CIVIL REGISTRATION AND VITAL STATISTICS ASSESSMENT: PHILIPPINES

by

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I. Introduction

Civil Registration is defined as the continuous permanent, compulsory and universal recording of the occurrence and characteristics of vital events and other civil status pertaining to the population as provided by decree, law or regulation in accordance with the legal requirement of each country. (United Nations 2001)

Civil registration in the Philippines has gone through various developments from the time it was legally instituted as a system with the ratification of Act No. 3753 in 1930. Under Republic Act No. 7160 (Local Government Code of the Philippines), civil registration is a function of the local government through the City/Municipal Civil Registrar (C/MCR).

Vital events such as birth and death are the milestones of human lives, and the most common way of collecting information is through civil registration-an administrative system used by governments to record the occurrence of the events in the lives of their population.

In response to growing recognition of the important role of reliable and timely statistics births, deaths and causes of death in effective public-health decision making the WHO, and the University of Queensland (UQ) developed a Framework that provides countries with comprehensive guidance on evaluating how well their civil registration and vital statistics systems are able to generate useful vital statistics.

The UQ/WHO Framework allows countries to comprehensively review their civil and vital statistics systems. It has five main components and 16 subcomponents, and by following the indicated review process, it is possible to identify deficiencies in the functioning of the systems as well as in the quality of the vital statistics. The process secures involvement and support from key country stakeholders and leads to a prioritized list of recommendations that forms the basis for a strategic development plan. This paper reports findings from the detailed review of the civil and vital statistics systems which the Philippines carried out as part of the pilot exercise.

The following are the five main components of the UQ/WHO Framework:

Inputs

A. Legal basis and resources for civil registration

A1 National legal framework for vital statistics
A2 Registration infrastructure and resources

Processes

B. Registration practices, coverage and completeness

B1 Organization and functioning of the vital statistics system
B2 Review of forms used for birth and death registration  
B3 Coverage and completeness of registration  
B4 Data storage and transmission  

C. Death certification and cause of death  
C1 ICD- compliant practices for death certification  
C2 Hospital death certification  
C3 Deaths occurring outside hospital  
C4 Practices affecting the quality of cause-of-death data  

D. ICD mortality coding practices  
D1 Mortality coding practices  
D2 Mortality coder qualification and training  
D3 Quality of mortality coding  

Outputs  

E. Data access, use and quality checks  
E1 Data quality and plausibility checks  
E2 Data tabulation  
E3 Data access and dissemination  

II. The Civil Registration and Vital Statistics Assessment  

The general purpose of the Assessment Framework is to help countries to assess and improve the quality of their vital statistics, and the use that can be made of them. The assessment is therefore best carried out by people who are familiar with the working of different aspects of the civil and vital registration systems and the data derived from them.  

On March 27, 2009, the Department of Health (DOH) in collaboration with the WHO and the University of Queensland launched the Vital Registration Assessment Project (VRAP). This project aims to provide policy makers, program planners, academies, and administrators with comprehensive results of the civil registration status of the country in legal aspect, registration practices including coverage completeness in reporting vital events, development of civil registry forms, production of quality data, archiving, tabulation and dissemination to base their vital registration programs and plans.  

The following government agencies and institutions were represented:  

1. National Statistics Office (NSO)  
2. DOH  
3. National Statistical Coordination Board (NSCB)  
4. Association of Municipal Health Officers of the Philippines (AMHOP)  
5. Philippine Medical Association (PMA)  
6. Philippine Medical Records Association of the Philippines (PMRA)  
7. National Children's Hospital  
8. Philippine Association of Civil Registrars (PACR)
A. The Assessment Committee and Sub-groups

After the key stakeholders have been identified, an Assessment Committee was formed to provide direction, take decisions and develop an assessment plan.

Right after the launching of VRAP on March 27, 2009, a workshop on “Improving the Quality and Use of Birth, Death and Cause of Death Statistics Generated by the Civil Registration System” was held. An Assessment Committee (AC) was formed to undertake the various activities of the project. The NSO and DOH were identified as the lead agencies. NSO became the chair of the AC while DOH was the Vice-Chair. A large number of stakeholders had been identified and formed part of the AC and the five sub-groups:

1. Legal Framework for Vital Registration (VR), infrastructure and resources
2. Organization and Functioning, Coverage and Completeness of Registration
3. Forms and Data Quality
4. Data Storage, transmission and dissemination
5. ICD Compliant Practices

B. The Vital Registration Assessment Tool

The WHO provided two assessment tools to help countries evaluate how well their civil registration systems are able to generate useful vital statistics. These assessment tools are:

1. WHO Assessment Framework (as mentioned in the preceding paragraph); and
2. Rapid Assessment Test (RAT).

The Rapid Assessment Test or RAT is a process to determine the strength and weakness of civil registration system. RAT consists of 25 questions on the functioning of the civil registration system. Each question allows countries to select one of four scenarios describing the typical range of hypothetical situations. A numeric value is attached to each scenario allowing a total score to be obtained. The outcome will provide useful evidence on whether or not there is a need to go through the comprehensive exercises detailed in the Assessment Framework.

On April 14, 2009, in order to organize the assessment committee, various stakeholders became members of the Assessment Committee. The Committee agreed to forego the Rapid Assessment Test (RAT) and decided to go straight to the sub-group formation.

The AC conducted three focus group discussions (FGDs) on the five sub-groups. During the FGDs, the AC and the members of the sub-groups determined that some
questions in the WHO Assessment Framework are not answerable by yes or no. Hence, the AC and the sub-groups decided to revise some of the questions to make the questionnaires applicable in the Philippine setting. Some questions in a particular sub-group in the WHO Assessment Framework were transferred to the different sub-groups.

As a result of the FGDs, the WHO Assessment Framework was revised by the AC and sub-groups. A revised Vital Registration Assessment Tool with the following sub-groups and components was created:

A. **Legal Framework for Vital Registration (VR), infrastructure and resources**
   - A.1 National Legal Framework for Vital statistics
   - A.2 Registration Infrastructure and Resources

B. **Organization and Functioning, Coverage and Completeness of Registration**
   - B.1 Organization and Functioning of the Vital Statistics System
   - B.3 Coverage and Completeness of Registration

C. **Forms and Data Quality**
   - B.2 Review of Forms Used for Birth and Death Registration
   - E.1 Levels of Fertility and Mortality
   - E.1 Causes of Death

D. **Data Storage, transmission and dissemination**
   - B.4 Data Storage and Transmission
   - E.2 Data Tabulation
   - E.3 Data Access and Dissemination

E. **ICD Compliant Practices**
   - C.1 ICD Compliant Practices for Death Certification
   - C.2 Hospital Certification
   - C.3 Deaths occurring outside hospital
   - D.1 Coding Practices
   - D.2 Coder Qualification and Training
   - D.3 Quality of Coding

On May 14, 2009, the AC conducted the first pre-test of the VR Assessment Tool in Cavite. Respondents were 13 Municipal Health Officers, two nurses and one local civil registrar. They were subdivided into 3 groups to discuss the 5 sub-group topics.

To discuss the result of the first pre-test, the AC had a meeting on May 26, 2009. The AC observed that some of the questions in the VR Assessment Tool were not answered because the questions were very technical. Also, there was an imbalance of the respondents and therefore the result was not conclusive.
Another pre-test was conducted on June 3, 2009 and the respondents were from Region IV (excluding Cavite). There were 5 Medical Records Officers, 3 from Hospital Administrative Office, 2 Medical Health Officers, 2 representatives from Rural Health Units, 3 Local Civil Registrars, 1 Statistician and 3 from PHIC (total of 19 respondents).

On June 15-16, 2009, a workshop was conducted in Tagaytay City to discuss the outcome of the pretests done and formalized the recommendations of the sub-groups based on the results of their analysis. Each of the groups submitted report with their comments and recommendations. There were 42 participants attended the workshop. They were the key persons involved in Civil Registration coming from the National Statistics Office (NSO), Local Civil Registry Office, Department of Health (DOH), representatives from Association of the Municipal Health Officers of the Philippines (AMHOP), Philippine Medical Records Association (PMRA), and other stakeholders like University of the Philippines Population Institute (UPPI) and the Philippine Health Insurance Corporation (PHIC).

III. Findings

A. Legal Framework for Vital Registration, Infrastructure and Resources

A.1 National Legal Framework

Civil registration in the Philippines became compulsory with the passage of Act No. 3753 otherwise known as the Civil Registry Law on November 26, 1930. In connection with this, new laws were passed to strengthen the registration of births and deaths such as:

- Presidential Decree No. 651 (Requiring the Registration of Births and Deaths in the Philippines which occurred from January 1, 1974 and thereafter);
- Presidential Decree No. 766 (Amending Section 2 and 5 of PD 651);
- Commonwealth Act No. 591 (Civil Registrar General);
- Republic Act (RA) 7160 (Local Civil Registrars);
- RA 8371 (Indigenous Peoples);
- PD 1083 (Muslim Filipinos), Executive Order 209 (Family Code);
- Republic Act No. 9048 (Clerical Error Law);
- R.A. 9255 (Act allowing illegitimate children to use the surname of the father); and
- Presidential Decree 856 (Code of Sanitation in the Philippines).

Administrative Order (AO) No. 1 Series of 1993 defines the functions, duties and powers of the Civil Registrar General (CRG), the civil registrars, the role of the Barangay secretaries regarding civil registration and designation of assistant civil registrar and other signatories in the civil registry personnel. Technical control and supervision over the local civil registrars by the CRG is also stipulated in the said AO.

The NSO lobbied for the possible amendment of the Civil Registry Law (Act 3753) during the fourteenth Congress both in the House of Representatives and the
Senate. The proposed amendments aim to incorporate and update civil registration laws and policies with the integration of new developments on civil registration like the institutionalization of the Barangay Civil Registration System (BCRS), implementation of free birth registration for Child in Need of Special Protection (CNSP). It also sought the legitimation of children born of minor parents which will expressly amend certain portions of Art. 176 of the Family Code of the Philippines.

A.2 Registration Infrastructure and Resources

The Local Government Units (LGUs) allocate the budget for civil registration operations for their respective Local Civil Registrar Offices (LCROs). The budget varies per LGU depending on the internal revenue allotment provided by the government. The Local Chief Executives make appropriations out of their available general funds. Most LGUs collect fees for both registration and in issuance of certified copies of civil registry documents.

The LCRO is headed by a civil registrar. Under the organizational structure of the LGUs, the office is a department consisting of several divisions, the birth, marriage, death/Court decrees and legal instruments divisions, and such other divisions as necessary to carry out the objectives of the office. Each division is headed by a registration officer and supported by registration clerks.

The salary of the C/MCR and other civil registry personnel is dependent on the classification of the city or municipality which is based on the revenue allotment of the LGUs.

B. Coverage and Completeness

B.1 Organization and functioning of the vital statistics system

Civil registration is decentralized in the Philippines since a civil registry office is particularly assigned to each municipality/city. The civil registry offices register and forwards civil registry documents to the National Statistics Office-Provincial Office for machine processing.

The Local Civil Registrar Office (LCRO) is responsible for the actual registration of vital events at the Local Government Units. LCROs can also generate vital statistics for their own use.

Births, deaths and marriages of citizens of the Philippines occurring abroad, are reported to the Philippine Foreign Service Establishment. The Consul acts as civil registrar in the country of assignment. The reports of vital events are forwarded to the Department of Foreign Affairs and then to the NSO for consolidation and archiving and generation of vital statistics.

The National Statistics Office (NSO) is responsible for coordination with other government agencies and private institutions, which are directly or indirectly involved with civil registration.
The cases most likely to escape the civil registration system in the Philippines are home births and deaths of marginalized populations (Muslim Filipinos and Indigenous Peoples, Children in Need of Special Protection), death certified by the Mayor for burial purposes, dead on arrival (DOA cases) and unidentified dead bodies. These categories are missed by both the civil registration and the vital statistics system.

B.2 Review of forms used for birth and death registration

The review of the Certificate of Live Birth (COLB) and the Certificate of Death (COD) showed that both certificates do not contain definition of the main concepts used as there is no space available. Definitions, however, are provided in the Manual of Instructions in filling up civil registry forms.

The most common errors or omissions made by those who fill in the registration forms are:

a. For birth registration:
   • Mother’s maiden name and child’s middle name
   • Incomplete middle name
   • First name
   • Date and place of marriage (Legitimation status)
   • Sex

b. For death registration:
   • Incorrect entries for the cause of death
   • Incomplete certification of death
   • Interval between onset of disease and death

B.3 Coverage and completeness of registration

The completeness of the vital statistics from the civil registration system has been assessed in the past through different methods. A study by Carmelita N. Ericka and Marites C. Espinoza (2004) gives some insight into the levels of completeness of death and birth registration in the Philippines in the period from the 1960s to 2000. The 1964 Labor Force Survey carried a rider questionnaire inquiring about births and deaths having occurred in the sampled households between January and December 1963. The results indicated that birth registration was 60% complete and death registration 70%. By 1973, death registration had increased to 77% according to the results of a study using the dual record method and the Chandrasekhar-Deming formula. However, another study using a modified Brass method for determining the level of death registration found that it was less than two-third complete for 1970. A report dating from 1980 using the Preston and Coale method found that the completeness level for death registration was 77%. Finally, the 2000 census was used to estimate the number of births that occurred in the last 12 months and the deaths were estimated using the Preston and Coale method. The results were 65% completeness for deaths registration and 87% for birth registration.
B.4 Data Storage and Transmission

The data storage and filing system used for civil registration data in the Philippines do not pose any major constraints to the functioning of the vital statistics system. The storage media for the birth and death information at the LCROs are registry books, electronic files and microfilms. Filing is done by date of registration, by name, by hospital, and by numerical index.

Different strategies of backing up records are implemented with some LCROs backing-up records through scanning and microfilming. In smaller LGUs, only Registry Books and documents in folios are filed.

At the national level, the NSO backs up records through scanning and microfilming. The implementation of the Civil Registry System – Information Technology Project in 2001 has enabled the computerization of statistical processing and electronic archiving of the vital events documents. As of November 30, 2009, a total of approximately 128 millions of records were stored in the NSO Central Database. Also available are records stored in microfilms for the period of 1944-1998.

Documents and files are consolidated by the LCROs before submission to the NSO Provincial Office. For LGUs using CRIS, the documents are submitted together with the data files stored in a diskette. LGUs can generate preliminary vital statistics reports at the municipality level. The documents received from the LCROs are screened and batched by the provincial NSO.

There is a fixed schedule for transferring data from local registration sites to the central site. Documents are sent by LCRO to the provincial NSO within 10 days after the monthly reference period, and it in turn sends electronic files to the NSO 45 days after the reference period. This is followed up with documents which are forwarded to the NSO after 60 days. For 2005, only 1.6% of 426,054 total deaths were delayed.

The NSO conducts consistency checks on selected data items from birth and death certificates, including the data files forwarded by the LCROs (Local Civil Registrar Offices). Validation of codes is also done to ensure accuracy of the generated statistics. Once errors are observed, LCROs are contacted through email, phone and via fax through the provincial office of NSO.

C. Death certification and cause of death

C.1 ICD-compliant practices

In 1998, the Philippines adopted version 10 of the International Classification of Diseases (ICD). It also introduced the International form of Medical Certificate of cause of death, which is now used all over the country for reporting cause-of-death. In 2000, the Department of Health issued Administrative Order No. 47 series 2000 to all health facilities stressing that ICD-10 training is a vital requirement for the initial processing and renewal of License to Operate. Further, the Philippine Health Insurance issued PHILHEALTH Circular No. 4 series 2001 requiring all accredited institutional health care providers, regional managers, claim processing departments and all concerned to use the ICD-10 for claims and reimbursements.
Because many doctors were not aware of important ICD concepts used to certify deaths, i.e. the concept of the underlying cause of death, the DOH and the NSO developed a booklet explaining these concepts for doctors as well as how to properly fill out the form. However the booklet was not well disseminated, and doctors are not aware of its existence. As no evaluation has been carried out of the quality of medical certification, the evidence regarding the most effective remedies in improving the quality of certification is lacking.

C.2 Hospital certification

Rule 33 of NSO Administrative Order No. 1 series of 1993 (persons responsible to report the death), is very clear that the completion of the death certificate is the responsibility of the Physician who last attended the deceased or the Administrator of the hospital or clinic where the person died. The death certificate must then be forwarded, within 48 hours after death, to the health officer who after examination of the Certificate of Death affixes his/hers signature in the appropriate box and orders its registration in the Office of the Civil Registrar. The Medical Records are physically available in the ward to assist the Medical Officer on duty to complete the cause of death form. For dead on arrival (DOA), hospitals do not certify the cause of death; instead they will refer these to the City Health Officer or the Municipal Health Officer.

C.3. Deaths occurring outside hospital

All deaths need to be certified prior to burial as per Presidential Decree (PD) 856. For those who died at home, the Municipal Health Officer or the city Health Officer can prepare the death certificate and certify the cause of death after consultation with the nearest relatives. As they are not the attending physicians, they have to check box number 22 of the medical certificate that indicates that they have not attended the deceased.

In case of deaths occurring outside of hospitals, it shall be the responsibility of the nearest relative or person who has knowledge of the death to report it to the health officer within 48 hours. The health officer shall examine the deceased and shall certify as to the cause of death and direct the registration of the death certificate to the Office of the Civil Registrar within the period of 30 days.

C.4 Practices affecting the quality of cause of death data

In medical schools, training in certifying the cause of death is part of Community Medicine and Family Health and Legal Medicine curricula. However, doctors are not given any pre-employment or in-service training on death certification and are usually not aware of the important uses of the data.

Many doctors particularly from primary hospitals, Municipal Hospitals, and ambulatory and private clinics are unaware of how to report external causes of deaths according to ICD-10 rules and regulations. Consequently, it is likely that some non-natural deaths are missed.
D. Coding practices

D.1 Coding practices

The cause-of-death coding takes place in hospitals, clinics, rural health centres, city health offices, local civil registrar’s office, NSO, and other offices of the Department of Health. Coding is done from a copy of the original death certificate with the complete medical record of the deceased on hand in hospital setting. The policy implemented in the Philippines is multiple conditions coding. The procedure is to identify the underlying cause of death first, followed by the antecedent causes and the immediate cause, and then to code them all. The Complete Tabular list and the summary Tabulation List of the ICD are both used in the Philippines for the selection of the codes.

D.2 Coder qualification and training

In the Philippines, no specific qualifications are required to become mortality coder. However, some hospitals now only consider new medical record officers that have finished the ICD 10 training for coders with a Certificate of Completion. The Department of Health, through the National Epidemiology Center (NEC), the Bureau of Licensing and Regulations, the Bureau of Health Facilities (BHFS) and the Philippine Health Insurance Corporation (PHIC) are responsible for providing ICD 10 training for coders. Since 2001, training of ICD coders is part of the requirements for the issuance/reissuance of License to Operate.

The guidelines for all hospital categories, government and private, for ICD 10 adoption and implementation are as follows:

- Medical Records Officers (MROs)/clinical Coders of all hospitals shall be trained on ICD 10 by accredited trainers of the Department of Health. Duly authorized personnel of the DOH shall sign certificates of training.
- For proper coding, hospitals are required to acquire ICD 10 books (3 volumes). These books shall be used as a reference for coding criteria/guidelines and specific coding of a particular disease.
- The Government Regulatory Officers/Licensing Officers from the Bureau of Licensing and Regulations (BLR) – DOH, in addition to the routine checklist for inspection of medical records services, shall strictly verify/check coding outputs done by MROs/clinical Coders including the ICD 10 books during the period of inspection.
- Hospital statistics, summaries and reports like Ten Leading Causes of Discharges and Consultations, Morbidity and Mortality, etc. submitted to the BLR shall be coded in ICD 10.

In addition to the National Trainers from NEC, BHFS and PHIC, the Philippines has regional trainers based at the Center for Health Development (CHD) who underwent 2 weeks of ICD-10 Training for Trainers course. The Association of Philippine Medical Colleges is currently considering whether to include ICD-10 training in the medical curriculum.
D.3. Quality of coding

In accordance with Administrative Order No. 47 series 2000, all coders must have an Index of Terms used by doctors (Volume 3, ICD-10) as well as complete Tabular List with corresponding ICD codes (Volume 1, ICD 10). DOH has a website of its own for updates to codes and coding practices.

The work of the coders is annually verified as a part of the routine inspection of government Regulatory/Licensing Officers so as to strictly verify/check coding outputs.

E. Data access, use and quality checks

E.1. Data quality and plausibility checks

Some simple quality checks are carried out on the civil registration data before releasing them for use. Age-specific fertility and mortality rates are annually calculated and sometimes compared to the rates derived from other sources. The latest census data available is from the 2000 Census of Population and Housing. The census, however, did not include a question on deaths in households in the past 12-24 months.

The exercises suggested in the review showed that mortality rates and national cause-of-death patterns are stable over time. There is a predictable and close relationship between causes of death and life expectancy in the Philippine setting. The percentage distribution of all deaths among the suggested 3 broad cause-of-death groups (I-III) at different levels of life expectancy were roughly as expected and can be seen in the table below:

Group I – communicable, maternal, perinatal and nutritional conditions
Group II – non-communicable diseases
Group III – intentional and non-intentional injuries (including homicide and suicide)

<table>
<thead>
<tr>
<th>Life Expectancy</th>
<th>60 years</th>
<th>65 years</th>
<th>70 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>16.3%</td>
<td>12.9%</td>
<td>10.9%</td>
</tr>
<tr>
<td>II</td>
<td>70.1%</td>
<td>74.5%</td>
<td>77.9%</td>
</tr>
<tr>
<td>III</td>
<td>13.7%</td>
<td>12.6%</td>
<td>11.2%</td>
</tr>
</tbody>
</table>

The age pattern of causes of death as obtained from vital statistics data for the three disease groups and injuries in the Philippines (Figure 1) was compiled and checked against the expected patterns.
Proportion of all deaths allocated to ill-defined categories in the Philippines (2005) is 5.45% (3.6% for 65 years and over age group and 1.83% for below 65 years age group). There are CODs with ill-defined cause of death but no entry in the age of the deceased. This accounts for the 0.02% difference between the two age groups.

In the Philippines, the proportion of all deaths allocated to ill-defined categories including injuries of undetermined intent as defined in ICD-10 are fairly consistent (Table 1 and 2).

Table 1: Proportion of deaths allocated to ill-defined categories in the Philippines, 2001-2005

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Deaths</th>
<th>Deaths allocated to ill-defined categories</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>381,834</td>
<td>15,874</td>
<td>0.042</td>
</tr>
<tr>
<td>2002</td>
<td>396,297</td>
<td>19,013</td>
<td>0.048</td>
</tr>
<tr>
<td>2003</td>
<td>396,331</td>
<td>21,363</td>
<td>0.054</td>
</tr>
<tr>
<td>2004</td>
<td>403,191</td>
<td>21,268</td>
<td>0.053</td>
</tr>
<tr>
<td>2005</td>
<td>426,054</td>
<td>23,235</td>
<td>0.55</td>
</tr>
</tbody>
</table>
Table 2: Proportion of injuries of undetermined intent in the Philippines, 2001-2005

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Deaths</th>
<th>Deaths allocated to ill-defined categories</th>
<th>Proportion</th>
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</tr>
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</table>

* V00-Y89: Codes for external causes of morbidity and mortality
** Y10-Y34: Codes for event of undetermined intent

The proportion of cancer with ill-defined primary site is 2.77% for all deaths in 2005. For all deaths due to cancer, the proportion with ill-defined primary site is 28% (Table 3).

Table 3: Cancers with an ill-defined primary site in the Philippines, 2005

- **Total Deaths**: 426,054
- **Total Deaths due to cancer**: 41,697
- **Malignant Neoplasm of Other and Unspecified Sites**: 11,804

The proportion of deaths due to cardio vascular disease assigned to “heart failure” and other ill-defined heart categories cannot be determined.
IV. Recommendations

The recommendations made by five subgroups that carried out the comprehensive review, were discussed at a workshop attended by all key country stakeholders. These have been summarized as follows:

A. National Legal Framework for Vital Registration (VR), Infrastructure and Resources

1. Lobby for approval of pending proposed bills on civil registration
2. Compliance with the Local Government Code of 1991 on creation of civil registration office and permanent civil registrar
3. Increase budget on civil registration at the Local Government Unit (LGU) levels
4. Strengthening the Administrative Order and Rules for civil registration units at the LGU level, elevating the importance and appreciation of civil registration.

B. Coverage and Completeness of Registration

1. Information dissemination for marginalized sectors (Muslim population and ICCs/IPs, CNSP) and poor provinces
2. Impose free registration of timely registered documents
3. Study on level of registration by province
4. Study on level of registration by sector (depressed areas, marginal sectors, Muslims, CNSPs, IPs)
5. Establish vital registration protocols, guidelines, and procedures for each sector including private and public hospitals, municipal health officers, and other institutions.

C. Forms and Data Quality

2. Study of medical certification comparing review of hospital records with Vital Registration
3. Create methodology/study to check data quality and pertinent adjustment techniques for Philippines
4. Conduct pattern of cause-specific death statistics (diseases shall be identified by a technical working group).

D. Vital Registration Tool and Data Storage

1. Make representations to the Mayors of LGUs to clearly define functions of a Local Civil Registrar Office with regards to timeliness and completeness of submission of civil registry documents.
2. Timely publication of Vital Statistics Report
3. Intensive promotion of the electronic Civil Registration Information System (CRIS) to LGUs, hospitals and other related institutions.

4. Enhance DVSS2K to include statistics on specific place of occurrence (hospitals, health institutions, homes, etc.) expand age groups.

5. To motivate LGUs in cities (1st to 3rd class) to purchase computers using their own resources and 4th to 6th class municipalities to device resource mobilization scheme in order to hasten the data storage and transmission to NSO.

6. Continuous training to LGU staff (systems, archiving, etc.)

E. ICD 10 Compliant Practices

1. ICD 10 Training of Coders (include related topics e.g. Verbal Autopsy, filling up of Certificate of Death)

2. Inclusion of ICD-10 in the medical and paramedical curricula

3. Conduct evaluation of the quality of ICD 10 coding

4. A guidebook or quick reference guide on certification of cause of death should be made available for doctors in the hospitals

5. Devise a mechanism to keep medically and lay reported data separate to improve the quality of data statistics.

6. Conduct an evaluation of the quality of medical certification on death certificates

7. Conduct a nationwide launching of the new Certificate of Death

8. All MHOs and medical doctors should be ICD 10 compliant

9. Continuing conduct of ICD 10 Trainings for MHOs and Medical Records Officers

V. Lessons Learned

Undertaking the comprehensive assessment was a wakeup call for joint action to strengthen the vital statistics system. The major stakeholders of VR are NSO, LCRs, DOH and the local health workers. The assessment brought these players together and they had an opportunity to work together for a common objective.

Discussions of how to improve the mortality statistics have been one of the priority agenda of the Technical Working Group on Mortality organized by the National Statistical Coordination Board in the Philippines. Efforts have been exerted to improve the collection of data and generation of reports. The new Assessment Framework and roadmap was a great opportunity to evaluate the vital statistics generated from the current civil registration system.

The stakeholders at the Results meeting agreed to use the findings from the review and the agreed prioritized recommendations to develop a strategic plan. For example, new training courses on ICD-10 for medical doctors and mortality coders have been conducted and several vital statistics strengthening activities have been identified in 2010 budget of the Department of Health and the biennium of the WHO.
In conclusion, it can positively be stated that application of UQ/WHO Assessment Framework facilitated identification of much needed improvement to the civil and vital registration system in the Philippines. The assessment was instrumental in improving the knowledge of the stakeholders of how their systems worked and in identifying the weaker areas in the existing systems. The assessment framework led to the development of a large number of recommendations for improvement and the process ensured the involvement of all relevant stakeholders in the exercise and thereby created ownership of the findings.

VI. Benefits

Among benefits derived from the Assessment were the following:

1. Improved coordination mechanism of CRVS stakeholders
2. Conducted 2 batches of trainings for Local Civil Registrars, Medical Records Officers and NSO coders through the assistance of the WHO and DOH
3. Conducted information dissemination on CRVS
4. Possible tie-up with other agencies on research studies such as study on the level of registration, fertility and mortality estimation, etc.

VII. Next Steps

The CRVS stakeholders will conduct strategic planning workshop for possible implementation of the assessment tool at the sub-national level.