**Guidelines and Questionnaire: Monitoring the Regional Action Framework on Civil Registration and Vital Statistics (CRVS) in Asia and the Pacific**

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# Acronyms

|  |  |
| --- | --- |
| ANACoD | Analysis of Mortality Levels and Causes of Death |
| CRVS | Civil Registration and Vital Statistics |
| CR | Civil Registration |
| DHS | Demographic and Health Survey |
| ESCAP | United Nations Economic and Social Commission for Asia and the Pacific |
| HMIS | Health Management Information System |
| ICD | International Classification of Diseases |
| MICS | Multiple Indicators Cluster Survey |
| MoH | Ministry of Health |
| NSO | National Statistics Office |
| RAF | Regional Action Framework |
| RSG | Regional Steering Group |
| SAVVY | Sample Vital Registration with Verbal Autopsy |
| UNICEF | United Nations Children’s Fund |
| VA | Verbal Autopsy |
| VS | Vital Statistics |
| WHA | World Health Assembly |
| WHO | World Health Organisation |

# Context

Civil registration and vital statistics (CRVS) are an essential function of government, as they provide individuals with legal proof of identity and facts such as births, deaths, foetal deaths, marriages, divorces, adoptions, legitimations or recognitions. For the State, CRVS provide a stable source of information on population changes, necessary for the effective delivery of public services such as healthcare. Hence, CRVS play a crucial role towards the realization of human rights (e.g. the right to vote, access to education, etc.).

All countries in Asia and the Pacific have some form of CRVS system. However, often those systems have room for improvement, especially in terms of meeting international norms and standards. For instance, communication between civil registration (CR) and vital statistics (VS) systems can be ineffective, which is reflected in the fact that the health system tends to be a better source for information for causes of death than the civil registry.

Mindful of the importance of CRVS and the ongoing challenges, the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) member and associate member countries requested assistance to improve CRVS systems across the region. Accordingly, a Ministerial Conference was held in November 2014, which forged a high-level political commitment for the improvement of CRVS systems and developed a shared vision: “by 2024, all people in Asia and the Pacific will benefit from universal and responsive civil registration and vital statistics systems that facilitate the realization of their rights and support good governance, health and development”.[[1]](#footnote-2)

Organized in coordination with other development partners[[2]](#footnote-3) and overseen by the Regional Steering Group for CRVS in Asia and the Pacific[[3]](#footnote-4), the 2014 Ministerial Conference achieved several major outcomes: (i) the adoption of the Ministerial Declaration to “Get Every One in the Picture” in Asia and the Pacific; (ii) the declaration of the Asian and Pacific CRVS Decade (2015 - 2024); and (iii) the endorsement of a Regional Action Framework (RAF) for improving CRVS systems in the region. [[4]](#footnote-5) The RAF covers seven areas of work (Annex A), to achieve three goals and 15 targets relating to CRVS (Annex B), through the implementation of eight steps (Annex C).

# Monitoring and Reporting Progress

This document deals with monitoring and reporting progress towards the RAF. At the 2014 Ministerial Conference, a timeframe to monitor and report progress was agreed (table 1). As per such timeframe, in 2015 members and associate members submitted reports on national targets and baseline data to ESCAP. Based on that information, the baseline report was prepared by the Regional Steering Group[[5]](#footnote-6) (and taken note of at ESCAP’s Seventy-Second Commission Session[[6]](#footnote-7)) in 2016. The baseline report is the benchmark against which progress must be assessed, and is useful in understanding the initial situation, not only of the targets, but also of the implementation steps. For instance, it shows that out of a total 62 members and associate members, 18 had not appointed a CRVS national focal point, which is an obstacle for regular reporting (Annex D).

While all eight implementation steps are important, reporting to ESCAP is crucial to be able to assess progress in the Regional Action Framework: as only 27 countries out of 62 did not report information (Annex D), the importance of this implementation step cannot be overemphasized. To facilitate the reporting process, it is highly recommended to appoint CRVS focal points within the Government.[[7]](#footnote-8) CRVS national focal points are responsible for reporting relevant information to ESCAP, in accordance with reporting structure for the RAF.

Table 1. Dates for reporting and reviewing progress on the Regional Action Framework

|  |  |
| --- | --- |
| **Year** | **Activity** |
| 2015 | Members and associate members submit baseline report to the secretariat |
| 2016 | Regional baseline analysis |
| 2019 | Members and associate members submit midterm report to the secretariat |
| 2020 | Midterm regional review is conducted |
| 2024 | Members and associate members submit final report to the secretariat |
| 2025 | Final regional review conducted |

In line with the established timeframe (table 1), by mid-2019 countries are expected to submit to ESCAP comprehensive information on the implementation of the RAF, including: i) the attached questionnaire with nationally representative data measuring progress towards each target and implementation steps[[8]](#footnote-9); ii) any recent progress report on CRVS improvement activities, if available; iii) any report on comprehensive assessments relating to CRVS conducted in the country, if available; and iv) any national CRVS strategy, if available.[[9]](#footnote-10)

In a similar vein, by 2024 countries will submit to ESCAP a questionnaire that contains comprehensive information and nationally representative data measuring progress towards each target and implementation steps[[10]](#footnote-11); ii) any progress report on CRVS improvement activities, if available; iii) any report on comprehensive assessments relating to CRVS in the country, if available; and iv) any national CRVS strategy, if available.[[11]](#footnote-12)

These are the minimum reporting requirements: besides reporting at the 2019 and 2024 checkpoints agreed in the RAF timeframe, countries are encouraged to submit, through their national focal points, relevant reports and/or any other information on an ad-hoc basis at their earliest convenience.

## Purpose and audience of these guidelines

The purpose of these guidelines is to assist countries in monitoring and reporting progress on the implementation of the RAF. The guidelines focus on the completion and submission of the attached questionnaire, which zooms in on the 3 goals and 15 targets and the 8 implementation steps. However, as noted, any other relevant information that is useful to assess progress should be reported – including qualitative data that may relate to the seven areas of work (e.g. political commitment, etc.)

The guidelines and questionnaire are intended for government officials responsible for overseeing the improvement of the national CRVS system (including, but not only the CRVS national focal point) – as they should be the ones filling out the questionnaire.

## Responsibilities of CRVS National Focal Points

Depending on the country, the functions of improving CRVS systems may relate to several institutional bodies, e.g. Civil Registration Authority, Ministry of Health, National Statistics Office (NSO), etc. When this is the case, different entities may be required for filling out various parts of the questionnaire. In this situation, the CRVS national focal point will coordinate the internal reporting of those entities to him/her. Should any entity responding a part of the questionnaire have questions about the overall process, the CRVS focal point is expected to explain it. The CRVS focal point may also wish to note that the data will be used exclusively by ESCAP (it may be shared with its member countries upon request, but it will not be shared with third parties).

Vis-à-vis ESCAP, all the reporting must be done exclusively by the designated CRVS focal point. Those countries that have not formally communicated to ESCAP who is their CRVS national focal point, should do so as they submit their reports. In case the CRVS national focal point changes, countries are kindly requested to communicate the change and the contact details of the new focal point to ESCAP at their earliest convenience.

In addition to coordinating internally the administration of the questionnaire with the several corresponding entities that are to fill it out (when applicable), the CRVS national focal point plays a leading role in ensuring high quality of the data reported. For instance, in the case that different entities report inconsistent figures for the same indicator, the CRVS focal point should discuss internally with them to find out the reason(s) for such discrepancies.

In a similar vein, CRVS national focal points are welcome to review the baseline and target values they reported in the past (and, had there been any mistake, report them to ESCAP). Ideally, each required indicator (whether target or implementation step) should have only one figure for a point in time. A datum will be considered as endorsed by a country in the moment the CRVS focal point of that country reports it to ESCAP.[[12]](#footnote-13) Ultimately, the objective is to have a dataset as comprehensive as possible over time, for each of the 15 targets of the three goals and the related eight implementation steps. Table 2 shows the generic structure of the dataset that, ideally, should be fully populated. Such quantitative data will be explained and enriched, as appropriate, with the qualitative information available in the reports submitted by CRVS national focal points.

Table 2. Ideal data collected for each indicator (target or implementation step)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Country | 2015  (Baseline) | … | 2020  (Mid Term Review) | … | 2025  (Final Review) |
| i | - | - | - | - | - |
| … | - | - | - | - | - |
| j | - | - | - | - | - |

## Key concepts to remember

There are distinct activities involved in the official registration of vital events such as births, deaths, marriages, divorces and adoptions.[[13]](#footnote-14) In line with the role of CRVS national focal points to assure data quality, it is important to highlight the difference between “notification”, “registration”, “certification” and “medical certification of cause of death” (Figure 1). Confusion between these terms may lead to statistical errors (e.g. if parents think that the ‘birth notification form’ constitutes proof of registration, this will lead to low birth registration rates).

Figure 1. Process for the registration of vital events

Source: WHO et al. 2012. *Strengthening civil registration and vital statistics for births, deaths and causes of death: Resource Kit; United Nations*. 2014. *Principles and Recommendations for a Vital Statistics System, Revision 3* and UNICEF 2013 *A Passport to Protection,* New York

# Filling out and submitting the questionnaire

The questionnaire is to be filled out after carefully consulting these guidelines, including the baseline and target values previously submitted by countries’ CRVS focal points (Annexes D and E), and the specific considerations for each of the targets (Section 4).

Should any entity replying to the questionnaire notice any mistake, or where the data has change, the CRVS national focal point should notify ESCAP and provide the correct figures.

Should the respondents require additional pages (e.g. to describe ongoing reforms in a country), they may feel free to add them, clearly indicating the questions to which they correspond.

Should the respondent(s) have any questions on specific terms, they may consult the definitions (Annex F). Should there be any outstanding doubts, CRVS focal points are welcome to contact ESCAP’s CRVS Team at [escap-crvs@un.org](mailto:escap-crvs@un.org) indicating in the subject of the email “Questions on Mid Term Reporting by [*COUNTRY*]”.

While the questionnaire can be filled out quickly, CRVS national focal points should not underestimate the time and effort required to gather the necessary data, as well as to resolve any inconsistencies. Hence, CRVS focal points are advised to start the process early (latest by 1st May 2019), and give any entities replying all or parts of the questionnaire ample time for doing so (the required time will vary greatly across countries).

After solving any data inconsistencies, **the completed questionnaire and any other relevant information should be sent back to ESCAP before 1st October 2019**.

National CRVS focal points may send the questionnaire to the following email: [escap-crvs@un.org](mailto:escap-crvs@un.org) indicating in the subject of the email “Mid Term Report – [*COUNTRY*] Responses”.

# Specific considerations for each of the targets

This section provides specific information for each of the targets:[[14]](#footnote-15) i) Method of estimation/calculation[[15]](#footnote-16), ii) Ideal target, iii) Issues and considerations and iv) Data sources for setting and monitoring the target.

|  |
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| **Target 1A: By 2024, at least … per cent of births in the territory and jurisdiction in the given year are registered** |
| Birth registration is a human right, as enshrined in the Convention for the Rights of Child (CRC). At the sixty-seventh World Health Assembly in 2014, member States endorsed a plan to end preventable deaths containing the strategic objective that “every new-born needs to be registered, and new-born and maternal deaths and stillbirths need to be counted”.**[[16]](#footnote-17)** This target enables countries to track their progress towards achieving and maintaining universal birth registration. |
| *Method of estimation/calculation*  Measuring completeness of birth registration can be done in several ways. A basic approach involves dividing the number of births registered within the year of occurrence in the country by the total estimated number of births for the same period, and then multiplying by 100 to give a percentage figure:   |  |  | | --- | --- | | Number of registered births within the year of occurrence | X 100 | | Estimated number of live births within the year |   The number of registered births (numerator) would be sourced from the civil registration authority. National estimates on the number of births (denominator) can be developed based on estimates from the ministry of health population census data or sample surveys. In the absence of national estimates, birth rates produced by the United Nations Population Division can be used for the denominator, as follows:   |  |  | | --- | --- | | Number of registered births within the year of occurrence | X 100 | | Crude birth rates as estimated by the UN (per 1000) x Total population size (in ‘000s) |   More sophisticated approaches for measuring completeness of birth registration, such as ‘capture-recapture’, are described in the *United Nations Principles and Recommendations for a Vital Statistics System*. However, these methods are complex to apply so would only be done on an occasional basis with the involvement of trained demographers.**[[17]](#footnote-18)** |
| *Ideal target*  All births should be registered, so countries should be aiming to achieve universal coverage (100 per cent). This but may be done in incremental steps. How quickly improvements in registration can be made will depend on factors such as: i) Political will and legal frameworks, ii) Budget allocation to the improvement and functioning of Civil registration, iii) Reasonable distance of civil registration points to the population (less than 30 km) or availability of mobile registration services, iv) Presence of registration services in hospitals and birth facilities, v) Public awareness or vi) Incentives and disincentives for registering births.  Experiences from other countries can assist in setting realistic targets. Globally, birth registration rates for children aged less than five years have increased from 58 per cent to 65 per cent between 2000 and 2010.**[[18]](#footnote-19)**With leadership and appropriate investment, countries may consider aiming to increase registration coverage by 10 per cent every five years. **[[19]](#footnote-20)** |
| *Issues and considerations*  Accessibility of the civil registration system: Completeness of birth registration is closely related to the accessibility of the civil registration system. Ease of access will depend on a range of factors, such as how many registration points exist, their distance from where the birth event occurs, road and transport infrastructure, affordability of registration, ease of the administrative process, opportunity costs and cultural and social norms such as naming ceremonies. Remote communities and specific groups may face more barriers than others in accessing registration points. Other factors such as national legislation and laws can also influence the coverage.  Although birth registration should ideally be free of cost, in cases where there are associated costs, this could act as a barrier to registration.**[[20]](#footnote-21)** Hence, there may be some unwillingness or delay in the registration process unless there is strong reason to register.  The language of the registry office, including the forms to be completed may also be a barrier for some groups. The ‘front end’ atmosphere of the office, such as the time it takes to register, may also be a disincentive.  To assess whether certain population groups or geographical areas are particularly likely to have low registration, estimates of the level of access can be produced to help interpret progress towards achieving this target. Access level (%) can be calculated by dividing the number of people in census enumeration areas with at least one civil registration office or facility to register births (numerator) by the total population of the country (denominator), and then multiplying by 100 to give a percentage figure.  Hard-to-reach and marginalized populations: In addition to estimating levels of access to civil registration, identification of those areas without an access point, and whether marginalized groups are concentrated around areas with poor access, will help to identify priorities for improving completeness of birth registration for hard-to-reach and marginalized populations.  Acts and laws: The country’s acts and laws may influence the coverage. For example, if birth registration/certification is a compulsory for obtaining citizenship, passports or other documents then there is greater motivation to register but this can also have negative consequences.  Disaggregation: For countries to improve their systems, it is important to analyse disaggregated data to understand where progress towards universal coverage is being made and where it is stalling. Monitoring national averages can hide major variations. Sub-national disaggregation may reveal very low levels of registration in a few poor states, whereas registration is high elsewhere. An urban/rural split should be the minimum level of sub-national disaggregation, but further breakdowns will provide more meaningful information. While disaggregated data will be useful for identifying gaps, reporting on these are on a voluntary basis.  When analysing disaggregated metrics, it may be useful to compare these data with information from the comprehensive assessments to identify potential explanations and associations for low levels of completeness. This is not a rigorous method of causal inference but might enrich disaggregated analysis with informative contextualization. It may also reveal blind spots where low (or lower than average) completeness levels are observed but the reasons for this are not clear. Analysis may help to identify the need for a small sub-national assessment to investigate what the underlying issues are.  To allow the reasons for improvements or a lack of progress to be better understood, completeness of birth registration should be disaggregated by: i) Sex – any differences in the tendency to register baby boys and girls may point to gender issues that require targeted education or services; ii) Location – geographic location to the level of census enumeration area and up to State/provincial/district/village/settlement level and urban/rural. Disaggregation of location should include place of registration (births that take place in a health facility are more likely to be reported and countries that have civil registrars located in hospitals and have introduced a midwifery reporting system have more likely to make improvements in the registration of births) and place of usual residence (comparing distances between place of residence and place of registration can shed light on whether long distances to get to registration points are preventing universal coverage of registration); iii) Late/delayed registration – the prescribed period within which births are to be registered, as well as the length of grace periods and from when penalties are applied, should be prescribed in laws, rules or regulations. Disaggregated data, allowing the percentage of registrations that occur within these deadlines to be tracked, can shed light on where and why late or delayed registration is occurring; iv)  Ethnic and/or national group of mother and father (if collected, this information provides valuable insight into the tendency for underreporting by certain populations).  Data quality assurance: Each live birth should be registered once and once only, thus enabling universal coverage. To avoid double counting, there is need for improvement in infrastructures, equipment, and capacity development. Also, births should be registered as soon as possible after the event, and data should be reported within one year of occurrence. Key characteristics of the birth, such as place, name of child, sex of child, date of birth, name of parents should be included on the birth registration. Additional information such as date of occurrence, place of usual residence, place of birth (hospital, home or other) and age of mother are often recorded on the certificate of live birth issued by the health authorities. |
| *Data sources for target setting and monitoring*  National Statistics Office (NSOs) for: total mid-year population, population by census enumeration area, and intercensal population projections national estimates of births for the given year, if available.  Civil registration authorities for: births registered by location and demographic characteristics of child/parents (e.g. place of usual residence), number and geographic location of civil registration points at different points in time (for estimating accessibility of the civil registration system)  Ministry of Health for: total number of live births recorded or live birth certificates issued by location.  United Nations Population Division for: crude birth rates (in the absence of national estimates of births).[[21]](#footnote-22) |
| **Target 1B: By 2024, at least … per cent of children under 5 years old in the territory and jurisdiction have had their birth registered** |
| It is estimated that across Asia and the Pacific, there are 135 million children under the age of five whose births have not been registered.[[22]](#footnote-23) Improving CRVS systems tends to focus on birth registration of new-born children, which is the ideal outcome. However, monitoring registration coverage for children under five is also promoted because it allows household surveys to be used for gauging the extent to which young children are missing out on their right to birth registration. Lack of birth registration leads to significant underestimation of infant and child mortality, because children whose births are not registered before age five will not have their deaths registered either. This target is included due to its relative simplicity of measurement but it should not be taken as equivalent to the percentage of births registered in a given year. |
| *Method of estimation/calculation*  Some sample surveys, such as the United Nations Children’s Fund (UNICEF) Multiple Indicator Cluster Survey (MICS), and the Demographic and Health Surveys (DHS), have included questions on whether children under 5 years of age have been registered with the civil registration authority (in addition, surveys generally ask whether the child possesses a birth certificate). Using such survey data, the completeness of birth registration for children aged under 5 years can be calculated as:   |  |  | | --- | --- | | Number of children aged under 5 years in a given year who have had their birth registered | X 100 | | Estimated number of children aged under five years old in a given year | |
| *Ideal target*  Universal birth registration should be the aim of all members and associate members. When setting this target, it is important to note that it examines birth registration coverage for the total population aged from birth to less than five years old. Where national policies and practices provide a significant window for registration (e.g. within 6- 12 months after birth) and/or where late registrations are common, achieving close to 100 percent for this target may not be possible.  Countries should aim at achieving universal coverage but may need to do so in incremental steps. How quickly improvements in registration can be made will depend on factors such as: i) Political will and legal frameworks, ii) Budget allocation to the improvement and functioning of Civil Registration, iii) Reasonable distance of civil registration points to the population (less than 30 km) or availability of mobile registration services, iv) Presence of registration services in hospitals and birth facilities, v) Public awareness or vi) Incentives and disincentives for registering births.  Experiences from other countries can assist in setting realistic targets. Globally, birth registration rates for children aged less than five years old increased from 58 per cent to 65 per cent between 2000 and 2010.**[[23]](#footnote-24)**With leadership and appropriate investment, countries may consider aiming to increase registration coverage by 10 per cent every five years. **[[24]](#footnote-25)** |
| *Issues and considerations*  Disaggregation: To allow the reasons for improvements or a lack of progress to be better understood, completeness of birth registration should be disaggregated by: i) Sex (any differences in the tendency to register boys and girls may point to gender issues that require targeted education or services); ii) Age at registration (in months); iii) Location (geographic location, from the level of census enumeration area – only possible for census and civil registration data- and up to provincial/district/state level and urban/rural). Disaggregation of location should include place of birth and registration (births that take place in a health facility are more likely to be reported and countries that have civil registrars located in hospitals and have introduced a midwifery reporting system are more likely to make improvements in the registration of births); and place of usual residence – comparing distances between place of residence or place of birth (in cases where the registrar has based themselves in the birthing hospital) and place of registration (from civil registration) can shed light on whether long distances to get to registration points are preventing universal coverage of registration; iv) Socioeconomic status of the household (wealth quintiles) if collected; and v) Ethnic and/or national group of mother and father – this information provides valuable insight into the tendency for underreporting by certain populations.  While disaggregated data will be useful for identifying gaps, reporting on these are on a voluntary basis. |
| *Data sources for target setting and monitoring*  Civil registration authorities that operate effectively may be able to provide data to estimate coverage of registration for the population. In the absence of reliable administrative data, household surveys are a key source of data to monitor birth registration and in most low- and middle-income countries, such surveys represent the only source of this information.**[[25]](#footnote-26)**  NSOs or data custodian of any survey data on completeness of birth registration for children aged under 5 years (numerator). It should be noted that surveys are subject to sampling variability and this should be considered when determining whether changes over time are significant. Sampling errors are likely to be significantly higher for sub national regions.  NSOs for estimates on the number of children aged under 5 years for the given year (denominator) based on national estimates derived from national population censuses, and/or household surveys census or mid-year population estimates. |

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| **Target 1C: By 2024, at least … per cent of all individuals in the territory and jurisdiction have had their birth registered** |
| *Method of estimation/calculation*  Some sample surveys, such as the United Nations Children’s Fund (UNICEF) Multiple Indicator Cluster Survey (MICS) and the Demographic and Health Surveys (DHS) have included questions on whether individuals have been registered with the civil registration authority, although the focus of interviews is often on mothers (or primary caregivers) of children under age 5. Population censuses and living standards surveys usually don’t ask about whether household members possess a birth certificate, but this could change in the future.  Using available survey or census data, the completeness of birth registration for the total population can be calculated by dividing the number of individuals who have had their birth registered by the total (mid-year) population, and then multiplying by 100 to get a percentage figure.   |  |  | | --- | --- | | Number of individuals in a given year who have had their birth registered | X 100 | | Estimated population in a given year | |
| *Ideal target*  All births should be registered, so the ideal level for this target is close to 100 per cent. Countries should aim for this but may need to do so in incremental steps. How quickly improvements in registration can be made will depend on factors such as: i) Political will and legal frameworks; ii) Budget allocation to the improvement and functioning of Civil Registration; iii) Reasonable distance of civil registration points to the population (less than 30 km) or availability of mobile registration services ; iv) Presence of registration services in hospitals and birth facilities; v) Public awareness and vi) Incentives/disincentives for registering. |
| *Issues and considerations*  Disaggregation: To allow the reasons for improvements or a lack of progress to be better understood, completeness of birth registration should be disaggregated by: i) Sex – any differences in the tendency to register boys and girls may point to gender issues that require targeted education or services; ii) Location – geographic location to the level of census enumeration area and up to provincial/district/state level and urban/rural. Disaggregation of location should include place of registration (births that take place in a health facility are more likely to be reported and countries that have civil registrars located in hospitals and have introduced a midwifery reporting system have more likely to make improvements in the registration of births), and place of usual residence (comparing distances between place of residence and place of registration can shed light on whether long distances to get to registration points are preventing universal coverage of registration); iii) Ethnic and/or national group of mother and father – if collected, this information provides valuable insight into the tendency for underreporting by certain populations.  While disaggregated data will be useful for identifying gaps, reporting on these are on a voluntary basis. |
| *Data sources for target setting and monitoring*  National statistics offices or the relevant data custodian of survey data on completeness of birth registration (numerator). It should be noted that surveys are subject to sampling variability and this should be considered when determining whether changes over time are significant. Sampling errors are likely to be significantly higher for sub national regions.  National statistics offices for estimates on the total mid-year population for the given year (denominator) or alternatively estimates from the United Nations Population Division. |

|  |
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| **Target 1D: By 2024, at least … per cent of all deaths that take place in the territory and jurisdiction in the given year are registered.** |
| Death registration enables proof of death and the provision of legal rights to the family, as well as contributing data to the production of vital statistics. In many countries of the Asia-Pacific region, a sizeable proportion of deaths occur without the involvement of actors from the health system, making registration a challenge. Establishing a well-functioning CRVS system guaranteeing that all deaths are registered is essential for development. |
| *Method of estimation/calculation*  Measuring completeness of death registration can be done in several ways. A basic approach involves dividing the number of registered deaths in the country for a given year by the total estimated number of deaths for the same period, and then multiplying by 100 to give a percentage figure.   |  |  | | --- | --- | | Number of registered deaths in a given year | X 100 | | Estimated number of deaths in that year |   The number of registered deaths (numerator) may be sourced from the registration authority. National estimates on the number of deaths (denominator) can be developed based on population census data or sample surveys. In the absence of national estimates, death rates produced by the United Nations Population Division can be used, as follows:[[26]](#footnote-27)   |  |  | | --- | --- | | Number of registered deaths in a given year | X 100 | | Crude death rates as estimated by the UN (per 1000) x Total population size (in ‘000s) | |
| *Ideal target*  Countries should be aiming to achieve over 90 percent coverage of death registration, but they may need to do so incrementally. Globally, progress with improving death registration has been much slower than for birth registration. In 2012, WHO estimated that two-thirds of all deaths are not registered, with low-income countries having the lowest registration coverage.**[[27]](#footnote-28)**The rate at which improvements in registration can be made will depend on factors such as: i) Political will and legal frameworks; ii) Budget allocation to the improvement and functioning of CRVS systems; iii) Reasonable distance of civil registration points to the population (less than 30 km) or availability of mobile registration services; iv) Presence of registration services in hospitals and facilities where deaths tend to occur; v) Burial customs and processes; vi) Public awareness; vii) Incentives and disincentives for registering deaths, including opportunity cost and fee structure or viii) Ease of administrative process.  Completeness of death registration and ease of administrative process varies widely across the region, from around 50 per cent in countries such as Papua New Guinea and the Philippines, to more than 90 per cent coverage in the Republic of Korea, the Islamic Republic of Iran and the Marshall Islands. However, for many countries there are no timely data available.**[[28]](#footnote-29)** In those cases, baseline information should be ascertained through a comprehensive assessment of the CRVS system.  Current coverage of death registration, combined with knowledge of impacting factors such as those outlined above, should inform the setting of realistic targets. With leadership and appropriate investment, countries may consider aiming to increase death registration coverage by 10 per cent every five years. **[[29]](#footnote-30)** |
| *Issues and considerations*  Accessibility of the CR system: Completeness of death registration is closely related to the accessibility of CR points. Ease of access will depend on a range of factors, such as how many registration points exist, their distance from where the death occurs, road and transportation infrastructure, affordability of registration and cultural and social norms, such as burial traditions. Remote communities and specific groups may face more barriers than others in accessing registration points. The barriers to birth registration outlined under target 1A may also apply to death registration.  Estimates of the level of access would ideally be produced to help interpret progress towards achieving this target. Access level (%) can be calculated by dividing the number of people in census enumeration areas with at least one civil registration office or facility to register deaths (numerator) by the total population of the country (denominator), and then multiplying by 100 to give a percentage figure.  While these estimates will be useful for identifying gaps, reporting on these are on a voluntary basis.  Hard-to-reach and marginalized populations: In addition to national estimates of access, identification of those areas without an access point, and whether marginalized groups are concentrated around areas without access, will help to identify priorities for improving completeness of death registration for hard-to-reach and marginalized populations.**[[30]](#footnote-31)** While disaggregated data will be useful for identifying gaps, reporting on these are on a voluntary basis.  Disaggregation: To allow the reasons for improvements or a lack of progress to be better understood, completeness of death registration should be disaggregated by sex (any differences in the tendency to register males or females may point to gender issues that require targeted education or services); location – geographic location to the level of census enumeration area and up to provincial/district/state level and urban/rural. Disaggregation of location should include: a) Place of registration - deaths that take place in a health facility are more likely to be reported and countries that have systems where notification is an integrated part of hospital processes are more likely to make improvements in the registration of deaths; b) Place of usual residence – comparing distances between place of residence and place of registration can shed light on whether long distances to get to registration points are preventing universal coverage of registration; c) Ethnic and/or national group of deceased – if collected, this information provides valuable insight into the tendency for underreporting by certain populations.  Data quality assurance: Each death should be registered once and once only, thus enabling universal coverage. Additional quality criteria are the amount of detail on the deceased including age, sex, date and place of death, cause of death – medically certified according to International Classification of Diseases (ICD) standards. If information from surveys are used, it should be noted that surveys are subject to sampling variability, which should be considered when determining whether changes over time are significant. Sampling errors are likely to be significantly higher for sub national regions. |
| *Data sources for target setting and monitoring*  Ministry of Health for data on total number of deaths recorded or death certificates issued by location.  National statistics offices for data on:   * total population and population by census enumeration area * national mid-year estimates by age and sex * estimates of deaths for the given year, if available   Civil registration authorities for data on:   * deaths registered by location and demographic characteristics of the deceased (e.g. age, sex, place of occurrence, ethnicity, place of usual residence) * number and geographic location of civil registration points at different points in time   United Nations Population Division for crude death rates (in the absence of national estimates of deaths). |

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| **Target 1E: By 2024, at least … per cent of all deaths recorded by the health sector in the territory and jurisdiction in the given year have a medically certified cause of death recorded using the international form of the death certificate.** |
| The cause of death information can be used for both legal and statistical purposes. The International Classification of Diseases (ICD) is endorsed by the World Health Assembly (WHA)[[31]](#footnote-32) as the standard used to classify deaths and diseases using death certificates and health records.[[32]](#footnote-33) Only a medically trained person can reliably diagnose and code causes of death in accordance with World Health Organization (WHO) standards. This target relates to those deaths that occur within health facilities, or where the health sector is involved in certifying the death. High-quality mortality data requires that all deaths are medically certified using the international form of death certificate (Figure 2), as it involves identification of the cause of death. Together with adequate training and processes, medical certification facilitates the correct coding of the underlying cause of death using the *International Classification of Diseases and Related Health Problems*, currently in its tenth revision (ICD-10). |
| *Method of estimation/calculation*  This indicator is calculated by dividing the number of deaths with medical certification for a given year using the international form of death certificate (numerator) by the number of deaths recorded by the health sector for the same period (denominator), and then multiplying by 100 to give a percentage figure.   |  |  | | --- | --- | | Number of deaths with medically certified cause of death using international form of death certificate | X 100 | | Number of deaths recorded by health institutions or health sector |   The international form of medical certificate is set out in the *United Nations Principles and Recommendations for a Vital Statistics System*. To clearly understand the issues relating to medical certification of death in the country, the proportion of deaths without adequate medical certification should be disaggregated by: deaths with medical certification, but whose certificate does not comply with the international standards; and deaths with no medical certification.  Figure 2 – International Form of Medical Certificate of Cause of Death |
| *Ideal target*  Many countries do not have accurate or reliable registration of causes of death. According to WHO, only 70 countries produce cause-of-death statistics that are of sufficient quality for planning purposes.**[[33]](#footnote-34)** This target relates to deaths that are recorded by the health sector, and therefore medical certification should be possible in all cases. An assessment of the CRVS system should reveal the extent to which deaths are recorded by the health sector. Completing subcomponents C1 and C2 of the WHO Assessment Framework will provide the baseline data needed to set a realistic national target for this indicator. |
| *Issues and considerations*  Data quality: The existence of a medical certificate of cause of death in the correct international form does not guarantee the quality of the information on the underlying cause of death. How well the medical practitioner manages to diagnose the diseases and factors relating to the death depends on a number of factors. An understanding of the importance of cause-of-death information, as well as training in death certification in accordance with ICD guidelines, is essential to ensure medical practitioners can competently certify deaths.  Disaggregation: To allow the reasons for improvements or a lack of progress to be better understood, completeness of medical certification of death should be disaggregated by i) Location of the health facility – it allows identification of health facilities and geographical areas that are performing better or worse than others. Exploring the reasons for differences in performance will allow successful approaches to be implemented more widely and for problem locations to be targeted; ii) Sex of the deceased – any differences in the tendency to medically certify the deaths of males or females may point to gender issues that require targeted education or policies; iii) Age of the deceased – any differences in the tendency to medically certify the deaths of people of certain age groups (e.g. infants or the elderly) may point to issues that need to be addressed through specific training or a revision of processes.  Coverage: In some cases, such as when the death occurs at home and in the absence of a medical practitioner, it is not possible to medically certify the cause of death. In countries where this is common, verbal autopsies can be used to ascertain cause of death. This target relates to deaths that are recorded by the health sector and therefore medical certification should be possible in all cases.  Perinatal deaths: Whenever possible, a separate certificate of cause of perinatal death (foetal death and neonatal death) should be completed (WHO provides the content and design of such a certificate). |
| *Data sources for target setting and monitoring*  The information needed to monitor this target should be maintained by the health sector. The number of deaths recorded should be maintained in central records, along with related details such as in which health facility the death occurred or was recorded, date of death, the sex and age of the deceased, whether an international form of medical certificate was completed, by whom, and when the certificate was completed. |

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| **Target 2A: By 2024, at least … per cent of all births registered in the territory and jurisdiction are accompanied with the issuance of an official birth certificate that includes, as a minimum, the individual’s name, sex, date and place of birth, and name of parent(s) where known.** |
| Registration of births is very important from a human rights perspective. The Convention of the Rights of Children (CRC) states that every child has the right to have a name, identity and acquire a nationality.**[[34]](#footnote-35)** The issuance of an official birth certificate is a distinct activity that should follow the registration of a birth, as it serves as proof of identity. The fundamental purpose is for furnishing or establishing legal instruments of direct interest to individuals: the issuance of an official birth certificate allows an individual to prove the facts relating to his/her existence, identity, personal and family situation. The continuous and permanent nature of these official documents allows them to be used as evidence in legal proceedings, to meet administrative requirements (e.g. proving identity to obtain a passport) and other purposes such as accessing immunization or education.**[[35]](#footnote-36)** |
| *Method of estimation/calculation*  This indicator is calculated by dividing the number of birth certificates issued (with minimum information) for children born in the given year (numerator), by the number of births registered in the given year (denominator), and then multiplying by 100 to give a percentage figure.   |  |  | | --- | --- | | Number of registered births issued with certificates (with minimum information) upon registration the given year | X 100 | | Number of births registered in the given year | |
| *Ideal target*  Ideally, all birth registrations will be accompanied by the issuance of an official birth certificate so the target should be 100 per cent.**[[36]](#footnote-37)** |
| *Issues and considerations*  Minimum information on official birth certificates: A variety of information is collected through the CR system. Some information, when identified with a specific individual, may be highly personal and sensitive. To protect confidentiality and prevent discrimination, only the minimum information needed to prove identity should be included on the official birth certificate, such as the individual’s name, sex, date and place of birth.  Issuance of a birth certificate: This target looks at whether births being registered are also issued a birth certificate. Birth certificates can be re-issued to individuals on their request, for example, to replace a lost certificate. To avoid double counting, the civil registration office should maintain records that facilitate some differentiation between those issued at the time of registration and subsequently-issued certificates. This may include when certificates are reissued because of e.g. name change, etc.  Disaggregation: To allow the reasons for improvements or a lack of progress to be better understood, issuance of birth certificates accompanying birth registration should be disaggregated by i) sex – any differences in the tendency to issue birth certificated for males or females may point to gender issues that require targeted education or policies; ii) Ethnic and/or national group if collected, this information provides valuable insight into the tendency for underreporting certain populations or barriers to being issued a certificate.  Comparison to survey data: Sample surveys such as MICS and DHS, and population censuses, sometimes include questions on the issuance and possession of a birth certificate. Such data may provide supporting information to set and monitor this target, and to identify specific groups less likely to have a birth certificate issued. |
| *Data sources for target setting and monitoring*  CR offices should keep records of the number of birth certificates issued. A standard format for official birth certificates should be developed that includes, at a minimum, the individual’s name, sex, date and place of birth. Registration and certification records kept by the CR authority are the primary data source for monitoring this target. These records should be structured in such a way that enables this indicator to be accurately and efficiently produced, including unique identifiers to match registration and certification records.  The establishment of electronic systems for CR is strongly recommended as it provides efficiency gains including the safe storage and linking of records.**[[37]](#footnote-38)** Development of these systems should include the automatic generation of reports on this indicator, as well as related indicators of CR system performance.  Biased reporting: Steps should be taken to ensure reporting against this target is accurate and not biased for reasons such as motivation to cover up any underperforming components of the system. Achieving this may involve using independent evaluators or auditors to assess the validity of reports from the CR system. |

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| **Target 2B: By 2024, at least … per cent of all deaths registered in the territory and jurisdiction in the given year are accompanied with the issuance of an official death certificate which includes, as a minimum, the deceased’s name, date of death, sex, and age.** |
| The death certificate provides the final and permanent confirmation of the fact of death, enabling matters relating to inheritance and settling of an estate. The death certificate is typically only issued if notification is accompanied by a completed medical certificate as proof of the occurrence and cause of death.**[[38]](#footnote-39)** |
| *Method of estimation/calculation*  This indicator is calculated by dividing the number of all certificates issued (with minimum information) for deaths registered in the given year (numerator), by the number of deaths registered in the given year (denominator), and then multiplying by 100 to give a percentage figure.   |  |  | | --- | --- | | Number of death certificates issued (with minimum information) in the given year | X 100 | | Number of deaths registered in the given year | |
| *Ideal target*  Ideally, all death registrations will be accompanied by the issuance of an official death certificate so the target should be 100 per cent.  In the case of death registration, it may be possible that no family member or interested party exists or is available to receive the official certificate at the time of registration. Such cases should be identified so it is possible for CRVS system stakeholders to understand why gaps in certificate issuance may be occurring. |
| *Issues and considerations*  Minimum information on official death certificates: A variety of information is collected through the civil registration system. Some of this information, when identified with a specific individual, may be highly personal and sensitive. To protect confidentiality and prevent discrimination, only the minimum information needed to prove identity should be included on the official death certificate. This includes basic information such as the deceased’s name, date of death, sex, and age.  Issuance of a death certificate: This target looks at whether deaths being registered are also issued a death certificate. Death certificates may be re-issued to individuals on their request, for example, to replace a lost certificate. To avoid double counting, the civil registration office should maintain records that facilitate some differentiation between those issued at the time of registration versus subsequently-issued ones.  Disaggregation: To allow the reasons for improvements or a lack of progress to be better understood, issuance of official death certificates should be disaggregated by location of the primary, secondary or mobile registration unit. Disaggregating data to the location of the registration unit will allow deficiencies to be identified and addressed. |
| *Data sources for target setting and monitoring:* Registration and certification records kept by the CR authority are the primary data source for monitoring this target. These records should be structured in such a way that enables this indicator to be accurately and efficiently produced, including unique identifiers to match registration and certification records.  The establishment of electronic systems for CR activities is strongly recommended as it provides efficiency gains including the safe storage and linking of records.**[[39]](#footnote-40)** Development of these systems should include the automatic generation of reports on this indicator, as well as related indicators of CR system performance.  Biased reporting: Steps should be taken to ensure reporting against this target is accurate and not biased for reasons such as motivation to cover up any underperforming components of the system. Achieving this may involve the use of independent evaluators or auditors to assess the validity of CR assessment reports. |

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| **Target 3A: By … (year), annual nationally representative statistics on births – disaggregated by age of mother, sex of child, geographic area and administrative subdivision – are produced from registration records or other valid administrative data sources.** |
| *Method of estimation/calculation*  Verifying achievement of this target involves liaising with the national vital statistics (VS) authority to ascertain whether statistics are being compiled based on registration records and/or other administrative data. The achievement of this target requires that information related to the age of the mother, sex of the child, geographic area and administrative subdivision are included as mandatory fields for completion during the registration process.  Documentation of the process and resulting information used to verify this target should be prepared and reported to the national mechanism overseeing the improvement of the CRVS system. |
| *Ideal target*  Being able to produce nationally representative statistics on births, which are appropriately disaggregated, will depend on several factors: (i) whether births are being registered; (ii) the quality of information being collected by the registration authority, and (iii) whether data are reported to allow for production of the statistics.  Determining by what year countries should aim to achieve this target is linked to progress in completeness of birth registration. Some countries may already have obtained the target. |
| *Issues and considerations*  National representation: Achieving national representation includes the government paying equal attention in facilitating death registration everywhere, irrespective of urban or rural areas, remote or non-remote areas. In the case of remote areas which often lack proper infrastructure and services, it may be necessary to have a higher number of the birth registration points in short term and the development of transport infrastructures in the long term. Also, there may need to be emphasis on girl’s birth registration in paternalist societies where properties are likely to be inherited by boys, and therefore the birth registration of girls is given less attention.  Decentralized systems: To ensure accuracy, uniformity and flexibility, it is recommended that compilation from individual reports, either paper-based or electronic, be undertaken centrally. Where this is not practical, a decentralized approach involving subnational offices could be set up to carry out all or selected data-processing functions. If decentralized, detailed written guidelines, dealing with procedures such as coding, editing, querying and data entry, must be issued by a central national authority, and measures adopted to ensure strict adherence to established/ standard procedures.  Disaggregation and tabulations: The exact age of the mother (in years) at the time of the birth of the child should be recorded. The geographic area should be compiled, as detailed as possible, for the total geographical area of the country, for each major or other minor civil division and for each principal town and city. When relevant, the geographic area should distinguish between urban and rural, for at least the entire country, and each major or other civil division.  Recommended formats for tabulation of statistics on births are outlined in the *United Nations Principles and Recommendations for a Vital Statistics System*. |
| *Data sources for target setting and monitoring*  Statistics should be produced based on birth registration records or other administrative data sources. At the time of registration, the local registrar should prepare a statistical report for each birth registered.  Population censuses and household survey data provide an opportunity to validate the coverage of birth records. |

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| **Target 3B: By … (year), annual nationally representative statistics on deaths – disaggregated by age, sex, cause of death defined by ICD (latest version as appropriate), geographic area and administrative subdivision – are produced from registration records or other valid administrative data sources.** |
| *Method of estimation/calculation*  Verifying achievement of this target involves liaison with the national VS authority to ascertain whether VS are being produced with appropriate disaggregation and based on registration records and/or other administrative data. |
| *Ideal target*  Being able to produce nationally representative statistics on deaths, which are appropriately disaggregated, will depend on whether deaths are being registered, the quality of cause-of-death coding, the quality of information being collected by the registration authority, and whether data are reported to allow for production of the statistics. Determining by what year countries should aim to achieve this target is linked to progress in completeness of death registration. |
| *Issues and considerations*  National representation: Achieving national representation includes the government paying equal attention in facilitating death registration everywhere, irrespective of urban or rural areas, remote or non-remote areas. In the case of remote areas which often lack proper infrastructure and services, it may be necessary to have a higher number of the death registration points in short term and the development of transport infrastructures in the long term.  Decentralized systems: To ensure accuracy, uniformity and flexibility, it is recommended that compilation from individual reports, either paper-based or electronic, be undertaken centrally. Where this is not practical, a decentralized approach involving subnational offices could be set up to carry out all or selected data-processing functions. If decentralized, detailed written guidelines, dealing with procedures such as coding, editing, querying and data entry, must be issued by a central national authority, and measures adopted to ensure accountability for following standard procedures.  Disaggregation: The age (in years) of the individual at the time of death and the cause of death based on individual ICD codes. The geographical area should be compiled, as detailed as possible, for the total geographical area of the country, for each major or other minor civil division and for each principal town and city. Where applicable, the geographic area should distinguish between urban and rural, at least for the entire country and each major or other civil division.  Publication of vital statistics: Such vital statistics should not only be produced but also be made publicly available through the usual dissemination channels for official statistics.  Low coverage of death registration: Simple tabulations are recommended for countries where coverage of death registration is less than 90 per cent. Recommended formats for tabulation of statistics on deaths are outlined in the *United Nations Principles and Recommendations for a Vital Statistics System*. |
| *Data sources for target setting and monitoring*  Statistics should be produced based on death registration records or other administrative data sources. At the time of registration, the local registrar should prepare a statistical report for each death registered.  Population censuses and household survey data provide an opportunity to validate the coverage of death records (this is not expected to be as accurate as in the case for births, because death coverage in both the census and surveys tend to underestimate mortality – especially adult mortality). |

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| **Target 3C: By 2024, at least … per cent of deaths occurring in health facilities or with the attention of a medical practitioner have an underlying cause of death code derived from the medical certificate according to the standards defined by ICD (latest version as appropriate).** |
| *Method of estimation/calculation*  This indicator is calculated by dividing the number of deaths occurring in health facilities or with the attention of a medical practitioner that have an underlying cause of death code derived from the medical certificate (numerator), by the number of deaths occurring in health facilities or with the attention of a medical practitioner (denominator), and then multiplying by 100 to give a percentage figure.   |  |  | | --- | --- | | Number of deaths occurring in health facilities or under the attention/supervision of a medical practitioner that have an underlying cause of death code derived from the medical certificate in the given year | X 100 | | Number of deaths occurring in health facilities or with the attention of a medical practitioner in the given year | |
| *Ideal target*  Ideally, all deaths that occur within health facilities or with attention of a medical practitioner will have a medical certificate with an underlying cause of death according to the standards defined by ICD. Death codes are subsequently derived based on the medical certificates. Countries should aim to achieve 100 per cent for this target, although improvements may need to be incremental. |
| *Issues and considerations*  Data quality: The existence of a medical certificate of cause of death in the international format prescribed by the WHO does not guarantee the quality of the information on underlying cause of death. How well the medical practitioner manages to diagnose the diseases and factors relating to the death depends on several factors. An understanding of the importance of cause-of-death information, as well as training in death certification in accordance with ICD guidelines, is essential to ensure medical practitioners can competently certify deaths. Training and certification in death coding is also critical for ensuring the accuracy of the codes assigned for cause of death. Collaboration with WHO on the provision of training on ICD coding as well as the identification of what constitutes underlying cause of death (if multiple causes are stated) is essential. |
| *Data sources for target setting and monitoring*  CR authorities have information on underlying cause of death when a death certificate has been issued. |

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| **Target 3D: By 2024, the proportion of deaths coded to ill-defined codes will have been reduced by … per cent compared with the baseline year.** |
| Ill-defined codes are a specific set of codes in the ICD that refer to symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified. As the ICD instruction manual states, a high proportion of these codes indicates the need to check the quality of coding and reallocate a more specific cause.**[[40]](#footnote-41)** The classification of “ill-defined” will depend on the code set adopted by the country, including the version of ICD being used and the level of detail being applied. |
| *Method of estimation/calculation*  This indicator is calculated by dividing the number of deaths with ill-defined codes (numerator), by the number of deaths coded to ICD (denominator), and then multiplying by 100 to give a percentage figure.   |  |  | | --- | --- | | Number of deaths with ill-defined codes in the given year | X 100 | | Number of deaths coded to ICD in the given year |   The WHO provides a tool for analysing mortality levels and causes-of-death (ANACoD) that can be used to facilitate the calculation of this indicator.[[41]](#footnote-42) The tool automatically reviews data on mortality levels and causes of death for errors, tabulates the information, presents the results in the form of easy-to-use tables and charts, and provides the opportunity to compare the findings with those from other groups of countries. |
| *Ideal target*  Ideally, all deaths will be coded to ICD and the proportion of deaths with ill-defined codes will be small. It is recognised that to achieving these will be difficult and incremental targets may be necessary – based on improvements to death certification and the application of ICD. |
| *Issues and considerations*  Data quality: The existence of a medical certificate of cause of death in the correct international form does not guarantee the quality of the information on underlying cause of death. How well the medical practitioner manages to diagnose the diseases and factors relating to the death depends on several factors. An understanding of the importance of cause-of-death information, as well as training in death certification in accordance with ICD guidelines, is essential to ensure medical practitioners can competently certify deaths.  In countries where CRVS systems are weak, it may be common for a layperson without medical training to be tasked with determining the death of an individual. A layperson is not asked to certify the cause of death but may make a pronouncement on cause of death. The national CRVS law should clearly state that only a trained physician can certify cause of death. Unfortunately, in some instances, physicians may be poorly trained in cause of death certification. This leads to deaths being attributed to ill-defined or non-specific causes, such as “old age”, “fever” and “stopped breathing”. Such diagnoses are of no value and lead to a high proportion of deaths coded to ill-defined codes. Reducing the proportion of deaths coded to these categories is an essential step in improving the quality of mortality statistics. |
| *Data sources for target setting and monitoring*  CR authorities have information on deaths registered by location and demographic characteristics of the deceased (e.g. ethnicity, place of usual residence), together with the ICD code for cause of death (where available). The NSO compiles the ICD codes. |

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| **Target 3E: By 2024, at least … per cent of deaths taking place outside of a health facility and without the attention of a medical practitioner have their underlying cause of death code determined through verbal autopsy in line with international standards.** |
| *Method of estimation/calculation*  This indicator is calculated by dividing the number of deaths taking place outside of a health facility that have an underlying cause of death code determined through verbal autopsy (VA) in the given year (numerator), by the total number of deaths taking place outside of a health facility in the given year (denominator), then multiplying by 100 to give a percentage figure.   |  |  | | --- | --- | | Number of deaths taking place outside of a health facility and without attention of a medical practitioner that have an underlying cause of death code determined through VA in line with international standards in the given year | X 100 | | Number of deaths taking place outside of a health facility and without attention of a medical practitioner in the given year |   Monitoring this target requires knowing the number of deaths taking place outside of a health facility and without the attention of a medical practitioner (i.e. the extent to which verbal autopsies are needed), how many verbal autopsies have taken place and whether they were conducted in accordance with international standards. |
| *Ideal target*  Verbal autopsies are used as a method of producing probable cause-of-death statistics where better sources are not available. Due to their complexity and time-consuming nature, they are typically conducted on a sample of the deaths occurring outside of health facilities. Some countries have used VA on a large scale as a part of developing their CRVS systems. In such cases a simplified VA instrument and automated methods of data capture (e.g. mobile phones or hand-held devices) could be an effective strategy in the incremental strengthening of civil registration and vital statistics.[[42]](#footnote-43)  Rather than aiming for 100 per cent, the ideal target for this indicator should be high enough to ensure that verbal autopsies are conducted on a sample of a sufficient size to be representative of deaths that occur in the absence of a medical practitioner. Countries with poor coverage of death registration could combine VA with sample vital registration (registration of vital events for a nationally representative sample) to produce vital statistics on the major causes of death. A series of manuals on sample vital registration with verbal autopsy (SAVVY) for mortality surveillance has been developed by the MEASURE Evaluation project based at the University of North Carolina at Chapel Hill and the United States Census Bureau.[[43]](#footnote-44) |
| *Issues and considerations*  The verbal autopsy method is complex. Those who conduct the interview require comprehensive training and completing the questionnaire is time-consuming and burdensome on respondents. If the national context and cultural traditions do not favour long interviews with a government official, response rates and the quality of information being gathered will be impacted.  Increasing the proportion of deaths that are medically certified, and ensuring medical practitioners are adequately trained and resourced to certify causes of death, should be a part of the national strategy to improve CRVS systems in the long term, reducing the need for verbal autopsies. |
| *Data sources for target setting and monitoring*  Depending on the national infrastructure, the offices typically involved in facilitating the conduct of VA and maintaining the resulting records, may include the NSO, CR authorities and the Ministry of Health.  Number of verbal autopsies conducted (numerator): The data source for the numerator will be the lead agency responsible for coordinating the conduct of VA to determine cause of death for any non-medically certified deaths in the country.  Monitoring this target requires verifying compliance of VA with international standards. This may involve establishing a system of random checks of completed questionnaires being used and the quality of resulting cause-of-death coding. The recommended methodologies and collection instruments for conducting Vas are available from WHO.[[44]](#footnote-45)  Number of deaths taking place outside of a health facility and without attention of a medical practitioner (denominator): In many countries, a sizable proportion of deaths occur in the absence of medical attention, that is, outside of health facilities (e.g. at home) and without the attention of a medical practitioner. If a sufficient proportion of deaths are registered, the CR records could be used to estimate the extent to which this occurs by comparing registration records to deaths recorded by the health sector and/or death registrations for which a representative of the health sector was the informant. |

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| **Target 3F: By … (year), key summary tabulations of vital statistics on births and deaths using registration or other administrative records as the primary source, are made available in the public domain in electronic format annually, and within one calendar year.** |
| *Method of calculation/estimation*  Verifying achievement of this target involves liaison with the national VS authority to locate key summary tabulations in the public domain and then verifying the primary source, format and timeliness of their publication.  Key summary tables[[45]](#footnote-46) include both rates and numbers and a geographical split of at least urban/rural (where applicable). They are compiled from CR systems. Death tables should include age and sex, while birth tables should include both live births and still births. The release of tables should be on the website of the NSO and be available in electronic format. Ideally, ages will be single years rather than ranges (depending on confidentiality issues). In some countries smaller geographic regions may be shown. |
| *Ideal target*  Being able to produce nationally representative VS and make them available in an electronic format in a timely manner, will depend on the strength of the CRVS system. Determining by what year countries should aim to achieve this target is linked to progress in other areas. |
| *Issues and considerations*  Timing: Date of occurrence of the event will be used for these tables. There is some delay between the event and registration: it is important that lags between the event and registration are examined to ensure all events are included in the correct reference period. It may be necessary to revise publication numbers in situations where there is a considerable time difference between the event and its registration.  Electronic data: For ease of analysis it is important that birth and death information be released in electronic format. Where the data is only released in paper format, a plan needs to be developed to either transition to electronic format or have both paper and electronic release of information.  Other information from CR system: The CR system collects additional information about the event itself as well as characteristics of the person affected by the event. Countries are encouraged to release as much information as possible. |
| *Data sources for target setting and monitoring*  The data sources for this indicator are the authority responsible for producing VS, and the public domain or channel through which official VS are usually published. |

|  |
| --- |
| **Target 3G: By … (year), key summary tabulations of vital statistics on causes of death using registration or other administrative records as the primary source, are made available in the public domain in electronic format annually, and within two calendar years.** |
| *Method of estimation/calculation*  Verifying achievement of this target involves liaison with the national VS authority to locate key summary tabulations in the public domain and then verifying the primary source, format and timeliness of their publication.  The tabulations on causes of death are to be directly calculated from CR records or other administrative sources such as the health management information system (HMIS) of the NSO or the MoH. Cause of death coding will be done using the latest version of ICD. Cause of death tables should include both rates and numbers and a geographical split of at least urban/rural (where applicable). Death tables should include age, sex and underlying cause. Ideally, age at death will be single years rather than ranges (depending on confidentiality issues). For some countries, geographic regions may be shown for smaller regions. ICD coding is hierarchical, with the ideal being for data to be published at the individual code level. |
| *Ideal target*  Being able to produce nationally representative vital statistics and make them available in an electronic format in a timely manner, will depend on the strength of the CRVS system. Countries should aim to issue provisional summary tabulations of nationally aggregated data on births and deaths as a priority. Where the CRVS system is computerised, the aim should be to issue the initial summary tables on a monthly or quarterly basis. More detailed tabulations that require careful quality assessment including on causes of death and subnational areas will be issued with a somewhat longer time lag. Determining by what year countries should aim to achieve this target is linked to progress in other areas. |
| *Issues and considerations*  Timing: Date of the occurrence of the event will be used for these tables. There is some delay between the event and registration. It is important that lags between the event and registration are examined to ensure all events are included in the correct reference period. It may be necessary to revise publication numbers in situations where there is a considerable time difference between the event and its registration[[46]](#footnote-47).  Electronic data: For ease of analysis it is important that cause of death information be released in electronic format. Where the data is only released in paper format, a plan needs to be developed to either transition to electronic format or have both paper and electronic release of information.  ICD coding: Ideally, all deaths will be coded to ICD and the proportion of deaths with ill-defined codes will be small. Only a trained physician can certify cause of death but because physicians are often poorly trained in cause of death certification they often do an inadequate job. This leads to deaths being attributed to ill-defined or non-specific causes, such as “old age”, “fever” and “stopped breathing”. Such diagnoses are of no value and lead to a high proportion of deaths coded to ill-defined codes. Reducing the proportion of deaths coded to these categories is essential to improve the quality of mortality statistics. |
| *Data sources for target setting and monitoring*  The data sources for this indicator are the authority responsible for producing VS and the public domain or channel through which official vital statistics are usually published. |

|  |
| --- |
| **Target 3H: By … (year), an accurate, complete and timely vital statistics report for the previous two years, using registration records or other routine administrative sources as the primary source, is made available in the public domain** |
| *Method of estimation/calculation*  Verifying achievement of this target involves liaison with the national VS authority to locate the VS report in the public domain and then verifying the primary source, accuracy, completeness and timeliness of its publication.  All countries should produce an annual VS report containing two years of data within one calendar year of the end of the reporting period. The data included in the report should be based on information from registration records or other valid administrative data sources such as the HMIS. Where there are data gaps or data weaknesses, these should be clearly described in the publication.  Publications of VS should be part of a series designed to meet specific user needs. They should also be released according to a regular and timely schedule. They should be complete with data tables, graphs, charts, maps and analyses. If possible, published data should also be downloadable.  While many countries may have incomplete data, it should be published and available as soon as possible after the end of the reference period. If the quality of VS is poor, the publication can consist of simple tabulations, which can be expanded as data quality improves. |
| *Ideal target*  Being able to produce nationally representative VS and make them available in a timely manner will depend on the strength of the CRVS system. Determining by what year countries should aim to achieve this target is linked to progress in other areas. |
| *Issues and considerations*  Publication format: The traditional publication format is a paper report. Consideration should be given to electronic methods of publishing data as these methods assist in user access and analysis. Also, consideration should be given to provision of micro data to researchers.[[47]](#footnote-48)  Data explanation: The VS report should include copies of the statistical collection forms for births, technical explanations and notes on the strengths and limitations of the published data. Information on delayed and late registration should also be included to assist in reconstructing the time series of births.  Broadcasting of information: Proactive dissemination of information is important. Communication with users can be achieved via letter, email, internet or social media. |
| *Data sources for target setting and monitoring*  The data sources for this indicator are the authority responsible for producing VS and the public domain or channel through which official vital statistics are usually published. |

# Annexes

## Seven action areas of the Regional Action Framework

## Three goals and 15 targets of the Regional Action Framework

**Goal 1:** Universal civil registration of births, deathsand other vital events

1.A. By 2024, at least … per cent of births in the territory and jurisdiction in the given year are registered.[[48]](#footnote-49)

1.B. By 2024, at least … per cent of children under 5 years old in the territory and jurisdiction have had their birth registered.

1.C. By 2024, at least … per cent of all individuals in the territory and jurisdiction have had their birth registered.

1.D. By 2024, at least … per cent of all deaths that take place in the territory and jurisdiction in the given year are registered.

1.E. By 2024, at least … per cent of all deaths recorded by the health sector in the territory and jurisdiction in the given year have a medically certified cause of death recorded using the international form of the death certificate.

**Goal 2: All individuals are provided with legal documentation of civil registration of births, deaths and other vital events, as necessary, to claim identity, civil status and ensuing rights**

2.A. By 2024, at least … per cent of all births registered in the territory and jurisdiction are accompanied with the issuance of an official birth certificate that includes, as a minimum, the individual’s name, sex, date and place of birth, and name of parent(s) where known.

2.B. By 2024, at least … per cent of all deaths registered in the territory and jurisdiction in the given year are accompanied with the issuance of an official death certificate which includes, as a minimum, the deceased’s name, date of death, sex, and age.

**Goal 3: Accurate, complete and timely vital statistics (including on causes of death) are produced based on registration records and are disseminated**

3.A. By … (year), annual nationally representative statistics on births – disaggregated by age of mother, sex of child, geographic area and administrative subdivision – are produced from registration records or other valid administrative data sources.

3.B. By … (year), annual nationally representative statistics on deaths – disaggregated by age, sex, cause of death defined by ICD (latest version as appropriate), geographic area and administrative subdivision – are produced from registration records or other valid administrative data sources.

3.C. By 2024, at least … per cent of deaths occurring in health facilities or with the attention of a medical practitioner have an underlying cause of death code derived from the medical certificate according to the standards defined by ICD (latest version as appropriate).

3.D. By 2024, the proportion of deaths coded to ill-defined codes will have been reduced by … per cent compared with the baseline year.[[49]](#footnote-50)

3.E. By 2024, at least … per cent of deaths taking place outside of a health facility and without the attention of a medical practitioner have their underlying cause of death code determined through verbal autopsy in line with international standards.

3.F. By … (year), key summary tabulations of vital statistics on births and deaths using registration records as the primary source, are made available in the public domain in electronic format annually, and within one calendar year.

3.G. By … (year), key summary tabulations of vital statistics on causes of death using registration records as the primary source, are made available in the public domain in electronic format annually, and within two calendar years.

3.H. By … (year), an accurate, complete and timely vital statistics report for the previous two years, using registration records as the primary source, is made available in the public domain.

## Eight Implementation Steps of the Regional Action Framework

(a). Establish an effective and sustainable national CRVS coordination mechanism comprising all relevant stakeholders;

(b). Conduct a standards-based comprehensive assessment of CRVS in their territory,[[50]](#footnote-51) which is inclusive of all relevant stakeholders, for the purpose of identifying gaps and making recommendations that will be the foundation of a comprehensive multisectoral national CRVS strategy;

(c). Set the national target value for each target, in consultation with all relevant stakeholders, and report these to the ESCAP secretariat,

(d). Develop and implement a plan for monitoring and reporting on achievement of the targets, including on reporting to the ESCAP secretariat;

(e). Assess inequalities related to CRVS experienced by subgroups of the population, including among hard-to-reach and marginalized populations and particular geographic areas and administrative subdivisions, and, where appropriate, set national targets to address those inequalities;

(f). Develop and implement a comprehensive multisectoral national CRVS strategy, aligned, where appropriate, with the action areas of the regional action framework, with political commitment, adequate funding, and a clear delineation of responsibilities for stakeholders to establish accountability for the implementation;

(g). Assign a national focal point within the Government that is responsible for coordinating with the ESCAP secretariat and development partners;

(h). Through the national focal point, report relevant information to the ESCAP secretariat or subregional body, as appropriate, in accordance with the reporting structure for the regional action framework.

## Overview of the eight implementation steps in the baseline report

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Countries | National coordination mechanism | Comprehensive assessment | National targets | Monitoring and reporting plan | Inequality assessment and/or targets | National strategy | National focal point | Reporting to ESCAP |
|
|
|
| Afghanistan |  | Yes | No |  |  |  | Yes | No |
| American Samoa |  |  | No |  |  |  | No | No |
| Armenia | No | Plans | Yes | Yes | No | Plans | Yes | Yes |
| Australia | Yes | Yes | Partial | Yes | Yes | Yes | Yes | Yes |
| Azerbaijan | Yes | Yes | Partial | Yes | Yes | Yes | Yes | Yes |
| Bangladesh | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes |
| Bhutan | Yes | Yes | Partial | No | No | Plans | Yes | Yes |
| Brunei Darussalam |  |  | No |  |  |  | No | No |
| Cambodia | No | Yes | Yes | No | No | Yes | Yes | Yes |
| China |  |  | No |  |  |  | No | No |
| Cook Islands | Yes | Yes | Yes | No | No | No | Yes | Yes |
| Democratic People’s Republic of Korea |  |  | No |  |  |  | Yes | No |
| Fiji | Yes | Yes | Yes | No | Yes | Plans | Yes | Yes |
| France |  |  | No |  |  |  | No | No |
| French Polynesia |  |  | No |  |  |  | No | No |
| Georgia |  |  | No |  |  |  | No | No |
| Guam |  |  | No |  |  |  | Yes | No |
| Hong Kong, China | Yes | No | Partial | No | No | No | Yes | Yes |
| India | Yes | Plans | Partial | No | No | Plans | Yes | Yes |
| Indonesia | Plans | Yes | No |  | Yes | Plans | Yes | No |
| Iran (Islamic Republic of) | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes |
| Japan | Yes | No | Partial | No | No | No | Yes | Yes |
| Kazakhstan | No | No | Yes | No | Yes | No | Yes | Yes |
| Kiribati | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes |
| Kyrgyzstan | No | Yes | No | No | No | No | Yes | Yes |
| Lao People’s Democratic Republic | Yes | Plans | Partial | No | Yes | Yes | Yes | Yes |
|
| Macao, China | No | No | Yes | No | No | No | Yes | Yes |
| Malaysia | Yes | No | No |  |  | No | Yes | No |
| Maldives | No | Yes | Partial | No | Yes | Yes | Yes | Yes |
| Marshall Islands |  | Yes | No |  |  |  | No | No |
| Micronesia (Federated States of) | Yes | Yes | Partial | No | No | Plans | No | Yes |
|
| Mongolia | No | Plans | Partial | No | No | Plans | Yes | Yes |
| Myanmar | No | Plans | Partial | No | No | Plans | Yes | Yes |
| Nauru | Yes | Yes | No |  |  | Yes | No | No |
| Nepal | Yes | Yes | Partial | No | No | Plans | Yes | Yes |
| Netherlands |  |  | No |  |  |  | No | No |
| New Caledonia |  |  | No |  |  |  | No | No |
| New Zealand | Yes | No | Yes | No | No | No | Yes | Yes |
| Niue | Plans | Yes | No |  |  | Yes | No | No |
| Northern Mariana Islands | Plans | Yes | No |  |  |  | No | No |
| Pakistan | Yes | Yes | Yes | No | No | Plans | Yes | Yes |
| Palau | Plans | Yes | No |  |  |  | Yes | No |
| Papua New Guinea | No | No | No |  |  |  | Yes | No |
| Philippines | Yes | Yes | Yes | No | Yes | Plans | Yes | Yes |
| Republic of Korea | Yes | No | Partial | No | No | No | Yes | Yes |
| Russian Federation |  |  | No |  |  |  | No | No |
| Samoa | Yes | Yes | Partial |  | No | Yes | Yes | Yes |
| Singapore |  |  | No |  |  |  | No | No |
| Solomon Islands | Yes | Yes | Yes | yes | No | Yes | Yes | Yes |
| Sri Lanka | No | Yes | No |  |  |  | Yes | No |
| Tajikistan | Yes | No | Partial | yes | No | No | Yes | Yes |
| Thailand | Yes | Yes | Yes | No | Yes | No | Yes | Yes |
| Timor-Leste | Yes | Plans | No | Yes | No | Plans | Yes | Yes |
| Tonga | Yes | Plans | Yes | No | Yes | Plans | Yes | Yes |
| Turkey | Yes | No | Partial | No | No | Plans | Yes | Yes |
| Turkmenistan |  |  | No |  |  |  | No | No |
| Tuvalu |  | Yes | No |  |  | Yes | No | No |
| United Kingdom of Great Britain  and Northern Ireland |  |  | No |  |  |  | No | No |
|
|
| United States of America | Yes | No | Partial | No | Yes | No | Yes | Yes |
|
| Uzbekistan |  |  | No |  |  |  | Yes | No |
| Vanuatu | Yes | Yes | No |  |  | Yes | Yes | No |
| Viet Nam | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Subtotal, Yes | 30 | 29 | 16 | 9 | 13 | 15 | 44 | 35 |
| Subtotal, No | 10 | 11 | 29 | 25 | 23 | 12 | 18 | 27 |
| Subtotal, Plans | 4 | 7 | 0 | 0 | 0 | 14 | 0 | 0 |
| Subtotal, Partial | 0 | 0 | 17 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **44** | **47** | **62** | **34** | **36** | **41** | **62** | **62** |

## Members and associate members’ baseline and target values[[51]](#footnote-52)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Target 1A | | | Target 1B | | | Target 1C | | |
| Countries | Year | Baseline | Target | Year | Baseline | Target | Year | Baseline | Target |
| Armenia | 2014 | 99.00% | 100% | 2014 | 96.00% | 100.00% | 2014 | 99.00% | 100.00% |
| Australia | 2014 | 95.00% | 99% | 2014 | 98.30% | 99.00% | NR | NR | 99.00% |
| Azerbaijan | NR | NR | NR | NR | NR | NR | NR | NR | NR |
| Bangladesh | 2014 | 12.80% | 100% | 2014 | 24.60% | 100.00% | NR | 86.50% | 100.00% |
| Bhutan | 2014 | 82% | 95% | NR | 98% | 99% | NR | 81% | 90% |
| Cambodia | 2014 | 53.00% | 90% | 2014 | 26.00% | 90.00% | 2014 | NR | 90.00% |
| Cook Islands | 2014 | 100% | 100% | 2014 | 100% | 100% | 2014 | 100% | 100% |
| Fiji | NR | 42% | 85% | NR | 73% | 85% | NR | 71% | 95% |
| Hong Kong, China | NR | 99.80% | NTS | NR | NR | NTS | NR | NR | NTS |
| India | 2013 | 85.60% | 100% | 2013 | 86.00% | 100.00% | 2013 | 50.00% | 75.00% |
| Iran (Islamic Republic of) | 2014-2015 | 94.60% | 100% | 2014-2015 | 99.70% | 100.00% | 2014-2015 | 99.90% | 100.00% |
| Japan | 2014 | 100.00% | NTS | NR | NR | NR | 2014 | 100.00% | NR |
| Kazakhstan | NR | 99.70% | 100% | 2014 | 99.70% | 100.00% | NR | NR | 100.00% |
| Kiribati | 2010 | 97.40% | 100% | 2010 | 87.00% | 100.00% | NR | 97.00% | 100.00% |
| Kyrgyzstan | 2014 | 97.70% | NR | 2014 | 97.70% | NR | 2014 | 97.70% | NR |
| Lao People’s Democratic Republic | 2014 | 44% | 70% | NR | N/A | 80% | NR | NR | 70% |
| Macao, China | 2014 | 100.00% | 100% | 2014 | 100.00% | 100.00% | 2014 | 100.00% | 100.00% |
| Maldives | 2014 | 100.00% | 100% | 2014 | 99.00% | 100.00% | NR | 98.60% | 100.00% |
| Micronesia (Federated States of) | 2014 | 80% | 95% | 2011-2015 | 80% | 95% | 2014 | 80% | 90% |
| Mongolia | 2015 | 100.00% | 100% | 2015 | 100.00% | 100.00% | 2015 | 100.00% | 100.00% |
| Myanmar | 2013 | 74.00% | 95% | 2013 | 75.00% | 95.00% | 2013 | 1.50% |  |
| Nepal | 2014-2015 | 76.00% | 99% | NR | NR | 90.00% | NR | NR | 80.00% |
| New Zealand | 2014 | 85.00% | 90% | 2010-2014 | 86.30% | 99.00% | 2014 | 97.60% | 99.00% |
| Pakistan | NR | NR | 100% | NR | NR | 100.00% | NR | NR | 100.00% |
| Philippines | NR | 90.60% | 99% | NR | 90.20% | 99.50% | 2010 | 93.50% | 99.50% |
| Republic of Korea | 2014 | 99.90% | 100% | NR | 100,2% | 100.00% | 2014 | 100.70% | 100.00% |
| Samoa | NR | 30% | 85% | NR | NR | NR | NR | NR | 95% |
| Solomon Islands | 2014 | 29% | 85% | 2014 | 17% | 90% | 2014 | 22% | 60% |
| Tajikistan | 2015 | 89% | 97% | 2015 | 95% | 98% | 2012 | 88.4 % | NR |
| Thailand | 2014 | 98.00% | 100% | 2014 | 98.00% | 100.00% | 2014 | 98.00% | 100.00% |
| Timor-Leste | NR | NR | NR | NR | NR | NR | NR | NR | NR |
| Tonga | 2014 | 89% | 95% | 2014 | NR | 97% | NR | 95% | 84% |
| Turkey | 2014 | 98.00% | 100% | NR | NR | 100.00% | 2014 | 100.00% | 100.00% |
| United States of America | NR | NR | 99% | NR | NR | 99.00% | NR | NR | 99.00% |
| Viet Nam | NR | NR | 97% | 2015 | NR | 98.50% | NR | NR | 75.00% |
| **Total responses** | **26** | **30** | **30** | **22** | **23** | **28** | **19** | **23** | **28** |

Note: NR: No response; NTS: No target set; TA: Target achieved

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Target 1D | | | Target 1E | | |
| Countries | Year | Baseline | Target | Year | Baseline | Target |
| Armenia | 2014 | 98.30% | 100.00% | NR | 100.00% | 100.00% |
| Australia | NR | 99.90% | NTS | 2014 | 100.00% | NR |
| Azerbaijan | NR | NR | NR | NR | NR | NR |
| Bangladesh | 2014 | 9.10% | 80.00% | 2014 | 16.00% | 80.00% |
| Bhutan | NR | 81% | 90% | 2011 | 11% | 85% |
| Cambodia | NR | NR | 30.00% | NR | NR | 30.00% |
| Cook Islands | 2014 | 100% | 100% | 2014 | 78% | 100% |
| Fiji | 2014 | 59% | 100% | 2014 | 99% | 100% |
| Hong Kong, China | NR | 99.30% | NTS | 2014 | 100.00% | NTS |
| India | 2013 | 70.90% | 100.00% | 2013 | 11.60% | 60.00% |
| Iran (Islamic Republic of) | 2014 | 79.00% | 95.00% | 2014 | 80.00% | 85.00% |
| Japan | 2014 | 99.90% | NTS | NR | NR | TA |
| Kazakhstan | 2014 | 98.60% | 100.00% | 2014 | 100.00% | TA |
| Kiribati | 2010 | 91.00% | 100.00% | 2014 | 16.00% | 80.00% |
| Kyrgyzstan | 2011 | 97.00% | NR | 2014 | 99.00% | NR |
| Lao People’s Democratic Republic | NR | NR | 60% | NR | NR | 85% |
| Macao, China | 2014 | 100.00% | 100.00% | 2014 | 100.00% | 100.00% |
| Maldives | 2014 | 90.10% | 100.00% | 2014 | 100.00% | 100.00% |
| Micronesia (Federated States of) | 2014 | 98% | 90% | 2014 | 98% | 100% |
| Mongolia | 2015 | 100.00% | 100.00% | 2015 | 100.00% | 100.00% |
| Myanmar | 2013 | 50.00% | 75.00% | 2013 | 50.00% | 75.00% |
| Nepal | 2015 | 75.00% | 80.00% | 2013/14 | 45.40% | NR |
| New Zealand | 2014 | 99.90% | 99.00% | 2014 | 100.00% | 99.00% |
| Pakistan | NR | NR | 80.00% | 2014 | NR | 80.00% |
| Philippines | 2010 | 66.00% | 90.00% | 2010 | 34.00% | 85.00% |
| Republic of Korea | 2014 | 99.70% | 100.00% | 2014 | 99.10% | 100.00% |
| Samoa | NR | NR | 70% | NR | NR | 95% |
| Solomon Islands | NR | NR | 60% | NR | 16% | 80% |
| Tajikistan | 2015 | 96% | 98% | NR | NR | NR |
| Thailand | 2014 | 98.00% | 100.00% | 2014 | 98.00% | 100.00% |
| Timor-Leste | NR | NR | NR | NR | NR | NR |
| Tonga | 2014 | 80% | 85% | NR | NR | NA |
| Turkey | 2014 | 99.00% | 100.00% | 2014 | 100.00% | 100.00% |
| United States of America | NR | NR | 99.00% | 2014 | NR | 100.00% |
| Viet Nam | NR | NR | 90.00% | 2014 | 14.00% | 80.00% |
| **Total responses** | **24** | **27** | **3 029** | **25** | **25** | **25** |

Note: NR: No response; NTS: No target set; TA: Target achieved

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Target 2A | | Target 2B | |
| Countries | Baseline | Target | Baseline | Target |
| Armenia | 99.00% | 100.00% | 100.00% | 100.00% |
| Australia | NR | NR | NR | NR |
| Azerbaijan | 99.50% | 100.00% | 99.90% | 100.00% |
| Bangladesh | 100.00% | 100.00% | 100.00% | 80.00% |
| Bhutan | NR | NR100% | NR | NR100% |
| Cambodia | 2.70% | 90.00% | 0.20% | 90.00% |
| Cook Islands | 100% | 100% | 100% | 100% |
| Fiji | 100% | 100% | 100% | 100% |
| Hong Kong, China | 100.00% | NTS | 100.00% | NTS |
| India | 60.00% | 100.00% | NR | 100.00% |
| Iran (Islamic Republic of) | 100.00% | 100.00% | 100.00% | 100.00% |
| Japan | 100.00% | NR | 100.00% | NR |
| Kazakhstan | 99.30% | TA | 100.00% | TA |
| Kiribati | 100.00% | 100.00% | 100.00% | 100.00% |
| Kyrgyzstan | 97.70% | NR | 97% | NR |
| Lao People’s Democratic Republic | 100% | 100% | 100% | NR |
| Macao, China | 100.00% | 100.00% | 100.00% | 100.00% |
| Maldives | 68.00% | 100.00% | 100.00% | 100.00% |
| Micronesia (Federated States of) | 90% | NTS | 98% | NTS |
| Mongolia | 97.20% | 99.90% | 99.70% | 99.90% |
| Myanmar | 74.00% | 95.00% | 50.00% | 75.00% |
| Nepal | 100.00% | 100.00% | 100.00% | 100.00% |
| New Zealand | 90.00% | 85.00% | 99.00% | 99.00% |
| Pakistan | NR | 100.00% | NR | 100.00% |
| Philippines | 100.00% | 100.00% | 100.00% | 100.00% |
| Republic of Korea | 99.90% | 100.00% | 99.10% | 100.00% |
| Samoa | 30.00% | 85% | NR | 70% |
| Solomon Islands | 49.00% | 70% | NR | 50% |
| Tajikistan | 89.00% | 98% | 97% | 97% |
| Thailand | 98.00% | 100.00% | 98.00% | 100.00% |
| Timor-Leste | NR | NR | NR | NR |
| Tonga | NR | 95% | NR | 80% |
| Turkey | NR | 100.00% | 100.00% | 100.00% |
| United States of America | NR | NR | NR | NR |
| Viet Nam | 100.00% | 100.00% | 100.00% | 100.00% |
| **Total responses** | **28** | **25** | **26** | **26** |

Note: NR: No response; NTS: No target set; TA: Target achieved

|  |  |  |
| --- | --- | --- |
| Countries | Target 3A | Target 3B |
| Armenia | 2024 | 2024 |
| Australia | TA | TA |
| Azerbaijan | NR | NR |
| Bangladesh | 2021 | 2021 |
| Bhutan | 2020 | 2022 |
| Cambodia | 2024 | 2024 |
| Cook Islands | TA | TA |
| Fiji | TA | 2016 |
| Hong Kong, China | TA | TA |
| India | 2020 | 2020 |
| Iran (Islamic Republic of) | TA | 2020 |
| Japan | TA | TA |
| Kazakhstan | TA | TA |
| Kiribati | 2020 | 2024 |
| Kyrgyzstan | NR | NR |
| Lao People’s Democratic Republic | 2018 | 2018 |
| Macao, China | TA | TA |
| Maldives | TA | TA |
| Micronesia (Federated States of) | 2016 | 2016 |
| Mongolia | TA | TA |
| Myanmar | NR |  |
| Nepal | 2024 | 2024 |
| New Zealand | TA | TA |
| Pakistan | 2024 | 2024 |
| Philippines | 2024 | 2024 |
| Republic of Korea | TA | TA |
| Samoa | NR |  |
| Solomon Islands | 2017 | 2018 |
| Tajikistan | NR | 2020 |
| Thailand | TA | TA |
| Timor-Leste | NR | NR |
| Tonga | 2017 | 2017 |
| Turkey | TA | TA |
| United States of America | TA | TA |
| Viet Nam | 2022 |  |
| **Total responses** | **28** | **28** |

Note: NR: No response; NTS: No target set; TA: Target achieved

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Target 3C | | | Target 3D | | |
| Countries | Year | Baseline | Target | Year | Baseline | Target |
| Armenia | 2014 | 98.60% | 99.00% | 2014 | 4.00% | 2.00% |
| Australia | 2014 | 100.00% | TA | 2013 (preliminary data) | 0.99% | NTS |
|  |  |  |  | 2011 (final data) | 0.70% |  |
| Azerbaijan | NR | NR | NR | 2015 | NR | NR |
| Bangladesh | 2014 | 39.00% | 100.00% | NR | NR | NR |
| Bhutan | 2011 | 11% | 85% | NR | NR | NR |
| Cambodia | NR | NR | 30.00% | NR | NR | NR |
| Cook Islands | 2014 | 78% | 100% | 2014 | 2.30% | 1% |
| Fiji | 2014 | 100% | 100% | 2014 | 3% | <1% |
| Hong Kong, China | 2014 | 100.00% | TA | 2014 | 3.70% | <5.0% |
| India | 2013 | 11.60% | 60.00% | 2013 | 13.30% | 7.00% |
| Iran (Islamic Republic of) | 2014-2015 | 75.00% | 85.00% | 2014 | 15.00% | <10% |
| Japan | NR | NR | TA | 2014 | 1.00% | NR |
| Kazakhstan | 2014 | 19.40% | TA | 2014 | 6.80% | 2%-3% |
| Kiribati | 2014 | 16.00% | 80.00% | 2014 | 31.50% | 19.20% |
| Kyrgyzstan | NR | NR | NR | 2014 | 2.00% | NR |
| Lao People’s Democratic Republic | NR | NR | 75% | NR | NR | NR |
| Macao, China | 2014 | 100.00% | 100.00% | 2014 | 3.10% | 1.50% |
| Maldives | 2014 | 85.90% | 100.00% | 2012 | 10.00% | 4.00% |
| Micronesia (Federated States of) | 2014 | 100% | 100% | 2014 | 10% | NR |
| Mongolia | 2015 | 100.00% | 100.00% | 2015 | 0.70% | NR |
| Myanmar | NR | NR | NR | NR | NR | NR |
| Nepal | 2013/14 | 45.40% | NR | 2015 | 100.00% | 50.00% |
| New Zealand | 2014 | 99.00% | 99.00% | 2014 | 0.80% | 1.00% |
| Pakistan | NR | NR | 80.00% | 2014 |  |  |
| Philippines | 2010 | 34.20% | 100.00% | 2010 | 2.50% | 1.25% |
| Republic of Korea | 2014 | 99.10% | 100.00% | 2014 | 8.90% | 7.00% |
| Samoa | NR | NR | 70% | NR | NR | NR |
| Solomon Islands | NR | 78% | 90% | 2014 | 4% |  |
| Tajikistan | NR | NR | 98% | 2014 | 2% | NR |
| Thailand | 2014 | 97.00% | 100.00% | 2014 | 97.00% | 100.00% |
| Timor-Leste | NR | NR | NR | NR | NR | NR |
| Tonga | 2014 | 50% | 95% | 2014 | 100% | 5% |
| Turkey | NR | 100.00% | 100.00% | 2014 | 1.20% | 0.60% |
| United States of America | 2014 | >99% | 99.00% | 2014 | 0.40% | 0.40% |
| Viet Nam | NR | NR | 80.00% | NR | NR |  |
| **Total responses** | **22** | **24** | **29** | **27** | **25** | **19** |

Note: NR: No response; NTS: No target set; TA: Target achieved

|  |  |  |  |
| --- | --- | --- | --- |
| Countries | Target 3E | | |
| Year | Baseline | Target |
| Armenia | NR | NR | Verbal autopsy is not practiced |
| Australia | 2014 | NR | n/a |
| Azerbaijan | NR | NR | Deaths outside medical facilities are registered following a judicial procedure. |
| Bangladesh | NR | NR | 50.00% |
| Bhutan | NR | NR | 70% |
| Cambodia | NR | NR | 10.00% |
| Cook Islands | NR | NR | Not Applicable. All deaths are to be identified and confirmed by a medical officer. |
| Fiji | NR | NR | Not applicable to Fiji |
| Hong Kong, China | 2014 | NR | Not applicable. All deaths are required to be attended by medical practitioner. |
| India | NR | NR | NR |
| Iran (Islamic Republic of) | 2014-2015 | 3.00% | 50.00% |
| Japan | NR | NR | NR |
| Kazakhstan | 2014 | NR | Verbal autopsy is not practiced |
| Kiribati | 2014 | NR | 80.00% |
| Kyrgyzstan | NR | NR | NR |
| Lao People’s Democratic Republic | NR | NR | 60% |
| Macao, China | NR | NR | TA |
| Maldives | 2014 | 14.00% | NR |
| Micronesia (Federated States of) |  |  | NTS yet |
| Mongolia | NR | NR | 70.00% |
| Myanmar | NR | NR | NR |
| Nepal | NR | NR | NR |
| New Zealand | NR | NR | Not applicable |
| Pakistan | NR | NR | 80.00% |
| Philippines | NR | NR | 85.00% |
| Republic of Korea | NR | NR | NR |
| Samoa | NR | NR | NR |
| Solomon Islands | NR | NR | 20% |
| Tajikistan | NR | NR | NR |
| Thailand | 2014 | 96.00% | 100.00% |
| Timor-Leste | NR | NR | NR |
| Tonga | NR | NR | 95% |
| Turkey | NR | NR | NR |
| United States of America | NR | NR | Not applicable |
| Viet Nam | NR | NR | 50.00% |
| **Total responses** | **10** | **3** | **14** |

Note: NR: No response; NTS: No target set; TA: Target achieved

|  |  |  |  |
| --- | --- | --- | --- |
| Countries | Target 3F | Target 3G | Target 3H |
| Armenia | TA | TA | TA |
| Australia | TA | TA | TA |
| Azerbaijan | NR | NR | NR |
| Bangladesh | 2021 | 2021 | 2021 |
| Bhutan | 2022 | 2022 | 2024 |
| Cambodia | 2024 | 2024 | 2024 |
| Cook Islands | TA | TA | TA |
| Fiji | 2016 | 2017 | 2018 |
| Hong Kong, China | TA | TA | TA |
| India | 2017 | 2018 | 2018 |
| Iran (Islamic Republic of) | TA | 2020 | TA |
| Japan | TA | NR | TA |
| Kazakhstan | TA | TA | 2016 |
| Kiribati | 2024 | 2021 | 2020 |
| Kyrgyzstan | NR | NR | NR |
| Lao People’s Democratic Republic | 2018 | 2018 | 2020 |
| Macao, China | 2024 | TA | TA |
| Maldives | TA | TA | NR |
| Micronesia (Federated States of) | 2017 | 2017 | 2024 |
| Mongolia | TA | TA | TA |
| Myanmar | NR | NR | NR |
| Nepal | NR | NR | 2024 |
| New Zealand | TA | TA | TA |
| Pakistan | 2024 | 2024 | 2024 |
| Philippines | 2018 | 2017 | 2019 |
| Republic of Korea | NR | NR | NR |
| Samoa | NR | 2019 | NR |
| Solomon Islands | 2025 | NR | 2025 |
| Tajikistan | 2018 | 2018 | 2018 |
| Thailand | TA | TA | TA |
| Timor-Leste | NR | NR | NR |
| Tonga | 2017 | 2017 | 2017 |
| Turkey | TA | TA | TA |
| United States of America | TA | TA | TA |
| Viet Nam | 2022 | 2024 | 2024 |
| **Total responses** | **28** | **28** | **28** |

Note: NR: No response; NTS: No target set; TA: Target achieved

## Definitions[[52]](#footnote-53)

**Administrative data:** refers to information collected primarily for administrative purposes. This type of data is collected by government departments and other organisations for the purposes of registration, transaction and record keeping, usually during the delivery of a service.

**Administrative data collection:** Administrative data collection is the set of activities involved in the collection, processing, storage and dissemination of statistical data from one or more administrative sources. The equivalent of a survey but with the source of data being administrative records rather than direct contact with respondents.[[53]](#footnote-54)

**Adoption:** Legal and voluntary taking and treating of the child of other parents as one's own in so far as provided by the laws of the country. By means of a judicial process, whether related or not to the adopter, the adopted child acquires the rights and status of a biological child born to the adopting parents.[[54]](#footnote-55)

**Age:** Interval of time between birth and the present time, expressed in completed units of solar time. For adults and children, age is usually measured in completed years, while for infants or very young children, in completed months, weeks, days, hours or minutes of life, as appropriate.[[55]](#footnote-56)

**Annulment**: the invalidation or voiding of a legal marriage by a competent authority, according to the laws of the country, thus conferring on the parties the status of never having been married to each other. [[56]](#footnote-57)

**Baseline:** The baseline is the set of projections used as a benchmark for the analysis of the impact of different economic and policy scenarios.[[57]](#footnote-58)

**Basic human rights:** within the scope of human rights, some human rights are claimed to be inalienable. Thus, Art. 4(1), International Covenant on Civil and Political Rights, 1966, permits derogation of human rights “in times of public emergency threatening the life of the nation” but prohibits any derogation from Arts. 6 (right to life), 7 (torture), 8(1) and (2) (slavery and servitude), 11 (imprisonment for breach of contractual obligation), 15 (retroactive criminal liability), 16 (recognition as a person in law) and 18 (freedom of thought, conscience and religion). This notwithstanding, the trend is to regard all human rights as universal, indivisible, interdependent, and interrelated, to be treated in fair and equal manner, on the same footing and with the same emphasis. [[58]](#footnote-59)

**Births (live births):** the result of the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live born (all live-born infants should be registered and counted as such, irrespective of gestational age or whether alive or dead at the time of registration, and if they die following birth, they should also be registered and counted as deaths).[[59]](#footnote-60)

**Birth certificate**: An original document or certified extract, usually issued by a government authority, stating when and where a person was born and usually identifying one or both of his or her parents as per the legal requirements of each country. [[60]](#footnote-61)

**Birth records**: compiled records of the births that have occurred and are registered. [[61]](#footnote-62)

**Birth registration**: The continuous, permanent, and universal recording, within the civil register, of the occurrence and characteristics of births in accordance with the legal requirements of a country. The recording can be physical (in a book) or electronic.[[62]](#footnote-63)

**Capacity building**: Building the capacity of governments, private sector, and civil society by strengthening their human capacity (knowledge, skills, and aptitudes), their processes, and technologies. In all cases, capacity building aims to improve a country’s management capacity.[[63]](#footnote-64)

**Cause of death:** To provide a comprehensive and comparable tool for identifying causes of death and diseases in general, WHO developed the *International Statistical Classification of Diseases and Related Health Problems* (ICD), currently in its tenth revision.[[64]](#footnote-65) All diseases, morbid conditions or injuries that either resulted in or contributed to death, and the circumstances of the accident or violence that produced any such injuries. Symptoms or modes of dying, such as heart failure or asthenia, are not considered to be causes of death for vital statistics purposes.[[65]](#footnote-66)

**Cause of death code:** the *International Statistical Classification of Diseases and Related Health Problems* (ICD) permits the systematic recording analysis, interpretation and comparison of mortality and morbidity data collected in different countries or areas and at different times. The ICD is used to translate diagnoses of diseases and other health problems from words into an alphanumeric code, which permits easy storage, retrieval and analysis of the data.[[66]](#footnote-67)

**Census**: The total process of collecting, compiling, evaluating, analysing, and publishing or otherwise disseminating statistical data pertaining, at a specified time, to all living quarters and occupants thereof in a country or in a well-delimited part of a country.[[67]](#footnote-68)

**Certificate**: public or private document which attests to the occurrence of an event.[[68]](#footnote-69)

**Certification**: The act by which a person or institution attests that something occurred. A document, in paper or electronic format, issued by the registrar and containing all or a part of the exact information contained in the original vital record, and which, when issued by the registrar, has the full force and effect of the original vital record.[[69]](#footnote-70)

**Child**: A person below the age of 18, unless the laws of a particular country set a different legal age for adulthood.[[70]](#footnote-71)

**Citizen**: A person who by birth or naturalization is a member of a sovereign state or jurisdiction and is entitled to enjoy all of its civil rights and protections.[[71]](#footnote-72)

**Citizenship**: The legal nationality of a person. Rights, responsibilities, and duties of citizens. The most common distinguishing feature of citizenship is that citizens have the right to participate in the political life of the state, such as by voting or standing for election.[[72]](#footnote-73)

**Civil and political rights**: the rights contained in the International Covenant on Civil and Political Rights, 1966. These include self- determination; free disposition of natural wealth and resources; non-discrimination; equal rights of men and women; the right to life; freedom from torture, cruel, inhuman, or degrading treatment or punishment; freedom from slavery and servitude; freedom from arbitrary arrest or detention; freedom of movement within a state; the right to liberty and security of person; equality before the courts; the right to a fair and public hearing by an impartial tribunal with respect to criminal charges; the right of recognition as a person before the law; freedom of thought, conscience, and religion; freedom of expression; the right to peaceful assembly; and freedom of association and of participation in public affairs.[[73]](#footnote-74)

**Civil register**: The repository of loose-leaf file, ledger book, electronic file, or any other official file set up for the universal, continuous, and permanent recording, in accordance with established procedures, of each type of vital event and its associated data of the population of a defined area (e.g., county, district, municipality, or parish).[[74]](#footnote-75)

**Civil registrar:** official in charge of civil registration of vital events in a defined area (country, district, municipality, parish, etc.) and responsible for recording and timely reporting of information on those vital events for legal and statistical purposes. [[75]](#footnote-76)

**Civil registration:** The continuous, permanent, compulsory and universal recording of the occurrence and characteristics of vital events pertaining to the population as provided through decree or regulation in accordance with the legal requirements in each country. It establishes and provides legal documentation of such events. These records are also the best source of vital statistics.**[[76]](#footnote-77)**

**Civil registration system**: the institutional, legal, and technical norms established by government to conduct civil registration in a technical, sound, coordinated, and standardized manner throughout the country, taking into account cultural and social circumstances particular to the country.[[77]](#footnote-78)

**Civil right**: the civil status of individuals, their rights and obligations, and the acquisition, use, and enjoyment of property and public or private goods. [[78]](#footnote-79)

**Civil society**: The whole body or community of citizens.

**Civil status**: the legal situation of a person before the state, society, and family.[[79]](#footnote-80)

**Confidentiality**: maintaining restrictions on access to and disclosure of information, except for authorized users. [[80]](#footnote-81)

**Coroner**: Officer of a county, district, municipality, parish etc., authorized by law to hold an inquest regarding deaths of persons who may have died by violence, injury or suspicious circumstances to determine if the death was due to non-natural causes, such as accident, suicide or homicide. [[81]](#footnote-82)

**Crude birth rate:** A vital statistics summary rate based on the number of live births occurring in a population during a given period of time, usually a calendar year, i.e., the number of live births occurring among the population of a given geographical area during a given year, per 1,000 mid-year total population of the given geographical area during the same year. [[82]](#footnote-83)

**Crude death rate**: A vital statistics summary rate based on the number of deaths occurring in a population during a given period of time, usually a calendar year, i.e., the number of deaths occurring among the population of a given geographical area during a given year per 1,000 mid-year total population of the given geographical area during the same year. [[83]](#footnote-84)

**Database:** An organized collection of data. In biometric systems, data can include sensor readings, templates, match results, and related end user information. **[[84]](#footnote-85)**

**Date of occurrence:** The exact date when the event occurred, and should be expressed in terms of day, month and year as well as hour and minute, if appropriate (for live births, foetal deaths and deaths). [[85]](#footnote-86)

**Deaths:** Death is the permanent disappearance of all evidence of life at any time after live birth has taken place (post-natal cessation of vital functions without capability of resuscitation). This definition excludes foetal deaths. [[86]](#footnote-87)

**Death certificate**: a document of proof produced by the civil register to certify the death of a person, including the cause(s) of death. [[87]](#footnote-88)

**Death records**: a compilation of all deaths recorded in a given year. [[88]](#footnote-89)

**Death registration:** the official recording of the death of a person through a public administrative process.[[89]](#footnote-90)

**Delayed registration**: The registration of a vital event after the prescribed period denoted in existing laws, rules or regulations (including any grace period, if one is specified). A late registration is the registration of a vital event after the prescribed time period but within a specified grace period. Since the grace period is usually considered to be one year following the vital event, delayed registration is usually considered the registration of a vital event one year or more after the vital event has occurred. [[90]](#footnote-91)

**Digital credentials**: Digital documents used to prove qualification, competence, or clearance attached to a person. May contain personal information such as the person’s name, birthplace, birthdate, and/or biometric information, such as a picture or a fingerprint. [[91]](#footnote-92)

**Discrimination**: Treating a group or individual unfairly or prejudicially based on sex, racial origin, ethnicity, religion, convictions, incapacity, age, sexual orientation, or some other quality. Denying a person or group of people social participation or human rights.[[92]](#footnote-93)

**Disaggregation:** Disaggregation is the breakdown of observations, usually within a common branch of a hierarchy, to a more detailed level to that at which detailed observations are taken.[[93]](#footnote-94)

**Divorce**: The final legal dissolution of a marriage, that is, that separation of spouses which confers on the parties the right to remarriage under civil, religious and/or other provisions, according to the laws of each country. In case a country recognizes registered partnerships, a legal dissolution of a registered partnership refers to the legal final dissolution of such a partnership, according to national laws, conferring the parties the right to re-enter into another partnership or marriage.[[94]](#footnote-95)

**Documentation**: used generically to refer to identity and identification documents.[[95]](#footnote-96)

**Electronic format:** Electronic media (CD‑ROMs or the Internet) for data dissemination. Disseminated data may be in the form of tabulations or in databases from which users can extract information or create their own tables. [[96]](#footnote-97)

**Ethnicity**: cultural values and practices that distinguish groups of people. There are two dimensions: social and cultural characteristics (language, religious faith, and residence) and a shared sense of identity, tradition, solidarity, or belonging. [[97]](#footnote-98)

**Family**: a group of two or more persons living together who are related by birth, marriage, or adoption. [[98]](#footnote-99)

**Gender:** Gender refers to the roles and responsibilities of men and women that are created in our families, our societies and our cultures. The concept of gender also includes the expectations held about the characteristics, aptitudes and likely behaviours of both women and men (femininity and masculinity). Gender roles and expectations are learned. They can change over time and they vary within and between cultures. Systems of social differentiation such as political status, class, ethnicity, physical and mental disability, age and more, modify gender roles. The concept of gender is vital because, applied to social analysis, it reveals how women’s subordination (or men’s domination) is socially constructed. As such, the subordination can be changed or ended. It is not biologically predetermined nor is it fixed forever.[[99]](#footnote-100)

**Grace period**: an extension of the time allowed for complying with a requirement after the legally prescribed period has passed. [[100]](#footnote-101)

**Health facility:** Any establishment that is engaged in direct patient care on site.

**Household**: A family, group of friends, or other grouping of people who live in the same dwelling, normally defined as having a common kitchen, and share meals and living accommodations.[[101]](#footnote-102)

**Human rights**: Liberties and benefits that, by accepted contemporary values and international public law, all human beings should be able to claim “as of right” in the society in which they live. These rights are contained in the International Bill of Rights, comprising the Universal Declaration of Human Rights, 1948, and the International Covenants on Economic, Social and Cultural Rights, and on Civil and Political Rights, 1966, and have been included in other treaties (e.g., Convention on the Rights of Persons with Disabilities, 2006; Convention on the Rights of the Child, 1989; Convention on the Elimination of All Forms of Discrimination against Women, 1979; and International Convention on the Elimination of All Forms of Racial Discrimination, 1965).[[102]](#footnote-103)

**Identification**: The determination of identity and recognition of who a person is; the action or process of determining what a thing is; or the recognition of a thing as being what it is.[[103]](#footnote-104)

**Identity**: A unique set of features and characteristics that individualize a person, including the name and other biographical data of the individual.[[104]](#footnote-105)

**Identity management:** A combination of systems, rules, and procedures that are defined between an individual and organizations regarding the entitlement, use, and protection of personal information in order to authenticate individual identities and provide authorization and privileges within or across systems and enterprise boundaries.[[105]](#footnote-106)

**Ill-defined cause of death codes:** The *International Statistical Classification of Diseases and Related Health Problems* (ICD), which provides a comprehensive and comparable tool for identifying causes of death and diseases in general, includes “ill-defined” causes for use when information is either too limited or not available to accurately classify the cause of death. [[106]](#footnote-107)

Ill-defined codes are a specific set of codes in the ICD that refer to symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified. As the ICD instruction manual states, a high proportion of these codes indicates the need to check the quality of coding and reallocate a more specific cause.[[107]](#footnote-108) The classification of “ill-defined” will depend on the code set adopted by the country, including the version of ICD being used and the level of detail being applied. [[108]](#footnote-109)

**Indicator:** An indicator provides evidence that a certain condition exists or certain results have or have not been achieved. Indicators enable decision-makers to assess progress towards the achievement of intended outputs, outcomes, goals, and objectives.[[109]](#footnote-110)

**Informant**: An individual whose legally designated responsibility is to report to the local registrar the occurrence of a vital event and to provide all the information and characteristics related to the event. On the basis of such a report, the local registrar may legally register the event.[[110]](#footnote-111)

**International form of the death certificate:** refers to the International Form of Medical Certificate of Cause of Death as defined in the United Nations Principles and Recommendations for Vital Statistics Systems, Revision 3 (2014). The medical certificate is an essential document that provides final and permanent confirmation of the fact of death, as well as the circumstances and underlying medical cause of death.[[111]](#footnote-112) This is not to be confused with a death certificate issued by the civil registration authority as proof of death.

**Issuance:** the creation of a legal document by the civil registrar that certifies a death. The certificate is a copy of the entry in the death register. [[112]](#footnote-113)

**Legitimation**: Formal vesting of a person with the same status and rights of a person born in wedlock, according to the laws of the country. [[113]](#footnote-114)

**Life** **expectancy**: the average number of additional years a person could expect to live if current mortality trends were to continue for the rest of that person’s life. [[114]](#footnote-115)

**Marriage**: The act, ceremony or process by which the legal relationship of spouses is constituted. The legality of the union may be established by civil, religious or other means as recognized by the laws of each country. Countries may wish to expand to cover civil unions if they are registered; in that case, registered partnership usually refers to a legal construct, registered with the public authorities according to the laws of each country, that leads to legal conjugal obligations between two persons. [[115]](#footnote-116)

**Marriage** **certificate**: The document that verifies the legal union of a couple, which necessarily and simultaneously affects both people. It is the only certificate on which the participants declare and sign personally. [[116]](#footnote-117)

**Maternal** death: A maternal death is the death of a woman while pregnant or within 42 days after the termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. [[117]](#footnote-118)

**Medical practitioner:** A person whose primary employment role is to diagnose physical and mental illnesses, disorders and injuries and prescribe medications and treatments that promote or restore good health.[[118]](#footnote-119)

**Medically certified:** Medical certification of the cause of death or foetal death is the responsibility of the attending physician, if there was one. In the case of medically unattended deaths or deaths believed to have been due to violence (accident, suicide, homicide), a medical-legal officer (coroner or medical examiner) is responsible for the certification under the laws of many countries. In any event, if the cause of death is determined by a medically qualified individual or a medical-legal officer, the diseases or injuries should be reported and recorded in the format and detail contained in the most current version of the International Form of Medical Certificate of Cause of Death.[[119]](#footnote-120)

**Micro data (statistical**): An observation data collected on an individual object - statistical unit.[[120]](#footnote-121)

**Midwife**: a person, with or without medical training, who helps women giving birth. [[121]](#footnote-122)

**Morbidity**: the incidence of disease in a population.[[122]](#footnote-123)

**Mortality**: The proportion of deaths to population in a given time or place.[[123]](#footnote-124)

**Name**: a word that distinguishes a person from others in his or her legal and social relationships. It can be composed of the first name and a surname. [[124]](#footnote-125)

**National**: A person who, either by birth or naturalization, is a member of a political community, owing allegiance to the community and being entitled to enjoy its civil and political rights and protections; a member of the state, entitled to its privileges; a person who holds nationality in a given state. The term can include both citizens and non-citizens. “Citizen” and “subject” are also used.[[125]](#footnote-126)

**Nationality**: Under traditional understanding of international law, the legal bond between an individual and a state. A national is a person over whom a state considers it has jurisdiction on the basis of nationality, including the right to bring claims against other states for their ill-treatment. Nationality also refers to membership in an ethnic, linguistic, or religious group. Within a state there may be various categories of nationality with differing names and associated rights.[[126]](#footnote-127)

**Network**: In computing, a connection between two or more computers for the purpose of sharing resources.[[127]](#footnote-128)

**Nuptiality**: the frequency, characteristics, and dissolution of marriages in a given period and geographical area.[[128]](#footnote-129)

**Other valid administrative data:** health services records and other administrative records, depending on the legal arrangements.[[129]](#footnote-130)

**Passport**: a government-issued document identifying a person as a national of the issuing state, which is evidence of the holder’s right to return to that state. In Western countries, passports have been used for foreign travel purposes, not as domestic identity documents. The passport is the internationally accepted certificate or proof of nationality. [[130]](#footnote-131)

**Perinatal mortality:** Perinatal mortality refers to the number of stillbirths and deaths in the first week of life (early neonatal mortality).[[131]](#footnote-132)

**Place of birth**: the municipality, province, department, state, and country in which a birth occurred. [[132]](#footnote-133)

**Population**: (a) A group of objects or organisms of the same species. (b) In biometrics, the set of potential end users for an application.[[133]](#footnote-134)

**Population census:** A population census is the total process of collecting, compiling, evaluating, analysing and publishing or otherwise disseminating demographic, economic and social data pertaining, at a specified time, to all persons in a country or in a well-delimited part of a country. [[134]](#footnote-135)

**Population** **projection**: An estimation of future changes in the number of people in a geographic area, subject to certain hypotheses regarding future trends in the fecundity, mortality, and migration rates. Demographers usually posit low, moderate, and high projections for the same populations, based on different hypotheses about the change of these rates in the future.[[135]](#footnote-136)

**Privacy**: Protection from interference in one’s private life, to which everyone is entitled.[[136]](#footnote-137)

**Proof** **of** **identity**: A document or process by which a credential service provider and a registration authority validate sufficient information to attest to the identity of a person.[[137]](#footnote-138)

**Proportion:** A proportion is a special type of ratio in which the denominator includes the numerator. An example is the proportion of deaths that occurred to males which would be deaths to males divided by deaths to males plus deaths to females (i.e. the total population).[[138]](#footnote-139)

**Record**: (a) An item in a list, in a paper register, in a digital spreadsheet, or in an electronic database. (b) A report of a vital event that has been registered by the registrar.[[139]](#footnote-140)

**Registration**: A process by which the authorities note, in a manner established by law, all facts, acts, and records whose occurrence must be recorded authentically in a specialized register.[[140]](#footnote-141)

**Registered (civil registration):** The continuous, permanent, compulsory and universal recording of the occurrence and characteristics of vital events pertaining to the population, as provided through decree or regulation in accordance with the legal requirements in each country. This process establishes and provides legal documentation for such events. The civil registration records are also the best source of vital statistics.[[141]](#footnote-142)

**Registration** **authority**: A trusted entity that establishes and vouches for the identity of a subscriber to a credential service provider (CSP). The registration authority may be an integral part of a CSP or it may be independent of a CSP.[[142]](#footnote-143)

**Registration records (civil registration):** The continuous, permanent, compulsory and universal recording of the occurrence and characteristics of vital events pertaining to the population, as provided through decree or regulation in accordance with the legal requirements in each country. This process establishes and provides legal documentation for such events. The civil registration records are also the best source of vital statistics.[[143]](#footnote-144)

**Regulations**: rules that mainly state the material legislative functions of public administration. [[144]](#footnote-145)

**Residence**: A place where one is physically present for a given period. This differs from domicile, which is the place one intends to make his or her permanent home. A person can have more than one residence but only one domicile.[[145]](#footnote-146)

**Rural area:** a populated area that does not encompass urban or semi-urban areas. [[146]](#footnote-147)

**Sample**: In demographics, a representative part of a population or large dataset that reflects the characteristics of the whole population or dataset.[[147]](#footnote-148)

**Sample survey:** a survey which is carried out using a sampling method, i.e. in which a portion only, and not the whole population is surveyed.[[148]](#footnote-149)

**Sex:** Sex describes the biological differences between men and women, which are universal and determined at birth.[[149]](#footnote-150)

**State**: The state as a person of international law should possess the following qualifications: a) a permanent population; b) a defined territory; c) government; and d) capacity to enter into relations with the other states. [[150]](#footnote-151)

**Survey**: a canvass of selected persons or households in a population, usually used to infer characteristics or trends for a larger segment or all of the population. [[151]](#footnote-152)

**Territory and jurisdiction:** a geographical area within which political or judicial authority may be exercised.[[152]](#footnote-153)

**Total population**: For census purposes, the total population of the country consists of all persons falling within the scope of the census. In the broadest sense, the total may comprise either all usual residents of the country or all persons present in the country at the time of the census.[[153]](#footnote-154)

**Treaty**: an international agreement concluded between states in written form and governed by international law, whether embodied in a single instrument or in two or more related instruments and whatever its particular designation.[[154]](#footnote-155)

**Underlying cause of death:** The disease or injury that initiated the train of morbid events leading directly to death or the circumstances of the accident or violence which produced the fatal injury. The underlying cause of death is used as the basis for tabulation of mortality statistics. [[155]](#footnote-156)

**Verbal autopsy (VA):** is a method used to ascertain the cause of a death based on an interview with next of kin or other caregivers. This is done using a standardized questionnaire that elicits information on signs, symptoms, medical history and circumstances preceding death. The cause of death, or the sequence of causes that led to death, are assigned based on the data collected by a questionnaire and any other available information. Rules and guidelines, algorithms or computer programs, may assist in evaluating the information to determine the cause of death. The main objective of VA is to describe the causes of death at the community level or population level where civil registration and death certification systems are weak and where most people die at home without having had contact with the health system. [[156]](#footnote-157) The World Health Organization (WHO) has developed international standards for conducting verbal autopsies, including recommended methods and questionnaires. The standards and further information are available from the WHO website at [www.who.int/healthinfo/statistics/verbalautopsystandards/en/](http://www.who.int/healthinfo/statistics/verbalautopsystandards/en/). [[157]](#footnote-158)

**Vital event**: The occurrence of a live birth, death, foetal death, marriage, divorce, adoption, legitimation, recognition of parenthood, annulment of marriage or legal separation. [[158]](#footnote-159)

**Vital statistics report:** reports on important events in people’s lives such as births, marriages, divorces, adoptions, deaths, and causes of death. It provides information for the whole country and geographic regions as well as relevant characteristics. Ideally, it should contain at least two years data.

**Vital statistics system**: The total process of (a) collecting information by civil registration or enumeration on the frequency of specified and defined vital events, as well as the relevant characteristics of the events themselves and of the person(s) concerned, and (b) compiling, processing, analysing, evaluating, presenting, and disseminating these data in statistical form.[[159]](#footnote-160)

1. ESCAP 2014 Report of the Ministerial Conference on Civil Registration and Vital Statistics in Asia and the Pacific. [↑](#footnote-ref-2)
2. UNICEF, UNDP, UNFPA, UNHCR, WHO, the Asian Development Bank and Plan International, in collaboration with the Partnership for Maternal, Newborn and Child Health, the World Bank Group, the Partnership for Statistics Development in the 21st Century (PARIS21), the Secretariat of the Pacific Community, World Vision International and the Asia Pacific Observatory on Health Systems and Policies. [↑](#footnote-ref-3)
3. The Regional Steering Group was convened in 2013 (ESCAP resolution 69/26) at the request of member States, consisting of 25 representatives from member States and development partners. [↑](#footnote-ref-4)
4. The Regional Action Framework on Civil Registration and Vital Statistics in Asia and the Pacific is available at: <https://www.unescap.org/sites/default/files/Regional.Action.Framework.English.final_.pdf> [↑](#footnote-ref-5)
5. The baseline report is available at: <https://www.unescap.org/sites/default/files/E72_22E.pdf> [↑](#footnote-ref-6)
6. Draft decision # 36, available at: <https://www.unescap.org/sites/default/files/E72_CRP2E.pdf> [↑](#footnote-ref-7)
7. Technically, this is not necessary: some countries reported to ESCAP without having appointed a national focal point, and others did not report despite having appointed a national focal point. However, facilitates the reporting and makes the process more resilient to institutional changes of specific people. [↑](#footnote-ref-8)
8. if not available, they can submit identification of how to obtain the relevant data. [↑](#footnote-ref-9)
9. This may be the same as in the baseline report, or a new / updated version. [↑](#footnote-ref-10)
10. where available; if not available, identification of how to obtain the relevant data. [↑](#footnote-ref-11)
11. This may be the same as in the baseline report, or a new / updated version. [↑](#footnote-ref-12)
12. However, several data are welcome if they relate to different phenomena, or to several aspects of the same phenomenon – provided all of them are clearly defined. [↑](#footnote-ref-13)
13. While the RAF welcomes progress in other areas such as marriages, divorces or adoptions, its core focus is births and deaths. [↑](#footnote-ref-14)
14. Due to variability in national settings, the data sources suggested for monitoring each target are intended as a guide and may not be exhaustive. Members and associate members should consider if other data sources are available that may better inform the setting and monitoring of targets. [↑](#footnote-ref-15)
15. Definitions are in Annex F. [↑](#footnote-ref-16)
16. World Health Organization (WHO). 2014. *Every newborn: an action plan to end preventable deaths*. Available online at <http://www.who.int/maternal_child_adolescent/topics/newborn/enap_consultation/en/>. [↑](#footnote-ref-17)
17. United Nations. 2014. *Principles and Recommendations for a Vital Statistics System, Revision 3* [↑](#footnote-ref-18)
18. UNICEF. 2013. *A Passport to Protection: A guide to birth registration programming.* [↑](#footnote-ref-19)
19. World Bank and WHO. 2014. *Global Civil Registration and Vital Statistics: Scaling up Investment Plan 2015-2030*. [↑](#footnote-ref-20)
20. United Nations General Assembly. 2015. Human Rights Council: Birth registration and the right of everyone to recognition everywhere as a person before the law, (A/HRC/28/L.23) [↑](#footnote-ref-21)
21. See [www.un.org/en/development/desa/population/](http://www.un.org/en/development/desa/population/) [↑](#footnote-ref-22)
22. UNICEF. *Every Child’s Birth Right: Inequities and Trends in Birth Registration* (New York, 2013). [↑](#footnote-ref-23)
23. UNICEF. 2013. *A Passport to Protection: A guide to birth registration programming.* [↑](#footnote-ref-24)
24. World Bank and WHO. 2014. *Global Civil Registration and Vital Statistics: Scaling up Investment Plan 2015-2030*. [↑](#footnote-ref-25)
25. UNICEF. 2013. *Every Child’s Birth Right: Inequities and trends in birth registration*. [↑](#footnote-ref-26)
26. There are various indirect demographic techniques for estimating the completeness of death registration; for example, the Bennett–Horiuchi, Chanrasekaran–Deming and Brass growth balance methods [↑](#footnote-ref-27)
27. World Bank and WHO. 2014. *Global Civil Registration and Vital Statistics: Scaling up Investment Plan 2015-2030*. [↑](#footnote-ref-28)
28. United Nations Statistics Division. 2012. *Coverage of civil registration system* (last updated August 2012). Available online at <http://unstats.un.org/unsd/demographic/CRVS/CR_coverage.htm>. [↑](#footnote-ref-29)
29. World Bank and WHO. 2014. *Global Civil Registration and Vital Statistics: Scaling up Investment Plan 2015-2030*. [↑](#footnote-ref-30)
30. Please see the Ministerial Declaration paragraph 15 for an outline of groups considered to be hard-to-reach or marginalized [↑](#footnote-ref-31)
31. The World Health Assembly is the forum through which the World Health Organization is governed by its 194 member states. It is the world's highest health policy setting body and is composed of health ministers from member states. [↑](#footnote-ref-32)
32. The most recent revision of ICD (ICD-10) was endorsed by the 43rd World Health Assembly in May 1990 and came into use in 1994. [↑](#footnote-ref-33)
33. WHO. 2013.*Strengthening civil registration and vital statistics for births, deaths and causes of death: Resource Kit.* [↑](#footnote-ref-34)
34. Pursuant to article 7 of the Convention on the Rights of the Child. [↑](#footnote-ref-35)
35. For more on the link between social protection, services and CRVS, see Lopez et al 2014 Civil Registration, human rights and social protection in Asia and the Pacific, Asia-Pacific Population Journal Vol 29, No 1, pg 75-99 [↑](#footnote-ref-36)
36. WHO. 2012. *Strengthening civil registration and vital statistics for births, deaths and causes of death: Resource Kit.* [↑](#footnote-ref-37)
37. United Nations. 2014. *Principles and Recommendations for a Vital Statistics System, Revision 3.* [↑](#footnote-ref-38)
38. Ibid. [↑](#footnote-ref-39)
39. United Nations. 2014. *Principles and Recommendations for a Vital Statistics System, Revision 3.* [↑](#footnote-ref-40)
40. WHO. 2010. *International Statistical Classification of Diseases and Related Health Problems, 10th Revision.* [↑](#footnote-ref-41)
41. See [www.who.int/healthinfo/anacod/en/](http://www.who.int/healthinfo/anacod/en/) [↑](#footnote-ref-42)
42. WHO et al. 2012. *Verbal autopsy standards: the 2012 WHO verbal autopsy instrument* (Release Candidate 1). [↑](#footnote-ref-43)
43. The manuals are available at http://www.cpc.unc.edu/measure/publications/index. [↑](#footnote-ref-44)
44. Available at [www.who.int/healthinfo/statistics/verbalautopsystandards/en/](http://www.who.int/healthinfo/statistics/verbalautopsystandards/en/) [↑](#footnote-ref-45)
45. Refer to United Nations (2014), *Principles and Recommendations for a Vital Statistics System, Revision 3,* for standard tabulations for vital statistics. [↑](#footnote-ref-46)
46. Refer to United Nations (2014) *Principles and Recommendations for a Vital Statistics System, Revision 3,* specifically paragraphs 241, 242, 250, 369, 592-594. [↑](#footnote-ref-47)
47. United Nations. 2014. *Principles and Recommendations for a Vital Statistics System, Revision 3.* [↑](#footnote-ref-48)
48. Given that Member States endorsed, at the sixty-seventh World Health Assembly, “Every Newborn: An Action Plan to End Preventable Deaths” (World Health Organization (Geneva, 2014), annex 1), which contains the strategic objective that “every newborn needs to be registered, and newborn and maternal deaths and stillbirths need to be counted”, members and associate members should aim to register every birth within 28 days of occurrence, and reflect this in their national target for target 1.A. [↑](#footnote-ref-49)
49. The classification of “ill-defined” will depend on the code set adopted by the country, including the version of ICD being used and the level of detail being applied. [↑](#footnote-ref-50)
50. Using a tool such as Improving the Quality and Use of Birth, Death and Cause-of-death Information: Guidance for a Standards-based Review of Country Practices (World Health Organization and the University of Queensland Health Information Systems Knowledge Hub, 2010). [↑](#footnote-ref-51)
51. The baseline report is available at: <https://www.unescap.org/sites/default/files/E72_22E.pdf> [↑](#footnote-ref-52)
52. While there are several sources for these definitions (indicated where appropriate), the main source is the Inter-American Development Bank’s *Dictionary for Civil Registration and Identification (2015).* [↑](#footnote-ref-53)
53. OECD. Administrative Data Collection. https://stats.oecd.org/glossary/detail.asp?ID=6 [↑](#footnote-ref-54)
54. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-55)
55. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-56)
56. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification.* [↑](#footnote-ref-57)
57. OECD. Administrative Data Collection. https://stats.oecd.org/glossary/detail.asp?ID=6 [↑](#footnote-ref-58)
58. Inter-American Development Bank (IDB). 2010. *Civil registration and identification glossary.* [↑](#footnote-ref-59)
59. United Nations. 2014. *Principles and Recommendations for a Vital Statistics System, Revision 3.* [↑](#footnote-ref-60)
60. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification.* [↑](#footnote-ref-61)
61. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification.* [↑](#footnote-ref-62)
62. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification.* [↑](#footnote-ref-63)
63. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification.* [↑](#footnote-ref-64)
64. United Nations. 2014. *Principles and Recommendations for a Vital Statistics System, Revision 3.* [↑](#footnote-ref-65)
65. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-66)
66. WHO. 2010. *International Statistical Classification of Diseases and Health Related Problems, 10th Revision, Volume 2: Instruction Manual.* [↑](#footnote-ref-67)
67. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification.* [↑](#footnote-ref-68)
68. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification.* [↑](#footnote-ref-69)
69. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification.* [↑](#footnote-ref-70)
70. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification* [↑](#footnote-ref-71)
71. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification* [↑](#footnote-ref-72)
72. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification* [↑](#footnote-ref-73)
73. Inter-American Development Bank (IDB). 2010. *Civil registration and identification glossary.* [↑](#footnote-ref-74)
74. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification* [↑](#footnote-ref-75)
75. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification* [↑](#footnote-ref-76)
76. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-77)
77. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-78)
78. Inter-American Development Bank (IDB). 2015*. Dictionary for Civil registration and identification* [↑](#footnote-ref-79)
79. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification* [↑](#footnote-ref-80)
80. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification* [↑](#footnote-ref-81)
81. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-82)
82. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-83)
83. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-84)
84. Inter-American Development Bank (IDB). 2015. Dictionary for Civil registration and identification [↑](#footnote-ref-85)
85. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-86)
86. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-87)
87. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil registration and identification* [↑](#footnote-ref-88)
88. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-89)
89. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-90)
90. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-91)
91. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-92)
92. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-93)
93. OECD. Source: <http://stats.oecd.org/glossary/detail.asp?ID=4337> [↑](#footnote-ref-94)
94. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-95)
95. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-96)
96. Inter-American Development Bank (IDB). 2010. *Civil registration and identification glossary.* [↑](#footnote-ref-97)
97. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-98)
98. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-99)
99. WHO. 2004. *A Glossary of Terms for Community Health Care and Services for Older Persons* [www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/BSP/GENDER/PDF/1.%20Baseline%20Definitions%20of%20key%20gender-related%20concepts.pdf](http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/BSP/GENDER/PDF/1.%20Baseline%20Definitions%20of%20key%20gender-related%20concepts.pdf) [↑](#footnote-ref-100)
100. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-101)
101. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-102)
102. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-103)
103. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-104)
104. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-105)
105. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-106)
106. Inter-American Development Bank (IDB). 2010. *Civil registration and identification glossary.* [↑](#footnote-ref-107)
107. WHO. 2010. *International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Volume 2: Instruction Manual.* [↑](#footnote-ref-108)
108. WHO. 2010. *International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Volume 2: Instruction Manual, Chapter 18.* [↑](#footnote-ref-109)
109. Harvard Family Research Project. <http://www.hfrp.org/publications-resources/browse-our-publications/indicators-definition-and-use-in-a-results-based-accountability-system> [↑](#footnote-ref-110)
110. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-111)
111. United Nations. 2014. *Principles and Recommendations for a Vital Statistics System, Revision 3.* [↑](#footnote-ref-112)
112. Inter-American Development Bank (IDB). 2010. *Civil registration and identification glossary.* [↑](#footnote-ref-113)
113. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-114)
114. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-115)
115. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-116)
116. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-117)
117. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-118)
118. Australian Institute of Health and Welfare ([www.aihw.gov.au/medical-practitioner-related-definitions/](http://www.aihw.gov.au/medical-practitioner-related-definitions/)). [↑](#footnote-ref-119)
119. United Nations. 2014. *Principles and Recommendations for a Vital Statistics System, Revision 3.* [↑](#footnote-ref-120)
120. OECD. http://stats.oecd.org/glossary/detail.asp?ID=1656 [↑](#footnote-ref-121)
121. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-122)
122. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-123)
123. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-124)
124. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-125)
125. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-126)
126. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-127)
127. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-128)
128. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-129)
129. United Nations. 2014. *Principles and Recommendations for a Vital Statistics System, Revision 3.* [↑](#footnote-ref-130)
130. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-131)
131. <http://www.who.int/maternal_child_adolescent/topics/maternal/maternal_perinatal/en/> [↑](#footnote-ref-132)
132. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-133)
133. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-134)
134. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-135)
135. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-136)
136. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-137)
137. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-138)
138. OECD. <https://stats.oecd.org/glossary/detail.asp?ID=6689> [↑](#footnote-ref-139)
139. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-140)
140. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-141)
141. United Nations. 2014. *Principles and Recommendations for a Vital Statistics System, Revision 3.* [↑](#footnote-ref-142)
142. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-143)
143. United Nations. 2014. *Principles and Recommendations for a Vital Statistics System, Revision 3.* [↑](#footnote-ref-144)
144. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-145)
145. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-146)
146. Inter-American Development Bank (IDB). 2010. *Civil registration and identification glossary.* [↑](#footnote-ref-147)
147. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-148)
148. OECD. <https://stats.oecd.org/glossary/detail.asp?ID=6689> [↑](#footnote-ref-149)
149. <http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/BSP/GENDER/PDF/1.%20Baseline%20Definitions%20of%20key%20gender-related%20concepts.pdf> [↑](#footnote-ref-150)
150. Art. 1, Montevideo Convention on the Rights and Duties of States, 1933. [↑](#footnote-ref-151)
151. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-152)
152. E: Black’s Law Dictionary, Seventh ed., 1999, p 855 as cited in UNTERM database record for ‘jurisdiction’. [↑](#footnote-ref-153)
153. OECD <https://stats.oecd.org/glossary/detail.asp?ID=2090> [↑](#footnote-ref-154)
154. Art. 2.1(a), Vienna Convention on the Law of Treaties, 1969). [↑](#footnote-ref-155)
155. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-156)
156. United Nations. 2014. *Principles and Recommendations for a Vital Statistics System, Revision 3.* [↑](#footnote-ref-157)
157. WHO et al. 2012. *Verbal autopsy standards: the 2012 WHO verbal autopsy instrument* (Release Candidate 1). [↑](#footnote-ref-158)
158. United Nations Statistics Division. UNSD Principles and Recommendations for a Vital Statistics System Revision. April, 2013*.* [↑](#footnote-ref-159)
159. Inter-American Development Bank (IDB). 2015. *Dictionary for Civil Registration and Identification.* [↑](#footnote-ref-160)