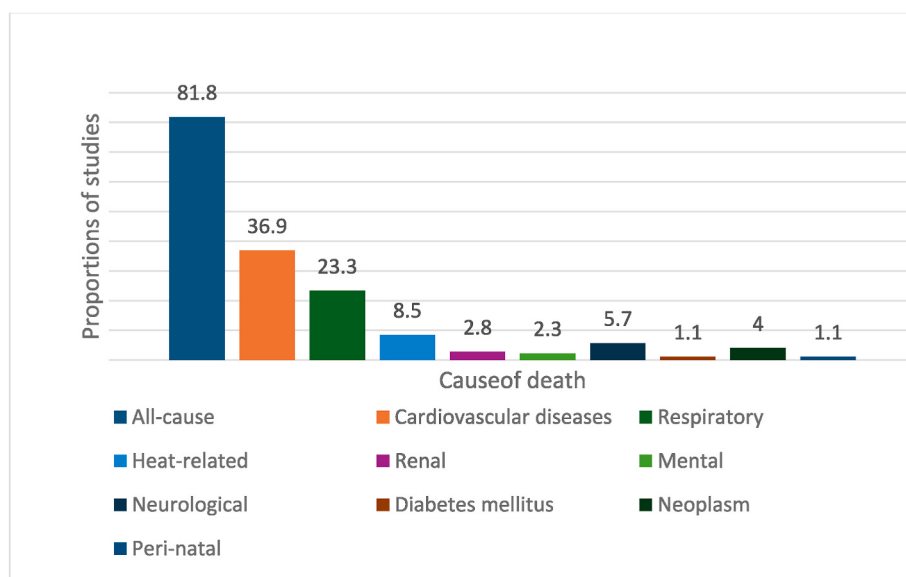


Fig. 4. Proportion of studies reporting each cause-specific mortality category (not the proportion of deaths).

4. Discussion

This global scoping review synthesizes how deaths occurring during heatwave periods are recorded, classified, and monitored across diverse jurisdictions. Analysis of 176 studies from more than 40 countries revealed that most mortality information is derived from passive, retrospective systems, with over 90% of studies relying on routinely collected vital statistics. While these systems provide broad coverage, their retrospective nature limits the timeliness with which exposure-mortality relationships can be identified during extreme heat events. This is consistent with previous assessments noting delays in mortality reporting and limited integration of meteorological and health data (Aromataris et al., 2022).

A fundamental challenge in heatwave mortality recording is the inherently indirect and probabilistic nature of heat as a cause of death (Hajat and Kosatky, 2010). Substantial heterogeneity was observed in how mortality during heatwave periods was defined and reported. All-cause mortality was the most frequently used outcome, while cause-specific mortality appeared less consistently. Only 8.5% of included studies applied heat-specific ICD codes, and more than half did (55.7%) not report any ICD codes. Importantly, the low use of heat-specific ICD codes should not be interpreted solely as systemic underestimation; it also reflects the indirect and multifactorial pathways through which heat contributes to mortality (Basu, 2009a). ICD codes describe individual-level medical causes of death, whereas excess mortality reflects population-level statistical estimates (Hajat and Kosatky, 2010). These represent distinct constructs and are not interchangeable (Organization, 2021). Variability in coding practices therefore reflects differences in reporting conventions, data availability, and institutional procedures rather than providing a direct indication of the extent of heat-attributable mortality (Longden, 2025; Orrall, 2025).

This distinction has direct implications for how surveillance reform should be framed (Vicedo-Cabrera et al., 2021). Systems oriented primarily toward increasing heat-specific ICD code capture are likely to underestimate the broader burden of heat-associated mortality, as mortality does not typically manifest as direct heat illness (Basu, 2009b). Effective surveillance therefore requires integrating ICD coding to flag clinically recognised heat illness with real-time excess mortality modelling to detect the broader population-level signal (Hondula et al., 2015).

Real-time heat-health surveillance remains uncommon globally, with clear regional and temporal disparities. Many surveillance systems developed reactively following catastrophic heat events rather than through proactive public health planning, particularly in the USA (Berko, 2014; Fowler et al., 2013), and in Europe after the 2003 European heatwave (Robine et al., 2008; Pascal et al., 2006). Several Asia-Pacific countries have more recently developed systems, often in response to severe events (Guo et al., 2017b). In contrast, evidence from low-income countries remains limited, with no representation from the Africa region, highlighting major global inequities in heat-health surveillance capacity (Ebi et al., 2021). These patterns suggest that surveillance improvements tend to be reactive, with many low- and middle-income settings lacking the institutional capacity and resources needed for systemic monitoring (Amoatey et al., 2025).

The study has several limitations. A major challenge identified across studies is the absence of a consistent global definition of heatwave (McGregor et al., 2015). Definitions varied widely, ranging from absolute temperature thresholds to percentile-based criteria and composite biometeorological indices (Perkins and Alexander, 2013). While locally adapted definitions improve relevance, the lack of harmonization limits cross-national comparison (Xu and Zhang, 2022; McGregor, 2024b). Future surveillance development should distinguish between locally calibrated operational definitions, which are appropriate and necessary, and cross-national comparative frameworks, which require harmonized standards (Vicedo-Cabrera et al., 2021).

Institutional capacity and professional training emerged as

additional constraints (Matthies, 2008). Although targeted education initiatives in Europe after the 2003 heatwave improved recognition and coding of heat-related deaths (Kovats and Kristie, 2006; D'Ippoliti et al., 2010b), such efforts remain limited globally. No standardized international training framework exists for clinicians, medical examiners, or coders to support consistent identification and documentation of deaths occurring during extreme heat (WHO, 2015).

Analytical methods have evolved substantially, with increasing use of DLNMs and machine learning techniques to estimate heat impacts, lag structures, and mortality displacement (Gasparrini et al., 2010). However, most existing surveillance systems have not yet incorporated these tools into real-time operational practice (Pascal et al., 2006). Limited linkage between meteorological and mortality data further restricts the development of predictive models and early warning systems (McGregor et al., 2015).

Many studies report only aggregated temperature metrics, limiting the ability to compare exposure measures or derive variability estimates without access to raw data. Despite these limitations, the findings of this review provide a foundation for developing more coherent and operationally relevant frameworks for recording and monitoring deaths during heatwave periods (Ebi and Bowen, 2016).

Strengthening surveillance will require harmonized definitions, improved data integration, and sustained investment in workforce capacity (Watts et al., 2019, 2021). Standardizing approaches to heatwave classification and ICD coding, linking meteorological and health datasets, and embedding environmental health training within medical and public health curricula would enhance the accuracy and timeliness of mortality monitoring (Hess et al., 2011). Incorporating vulnerability indicators such as age, occupation, and chronic illness into surveillance frameworks may further support targeted public health responses (Åström et al., 2011; Kovats and Hajat, 2008).

The evidence suggests that more effective surveillance is likely where standardized coding practices, integrated data systems, and appropriate professional training are in place (Semenza and Menne, 2009). An effective global framework for heatwave mortality surveillance requires the integration of two methodologically distinct approaches: individual-level clinical flagging of heat illness through ICD systems and population-level real-time excess mortality estimation through statistical modelling linked to meteorological data (Mathes et al., 2017; Organization, 2021). Neither approach alone can adequately capture the full spectrum of heat-associated mortality (Lippmann et al., 2013; Gronlund et al., 2014). Achieving these improvements globally will require sustained policy commitment, cross-sector collaboration, and investment in governance and workforce capacity (Organization, 2015). Strengthening coordination among meteorological, forensic, and public health agencies, harmonizing classification systems, and embedding environmental health training within medical and public health education are critical steps toward building a more coherent, responsive, and context-appropriate global heat-health surveillance framework (Organization, 2021; Almohammadi, 2026; Chandra and Lee, 2025).

Future work should explore real-time analytic approaches beyond passive surveillance (May et al., 2009). For example, artificial intelligence applied to emergency department or ambulance records could provide near real-time signals of heat-related health impacts (Reesman, 2022). Comparative assessments across regions may clarify how definitional and methodological differences influence mortality estimates, while modelling studies integrating climatic projections with demographic and health data will be essential for anticipating future heat-related mortality under climate change (Gasparrini et al., 2015).

5. Conclusion

While heat-specific ICD codes capture only a small fraction of deaths occurring during heatwaves, this reflects both the indirect and multifactorial pathways through which heat contributes to mortality and limitations in coding practices. For this reason, low coding rates should

be interpreted cautiously and not assumed to represent systematic underestimation on their own. Real-time monitoring capacity also remains limited, and geographic and institutional disparities contribute to inconsistent practices and reduced comparability across jurisdictions. In countries where it exists, it has developed reactively following catastrophic events rather than proactively. Finally, geographic and institutional disparities produce inconsistent practices and systematic underestimation of heat-associated mortality in low- and middle-income settings. These findings advance our understanding of heatwave mortality recording and surveillance systems globally.

Data sharing statement

Data will be available upon request from the corresponding author.

CRediT authorship contribution statement

Temesgen Yihunie Akalu: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Software, Validation, Visualization, Writing – original draft, Writing – review & editing. **Matthew Anthony Borg:** Conceptualization, Data curation, Investigation, Methodology, Resources, Supervision, Validation, Visualization, Writing – review & editing. **Yohannes Tefera Damtew:** Conceptualization, Data curation, Investigation, Methodology, Resources, Validation, Visualization, Writing – review & editing. **Susan L. Heatley:** Conceptualization, Data curation, Investigation, Methodology, Project administration, Resources, Validation, Visualization, Writing – review & editing. **Matt Beaty:** Methodology, Validation, Visualization, Writing – review & editing. **Vanessa Prescott:** Methodology, Validation, Visualization, Writing – review & editing. **Peng Bi:** Conceptualization, Data curation, Funding acquisition, Investigation, Methodology, Project administration, Resources, Supervision, Validation, Visualization, Writing – review & editing.

Conflict of interest

All authors declare that they have no conflict interests:

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ijheh.2026.114858>.

Abbreviations and acronyms

Numerous abbreviations and acronyms are used in our scoping review, including ABS: Australian Bureau of Statistics, CDC: Center for Disease Control, CINAHL: Cumulative Index to Nursing and Allied Health Literature, DLNM: Distributed Lag Non-Linear Models, ECMWF/ERA5: European Center for Medium Range Weather Forecasts/ECMWF Reanalysis 5th Generation, EHF: Excess Heat Factor, GAM: Generalized Additive Models, GFS: Global Forecast System, GLM: Generalized Linear Modelling, HHWS: Heat Health Warning System in South Australia, ICD: International Classification of Diseases, INE: Instituto Nacional de Estadística, Spain, INSERM: Institut National de la Santé et de la Recherche Médicale, France, JBI: Joanna Briggs Institute, MERRA:

Modern-Era Retrospective Analysis for Research and Applications, MeSH: Medical Subject Headings, NGO: Non-Governmental Organization, ONS: Office for National Statistics, OSF: Open Science Framework, PCC: Population–Concept–Context, PET: Physiologically Equivalent Temperature, and PRISMA-ScR: Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews.

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