Component A

Subcomponent A1: National legal framework for civil registration and vital statistics systems

Supporting material to be prepared in advance:

- **Diagram that describes in detail the entire civil registration and vital statistics systems currently used in the country (see Figure 3.1 for an example).**
- **Inventory of all legal instruments (laws, rules and regulations) regarding civil registration and vital statistics, including relevant regulation concerning cemeteries, funeral parlours, sanitation (i.e. transportation and disposal of cadavers) and hospitals. Indicate the year each law or regulation was implemented. Briefly describe in lay terms the key elements of the law or regulation (this may be done by someone with legal experience from the registrar general's office).**

The subgroup will use this material when discussing the questions and issues below on the laws and regulations governing the civil registration and vital statistics systems.

Civil registration is the system with which a government records the vital events of its citizens. The primary purpose of civil registration is to create legal documents that are used to establish and protect the civil rights of individuals.
A secondary purpose is to create data for the compilation of vital statistics. The system that uses the records for deriving statistics on vital events and the relevant characteristics of the events is referred to as the vital statistics system.

A1.1 Does the country have a law defining a civil registration system?
Yes there is a law for kuwait for organizing the birth and death 36 for year 1996
A1.2 Does the country have a law defining a vital statistics system?
no

To be useful, vital statistics should be derived from universal and continuous registration. By explicitly stating that registration is compulsory, and laying down penalties for non-registration, the law supports the registration of vital events. While timely registration should be encouraged, the penalty for registering older children should be low so that it does not constitute a barrier to "delayed registration".

A1.3 Does the law clearly state that birth and death registration is compulsory?
A1.4 Is there a penalty for non-registration of: نعم يوجد قانون سواء للموايد والوفيات

- **Births?** المادة 1 و2 من القانون الاول
-
- **Deaths?** بالنسبة للوفاة خارج الكويت المادة رقم 10 والمادة 7 وفيات داخلية

A1.5 If yes, please indicate the nature of the penalty.
If there is a financial penalty, specify the current amount.
في الكويت يوجد قانون المادة رقم 19 الحبس والغرامة من 10 دناتير الى 100 دينار او احدى هاتين العقوبتين
A1.6 Is the penalty routinely applied?
غير مفعلة بالنسبة للغرامة وعقوبة الحبس ايضافيما يتعلق بالتليغ عن الموايد او الوفيات

وفيات

The WHO and the UN have agreed on definitions for what constitutes a live birth and a "stillbirth". These definitions have been included in the Glossary and, if not already given, should be introduced.

A1.7 Does the birth registration law give clear and unambiguous definitions to be used for:

- **live birth?**

- اذا نزل حي يسجل بلاغ مولود حي
- **fetal death or stillbirth?**
- نعم **28** اسبوع

A1.8 Are these definitions aligned with the international standards in the Glossary?
نعم يعتبر القانون الكويتي متزامن مع القانون بالمنظمة الصحة العالمية

The responsibility for registering birth usually falls on a parent. Usually, the birth attendant or institution where the birth took place must write a birth “notification” that parents use to register the child, and sometimes must also report the birth to an official authority. For death, responsibility for registration falls on a near relative of the deceased. The reporting is the responsibility of the attending or family doctor or, if there was no witness to the death, the person who found the body of the deceased person.

A1.9 Is it stated in law who is responsible for registering births or deaths and who should declare or report births or deaths? Law number 3 << **نص المادة الثالثة الوالد او من حضر الولادة من الاقارب او الطبيب الذي باشر الولادة**

الموظف المختص بتسجيل البيانات ورئيس قسم القيد بالتسجيل المركزي اما بالنسبة للبلاغ القانوني في المستشفى الموظف البلاغات مع رئيس قسم السجلات الطبية بالمستشفى

A1.10 If yes, provide details of all possible informants.
نعم نص المادة الثالثة من القانون الكويتي للمواليد والوفيات

When a vital event takes place in a health facility, the facility is often required to report it. Such facility-reported data can be used to verify the registration figures.
In many countries, the private sector is a significant provider of health care; hence, a substantial proportion of births and deaths occur in nongovernmental institutions. The law should require all of these institutions to report vital events.

A1.11 Is there a law or regulation requiring hospitals and health facilities to report births and deaths? If so, to what authorities do they report the births and deaths?
نعم نص المادة الثانية من القانون وينص على يجب التبليغ عن المواليد بالكويت بمكتب الصحة المختص في موعد لا يتجاوز 15 يوم من يوم الولادة ،،، نص المادة

A1.12 If yes, to what authorities do they report the births and deaths?
ادارة السجل المركزي للمواليد والوفيات

A1.13 Does the law or regulation cover the private sector?
نعم القانون يغطي جميع القطاعات القانوني والاهلي

Does the law or regulation also include social security and other nongovernmental facilities?
نعم يطبق على جميع القطاعات في النشاط الصحي سواء اهلي او حكومي

The period within which the vital event must be reported must be specified in the civil registration law. This period may vary between countries, but should be consistent throughout the country. A shorter notification period is better than a longer one.

A1.14 Does the law state the time within which births and deaths should be registered?
نص المادة السابعة بحيث للولادة 15 يوم من تاريخ الولادة والوفاة 48 ساعة من ساعة الوفاة

A1.15 If yes, how long is the reporting period?

A1.16 Is the reporting period suitable and is it respected throughout the country?
نعم مناسبة جدا لانها منصوص عليها في قانون المواليد الوفيات .نعم تحترم

Most countries have a grace period of one year within which "late registrations" are accepted before penalties apply. The law should make specific provision for the handling of late and delayed registration of vital events. Every effort should be made to avoid delayed registration.

A1.17 Does the law make provision for:

- **late registration?** نص المادة 20 يقبل التبليغ عن المواليد والمتوفين الذين يبلغ عنهم بعد الموعد القانوني للتبليغ المنصوص عليه في المواد 2 و5 و7 و10 من هذا القانون شريطة الا تمضي سنة على تاريخ الولادة او الوفاة و نص المادة 21 لا يقيد المواليد والمتوفون الذين يبلغ عنهم بعد سنة من تاريخ الميلاد او الوفاة الا بعد صدور قرار بالقيد من لجنة المواليد والوفيات المنصوص عليها في المادة 15 من هذا القانون....
- **delayed registration?**

A1.18 Are there clear procedures for dealing with these cases?
كما جاء بنص المادة 20 و21

Most countries have adopted the place of occurrence of the birth or death as the place for registration, but also request information about "usual residence" so that birth and death statistics can be compiled in both ways, according to intended use.

A1.19 Is it stated where births or deaths should be registered; for example, according to place of occurrence or place of usual residence?
مكان تسجيل المواليد او الوفيات يتم في مكان وقوع الميلاد او الوفاة

The best way to avoid unnecessary duplication and ensure good collaboration is to have clarity in the law concerning the duties of each government department involved. The diagram of the civil and vital statistics systems prepared for discussion of this question can be used to examine the role of each government agency or office.

A1.20 Does the law clearly designate the functions, duties and responsibilities of each government department involved?
التحديد المهام والواجبات يكون وفقا للاختصاص المكاني سواء لادارة السجل المركزي ومراكز المواليد الموجودة بالمحافظات الفروانية والفحيحيل والجهراء

Registration of vital events should be free; hence, the cost of registration needs to be funded by government (national or local) budgetary allocations. This should be stated in law. The continuity of the registration process is a necessary part of producing useful outputs, and requires an agency with sufficient administrative stability and an appropriate annual budget allocation.

A1.21 Does the law establish how the civil registration and vital statistics systems are to be funded?
لا يوجد تمويل للتسجيل بالكويت

A1.22 Does the law stipulate that registration should be free of charge for all?

A1.23 If registration is not free, what is the fee to register:

- **a birth?** التسجيل واصدار شهادة مجانا اول مرة وفي حالة طلب مستخرج يتم دفع مبلغ دينارين لوضع طابع
- **a death?** اصدار شهادة وفاة اول مرة مجانا في حالة مستخرج 750 فلس

It is generally in the interest of both the country and individuals for all the population to be registered, including citizens living abroad or displaced, and foreign nationals (including refugees and asylum seekers living in the country). However, it may be helpful to identify these groups separately for some uses of the data.

A1.24 Is the population covered by civil registration laws clearly defined? Is it, for example:

- **the entire population living in the country?**
- **جميع السكان الذين يعيشون في هذا البلد**
-
- **only citizens living in the country?all people living in kuwait**
- **some other subsets of the population?**

A1.25 What does the law require in relation to registering births and deaths of citizens living abroad?

المادة 5 والمادة 10 يجب التبليغ عن من يولد للكويتيين اثناء الاقامة او السفر خارج الكويت الى قنصلية دولة الكويت التي حصلت الولادة بدائرة اختصاصها وذلك خلال 30 يوم من يوم الولاده او يوم الوصول الى الجهة المقصودة ... اما بالنسبة للوفيات نص المادة 10 اذا توفي كويتي اثناء الاقامة او السفر خارج دولة الكويت وجب التليغ الى قنصلية دولة الكويت التي حصلت الوفاة بدائرة اختصاصها خلال 30 يوم من تاريخ الوفاة ويجب التبليغ شخصيا او بطريق البريد المسجل.

A1.26 What does the law require in relation to registration of births and deaths of:

- **foreign nationals living in the country?**
- **المتطلبات للتسجيل بالنسبة للرعايا المقيمين للمواليد وجود بلاغ الولادة مستندات الام والاب (الجنسية والبطاقة المدني او جواز السفر لغير الكويتي) وعقد الزواج الاصلي صادر من وزارة العدل اما اذا كان غير كويتي يجب ان يكون عقد الزواج مصدق من الخارجية الكويتية .**
- **nomadic or displaced populations?**
- **يطبق عليه ما ذكر سابقا**
- **refugees and asylum seekers?**
- **يطبق عليه ماذكر سابقا**

The confidentiality of the information provided in the individual records must be protected. The law must state who can access the information and for what purposes, in a way that protects confidential information from misuse.

A1.27 Does the law include confidentiality measures to protect individuals?

نعم نص المادة 4 يعطى المبلغ صورة من قيد الميلاد عقب وصوله من دون مقابل ويجوز لكل ذي شأن طلب مستخرج بعد دفع المستحق(ويفهم من ذلك ان اعطاء صورة من قيد الميلاد يكون لصاحب الشان او من ينوب عنه بصورة رسمية)

A1.28 Is it specified who can obtain copies of a person's birth and death certificates?

نعم كما جاء بنص المادة 4 يجوز يجوز لكل صاحب شأن طلب مستخرج بعد دفع المستحق (وكالة)
بالنسبة شهادة الوفاة تعطى المستخرج الى احد ورثة المتوفي او من ينوب عنه بوكالة رسمية

For public health purposes, medical certification of the cause of death is essential, because without it there will be little confidence in the accuracy of statistics on causes of death. In countries where many births and deaths take place at home, non-medically trained persons are given the task of certifying cause of death. However, there is limited public health value in non-medically certified data on causes of death.

A1.29 Does the law state who can certify death and the cause of death?

الطبيب الذي باشر الشخص المتوفي او يتم احالته على الطب الشرعي لتحديد اسباب الوفاة

Many countries have laws referring to the disposal of bodies. An effective way to ensure that deaths are registered is to require death registration documents before burial or cremation can take place. Indeed, often it is the undertaker who is responsible for the registration, in which case the undertaker, with the assistance of relatives, prepares all the papers necessary for death registration, and must file these with the civil registration office before the deceased person can be transported to a final resting place.

A1.30 Does the law specify the official document(s) needed before a burial or cremation can take place?
التقرير الطبي لحالة الوفاة والمسؤول عنها اما الطبيب المسؤول عن الحالة

الطب الشرعي

Subcomponent A2: Registration infrastructure and resources

Supporting material to be prepared in advance:

- **Map showing the location of all civil registration offices in the country and the administrative areas they cover. Indicate separately all other points of registration (e.g. hospitals or local registrars).**

- **Current budget allocations for civil registration functions at all levels of government, where available. (If these are unavailable, use estimates).**

The civil registration budget should include all annual costs such as salaries and social contributions, maintenance of buildings and equipment, electricity and other running costs, and staff training and supplies. If the cost of the vital statistics system is included in the same budget, it should be indicated separately. Both the actual cost (or estimate) and a per capita figure should be provided for discussion.

A2.1 What is the annual national operating budget for civil registration?
A2.2 Can this budget be separately identified at state and municipal levels?
Can the budgets for national, state and municipal levels be separately identified?

It is important to debate whether the annual funds allocated for operation of the vital statistics and civil registration systems are adequate. In this context, adequate means sufficient to carry out the intended functions within specified time limits and to the satisfaction of users, particularly government planning departments.

A2.3 Are these funds adequate to ensure the proper functioning of the system?
A2.4 Where would additional funding be likely to make the most difference?

Local "civil registrars" are people authorized to record vital events, irrespective of whether they are civil servants or are carrying out this function under another status rather than as their primary function.

A2.5 How many local civil registrars does the country currently have?
A2.6 Are they paid by:
- **central government?**
- **local government?**
- **fee-for-service?**
- **other source?**

A2.7 Are there local variations in the way, and amounts, that registrars are paid?
Explain these variations.

The most commonly reported obstacle to registration is that the registration office is too far away. Integrating registration points into hospitals is an effective way to improve the number of registrations. The map prepared for discussion of this question – showing the location of local civil registration offices and subsidiary registration units – can be used to respond to the following questions.

A2.8 Are the number and distribution of local civil registration offices or registration points sufficient to cover the whole country?

A2.9 Are there subsidiary reporting or registration units, such as hospitals or village officials, with registration duties?
A2.10 Is there access to registration 24 hours a day, 7 days a week?

If poor access to civil registration points appears to contribute to low registration coverage, discuss whether mobile registration facilities would be useful or effective. In several countries, such registration outreach has improved civil registration among remote and hard-to-reach sectors of the population.

A2.11 Are mobile registration facilities operational in remote or underserviced areas?
A2.12 If yes, how many? Is the number of mobile registration services sufficient?
A2.13 Is there a separate budget for registration outreach?

If an overall national registration development plan and continuous coverage of all regions are lacking, it will be difficult to lobby for additional funds for full coverage. Discuss possible approaches to achieving better coverage of birth and death registration, including the use of other public facilities such as schools and health clinics.

A2.14 Is there a national plan for achieving complete coverage of the country with registration offices or registration points?
A2.15 Over what period does this plan extend?

Based on the structure of the civil registration system, a matrix should be prepared, with the rows being the types of registration facility (e.g. urban office, rural and remote registration facility) and the columns the types of equipment. Respond to the following question separately for each equipment category.

A2.16 For each type of civil registration point, describe the technical equipment available in all or most offices; for example, telephones, photocopiers, scanners, computers and internet.

Training materials and published standards are crucial to ensure that all vital events are registered in the same way, irrespective of the office and person registering the event. Poorly trained or poorly motivated staff is less likely to help improve data quality at the critical point of data collection. Staff training with an adequate budget is essential, especially when new registration procedures are introduced.

A2.17 How are civil registrars selected?
A2.18 What qualifications do civil registrars need?
A2.19 Is there a budget for training civil registrars and staff involved in registration?

	√	
8 -1 Are computers used for any or all of:		
a - Data collection?	√ Yes	No
b- Data transmission?	√ Yes	No
c - Data validation?	√Yes	No
d - Data Storage?	√Yes	No
e– others	√Yes	No
8 .2 Are there any plans for further computerization in the near future?	√Yes	No

8.3 If so, what are the priorities?

(Please specify) currently, work is done electronically at the level of the health directorates and the automation project is under implementation in health offices

9. What procedures for checking the completeness and consistency of information collected at points of registration are currently being carried out at the points of registration?

(Please specify) None

9 -1 What procedures for checking completeness and consistency of information are carried out at central and other levels?

(Please specify) In which of the following three levels checking is carried out between the Center for Information and Technical Department?
At the level of the health department
Directorate level
At the central level

10. Are data registration routinely checked monthly or quarterly to ensure that they are comparable with previous years?	√Yes	No
10.1 At the central level, are the expected numbers of births and deaths, which should occur each year routinely, estimated for each registration area and compared to the	√Yes	No

Component B

Subcomponent B1: Organization and functioning of civil registration and vital statistics systems

Supporting material to be prepared in advance:

- **Flowchart(s) showing the administrative structures of the civil registration(s) and vital statistics systems, how data flows between them and how they interact.**
- **Flowchart(s) of the death and birth-registration processes in and outside of hospitals, and for deaths that are handled by the police, coroners or special medical examiners (see Figures 3.2 and 3.3 for examples from Mexico of death and birth registration processes).**

Local adaptation of the wording and contents of some questions may be necessary to make them more relevant for assessing the system. This is particularly important in countries where vital statistics are not collected by the civil registration system but by a parallel system.

The many steps between when vital events occur and when they are registered and consolidated into national statistics require good coordination between the different components of the system. The purpose of the review is to discuss any organizational or administrative limitations that may affect the functioning of the system. It is important to focus on the weaker parts or bottlenecks that may decrease the timeliness or quality of the vital statistics.

B1.1 What are the organizational and administrative arrangements of the civil registration and vital statistics systems (reviewed using the prepared diagrams)?

See attached chart

B1.2 What have been the main changes in the functioning of the systems over the last 10 years?

1- Registration and data entry become electronic with cooperation with PACI.
2- Birth certificate was written manually, now it is printed electronically.

B1.3 How have these changes affected functioning of the system or systems?

Speed of the performance

B1.4 What areas need improvement?

Still in some places, data are collected manually (need to be automated).

Most countries have separate agencies responsible for the collection of information on vital events (e.g. civil registration) and the production of vital statistics (e.g. a national statistical office or ministry of health). Many countries have formal communication mechanisms between these agencies to ensure smooth coordination and cooperation. Some countries also have broader cooperation committees that meet regularly and include representatives from the health department, hospitals, coroners, police, funeral agencies and religious authorities. Such meetings are particularly important when there is a need to change procedures.

B1.5 What are the current communication mechanisms between the civil registration authority and others involved in the collection and production of vital statistics?

VSD is communicating with CRD on frequent-but not regular bases- either to collect the needed forms or to check for the completion of the total numbers of births and deaths for quarterly and annual reports… but we hope the connection to be electronically including the PACI as well

Unclear or overlapping responsibilities between agencies can be a major impediment to the smooth functioning of the system and often lead to waste of resources. For instance, is it clear who is responsible for transferring records from one unit to another, or for verifying the data? If someone is absent from work, are there procedures in place to ensure that the person's duties are carried out in a timely fashion?

B1.6 Are there any areas where the responsibilities for specific functions overlap or are unclear?

The responsibilities for specific functions are available in the circulars of establishment of the concerned directorates (VSD, CRD, and PACI) need to be revised during suggested meetings with these stakeholders

Data are entered in two different places (VSD and CRD+PACI),

PACI issue annual mortality and births reports that should be identical with that of VSD

B1.7 Are national, state or provincial and local responsibilities clearly defined?

The responsibilities for specific functions are available in the circulars of establishment of the concerned directorates (VSD, CRD, and PACI) need to be revised during suggested meetings with these stakeholders

B1.8 Are there any areas where bottlenecks regularly occur?

Yes, for VSD in particular, during the last times of the Quarterly and annual report (March, June+++, September and December)

The flowcharts prepared (including those showing detailed birth and death registration practices) should form the basis of discussion. All the steps in the different registration processes (e.g. covering events in and outside hospital) should be included, with a focus on trying to pinpoint where in the process there are leakages that lead to events not being registered. For example, in some countries, the rules may discourage registration of abandoned children or children of under-aged or unmarried mothers.

B1.9 Review in detail the country's practices for birth and death registration. Which types of births and deaths are likely to escape the civil registration system?

None

B1.10 Are these types of births and deaths also missed by the vital statistics system?

NA

B1.11 Are there some vital events that cannot be registered through the normal system?

No

All subnational entities should collect information in a standard format; this will allow comparable national figures to be compiled. This generally requires that a specific national entity be given the task of setting standards and coordinating data collection. In countries where there are separate data collection systems at the state or provincial levels, coordination will be needed.

B1.12 Are the same data on births and deaths collected across the country and at every level of the system (including state or provincial, national and local levels)?

Yes

B1.13 Is there an entity responsible for national vital statistics standards and coordination?

Yes, VSD- HIMRD, MOH

The civil registration system focuses on the birth or death event itself. However, for public health purposes, information on the circumstances of birth and the cause of death are crucial. Cause-of-death information is often collected on a separate form, and sent to the ministry of health as the main user of the data. Medical details related to births are also extremely valuable for identifying subpopulations of children or mothers at risk. Details of particular public health relevance include birth weight, prematurity, birth deformity, birth order (for multiple births), method of delivery and complications.

B1.14 Is cause of death included on the death registration form?

Yes

B1.15 If not, is information about the cause of death collected at the same time as the death is registered but using a different form? Also discuss what happens with coronial cases and deaths from suspected non-natural causes.

NA

B1.16 Who decides what details to collect on births and on causes of death?

Yes, MOH (VSD+CRD) with other stakeholder (PACI).

B1.17 How is medical information on births and deaths exchanged among the different government agencies involved?

Through the Q+Annual reports as well as the DB of VSD- HIMRD, MOH

B1.18 Is this process currently working well or does it need improvement?

For fertility data, it needs to be completed (cooperation with maternity hospital as well as Ob&Gy depart in Jahra, Adan, Farwaniya + all private sector hospitals)

In many countries the establishment of a “population register” has been a natural extension of the computerization of civil registration and a desire to streamline government agencies and reduce duplication. The population register is derived from the data collected by the civil registration system, and integrates all information on individuals into one record per person, identifiable by a personal identification number (PIN).

B1.19 Is there a national population register?

Yes, PACI

B1.20 If so, how does information flow between the national population register and the civil registration system, and which government agency is responsible for maintaining the national population register?

There is communication among the three departments. There is electronic communication between PACI & CRD. There is cooperation between VSD and PACI (by email for population and at the end of the annual data collection-April). There is cooperation between PACI & CRD. However, networking of these departments will save time, avoid errors and ensure completion of data especially as regards occupation. Also international support is needed for clarification of how to present Occupation data.

B1.21 Is each individual assigned a PIN at birth registration or at the time of receiving identity papers, and is this PIN used throughout the government's administrative databases?

Yes

B1.22 If a PIN is not given, how are records from various data systems linked, and how is the population register updated?

Not applied, however networking will solve many problems

Computerization of civil registration and vital statistics records cannot by itself improve the quality of the data contained in civil registration records, but it does have a number of advantages. For example, computerization helps to promote timeliness of different processes, including data production and management; it also facilitates the verification, validation and sharing of vital statistics data. If there are plans to expand the computerization of the data system in the near future, it is important to discuss the effect that further computerization is likely to have on the quality and timeliness of the statistics produced.

B1.23 Are computers used at any stage of the birth and death registration process?

Yes after registration in CRD

B1.24 Are computers used for any or all of:

- **data compilation?**
- **data transmission?**
- **data validation?**
- **data storage?**

CRD computer is used for mortality data compilation, transmission and storage & this is underway for births.

VSD computer is used for Vital Statistics data compilation validation, presentation and storage

B1.25 Are there any plans for further computerization in the near future.

Yes

B1.26 If so, what are the priorities?

Networking to avoid duplication

Systems for checking data for errors or inconsistencies should be in place at all levels of the vital statistics system, beginning at the data collection point. Ideally, a set of standard data checking procedures should be determined centrally and distributed for use at every data collection office. These procedures should include checks on the logic and completeness of the raw data, as well as checks on the arithmetic and logic of the vital statistics once they are compiled.

B1.27 What procedures for checking the completeness and consistency of information collected at points of registration are currently being carried out at the points of registration?

No checking (need training + Quality Assurance personnel to have a role)

B1.28 What procedures for checking completeness and consistency of information are carried out at central and other levels?

At central level, checking for **completeness and consistency** is carried out 5 times/year (4 Q + 1 Annual)

There should be no large fluctuations from year to year in the numbers of births and deaths registered, as well as causes of death, including deaths without specified causes. If there are large fluctuations, the causes should be investigated, including querying the people who collected the data.

B1.29 Are monthly or quarterly registration data routinely checked to ensure that they are comparable with previous years?

Yes, at central level, checking for **comparability with the previous 5 years** is carried out in the Annual and with the previous year for the Quarterly.

B1.30 At the central level, are the expected numbers of births and deaths that should occur each year routinely estimated for each registration area, and compared to the actual numbers of registered events?

No, but we can do it if it is of local and IN value.

Subcomponent B2: Review of forms used for birth and death registration

Supporting material to be prepared in advance:

- **all forms related to the registration and certification of births and deaths;**
- **a copy of Box 3.2 (see below), showing a list of topics that the UN recommends be included in birth and death registration.**

B2.1 Which of the UN-recommended items are collected on birth and death registration forms? Use Box 3.2 and tick off all items collected.

See the Kuwait birth and death registration forms

Generally, all items are present except for Rural/Urban locality as this is not suitable for Kuwait

B2.2 Which of the UN-recommended items that are not collected on the birth and death registration forms would be useful?

Rural/Urban locality as this is not suitable for Kuwait situation.

B2.3 What additional items are collected on the birth and death registration forms? List and discuss these items.

BC: birth attendant
Country if outside Kuwait for K only
Age, Nationality, Religion, and Occupation of parents
DC: Nationality, Religion, Occupation, Education and country if outside Kuwait for K only

Hospital file number need to be added for hospital deaths and other deaths if possible- as this will facilitate data retrieval for statistical, admin and research purposes.

As increasing numbers of births take place with medical assistance, it is recommended that the birth form include an attachment for collecting medical details about the birth, the baby and the mother. This information is important for improving maternal and child health care, because birth records can be used to identify high-risk infants and mothers for subsequent follow-up. Data other than birth weight might include prematurity, birth order (for multiple births), method of delivery, complications during delivery, stillbirth and date of the mother's most recent delivery.

B2.4 Are any medical details collected (either on the birth registration form or a separate form) regarding the health of the child or the birth process?

Yes, Medical details are additional to the classical form (Yellow, Pink and blue copies).(There is a suggestion to be unified as it will enter the system once after the implementing the proposed networking)

The quality of the information obtained is affected by the clarity of the question, the layout of the form (which should be uncluttered and leave sufficient space for adding comments), and the amount of information requested. Errors are also likely to be introduced each time information is transcribed from one form to another.

B2.5 Review all the forms used for registering and certifying births and deaths and answer the following questions for each set of forms:

- **Is all the information collected used? No**
- **How long does it take, on average, to fill out each set of forms? 5-15 minutes**
- **Is the layout of the forms user-friendly? Explain why or why not. Yes, precoded**
- **Is the form available in each of the main national languages? Yes**
- **Which items come from the "declarant" and which are transcribed from other documents; All except COD**
  for example, is the cause of death transcribed from the death certification form?

Box 3.2 Recommended list of high-priority characteristics to include in birth and death registration information

The UN recommends that the data collected during registration of a birth or death should include the specific characteristics of the event, of the parents (if a birth) or of the deceased person (if a death). The characteristics listed below have been selected because they are potentially useful for supporting national policy and programme development, and for building and maintaining regional and global comparability.

Although the list shows high-priority characteristics (which ideally should constitute an immediate goal), countries may wish to begin with a shorter list. For example, the long list of parental characteristics may be irrelevant to some countries, or too burdensome. Further, some of this information can be derived from other information and does not need to be asked again. Countries are encouraged to identify their own priorities from the list provided below. However, each country will need to include a registration serial number, the place of registration (or the code of the registration office) and the names of those people directly involved with the event (*1*).

Live births

Characteristics of the event:

- Date of occurrence
- Date of registration
- Place of occurrence
- Place of registration
- Locality of occurrence (derived)
- Urban or rural occurrence (derived)
- Type of birth (i.e. single, twin, triplet, etc.)

Characteristics of the child:

- Sex
- Birth weight

Characteristics of the parents:

- Date of birth and age (derived) of both parents
- Marital status of both parents
- Educational attainment of both parents
- Place of usual residence of both parents
- Locality of residence (derived)
- Urban or rural residence (derived)
- Children born alive to mother during her entire life (to date)
- Children born to mother and who are still living
- Fetal deaths to mother
- Date of last previous live birth
- Date of marriage and duration (derived)

Deaths

Characteristics of the event:

- Date of occurrence
- Date of registration
- Place of occurrence
- Place of registration
- Locality of occurrence (derived)
- Urban or rural occurrence (derived)
- Cause(s) of death
- Certifier and type of certification (derived)

Characteristics of the deceased:

- Date of birth and age (derived)
- Sex
- Marital status
- Place of usual residence (for deaths, less than one year residence of mother)
- Locality of residence (derived)
- Urban or rural residence (derived)

Box 3.3 Access to civil registration and completeness of vital registration

As a country develops its civil registration system, it is important to regularly monitor progress. One way to do this is to measure the access that people have to civil registration and the completeness of the registration data, although doing so can be quite complex. For example, access is a complex concept that covers a range of issues, including availability of registration points, distance, affordability, and cultural and social acceptability. This box describes two measures, one of access and one of completeness of registration.

Access

Access, as measured by availability, can be calculated by dividing the number of people living in census enumeration districts that have at least one civil registration office or other facility to register births or deaths (numerator in the equation below) by the total national population (denominator) for the same year, and then multiplying by 100 to give a percentage figure.

Thus, access level (in %) can be calculated as $X = C/P \times 100$

X	Access level in %
C	Size of population in districts with registration points
P	Total population of the country

Completeness

Completeness is a measure of the extent to which the births and deaths that occur in a country in a given year are registered by the civil registration system. Several demographic techniques have been developed to assess and adjust information on births and deaths that come from civil registration. Some methods compare data from independent sources (direct "capture–recapture" approaches) whereas others are indirect analytic methods, based on assumptions about the population age distribution. 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 (*1*). These methods are not described in detail here, but are often used by a national statistics office or academic institution to estimate registration completeness.

If such methods have not been applied, a more basic approach is to estimate completeness by dividing the *actual* number of registered births (or deaths) in the country by the total *estimated* number of births (or deaths) in the country for the same period and multiplying by 100 to give a percentage. A simple way to measure completeness in this way is to use an independent estimate of the total number of births (or deaths) in the country. If no reliable national estimate is available, then an international one can be used. For example, each year the UN estimates birth and death rates in its Member States using various sources and demographic estimation techniques (*19*). The reliability of such calculations of registration completeness clearly depends on the reliability of the independent estimates of crude birth rate and crude death rate.

Completeness of birth registration can be calculated as: $YB = (RB/CBR \times P) \times 100$

YB	Estimated birth registration completeness (%)
RB	Actual number of registered births
CBR	Crude birth rates as estimated by the UN (per 1000)
P	Total population size (in '000s)

Completeness of death registration can be calculated as: $YD = (RD/CDR \times P) \times 100$

YD	Estimated death registration completeness (%)
RD	Actual number of registered deaths
CDR	Crude death rates as estimated by the UN (per 1000)
P	Total population size (in '000s)

Example

The UN estimates that the CDR for country A in 2005 was 5.4 per 1000 population. The population of country A in that year was reported as 69,421,000.

If the civil registration system registered 280,510 deaths in 2005, the completeness of death registration in country A would be estimated as follows:

$YD = (280{,}510/5.4 \times 69{,}421) = 280{,}510/374{,}873 = 74.8\%$

• The social stigma of illegitimate children;	**Yes√**	**No**
• cultural barriers;	**Yes√**	**No**
• Financial barriers;	**Yes**	**No√**
• Illiteracy;	**Yes√**	**No**
• Shortage of doctors and midwives;	**Yes**	**No√**
Other obstacles (Please specify)		
marriage below the legal age		

20. **When did the country last have a campaign to increase public awareness of the need to register vital events?** None		
20-1 Were the results evaluated?	**Yes**	**No√**
20-2 Is there a committee that regularly monitors and evaluates civil registration completeness?	**Yes**	**No√**

less likely to be registered than deaths among males. It is useful to list any subpopulations that may be being missed by the vital statistics system; for example, people living in remote rural areas, indigenous peoples, nomadic populations and specific age groups, especially neonates.
Some countries have carried out registration campaigns, set up mobile registration, or instituted informal reporting from primary health-care workers to increase the completeness of registration.

B3.7 What subpopulations are most likely to be undercounted in vital registration? (Note: undercounting may be different for births and deaths.)

Nobody

B3.8 If only part of the country is covered (e.g. urban areas), have alternative ways of obtaining vital statistics for non-covered populations been considered or implemented; for example, a "sample registration system" (SRS) or a demographic surveillance system (DSS)?

NA

B3.9 What has been done in the last 10 years to increase:

- **birth registration?**

NA

- **death registration?**

NA

Late registration only becomes a problem where year of occurrence and registration differ. Nonetheless, the extent of late registration should be tracked and monitored to ensure that it is decreasing and not increasing.

B3.10 Is late registration tracked and monitored over time and at the subnational level?
Yes

B3.11 Is late registration more common in some areas than others?
No

Births and deaths that take place in health facilities are more likely to be reported. Hence, as the proportion of these events increases, so should the completeness of registration. Countries that have civil registrars located in hospitals and that have introduced a midwifery reporting system have made substantial improvements in the registration of births and deaths. More generally, matching reported events from hospitals and health facilities with registered vital events provides an estimate of the extent of non-registration.

B3.12 What proportion of registered births take place in health facilities?
98%

B3.13 What proportion of registered deaths take place in health facilities?
60%

B3.14 What proportion of hospitals or other health facilities have registration officers on the premises?
All

B3.15 Do midwives or other health personnel attending home births also report these births? If so, to whom?
NA

B3.16 Are reported births from such sources routinely compared with registered births?
NA

The reporting of births and deaths occurring in private institutions may be poor if not compulsory and specified by law.

B3.17 What proportion of births take place in nongovernmental health facilities?

45%

B3.18 What proportion of deaths take place in nongovernmental health facilities?

<3%

It is generally recommended that there should be no charge for initial registration of births and deaths and issuing of original certificates. A fee is commonly charged for issue of subsequent copies of birth and death certificates.

B3.19 Does registration involve any financial costs to the family or informant:

- **for births?**

  No
- **for deaths?**

  No

Some countries have maternity or child allowances that the mother can access, provided she can produce a birth certificate. Also, a death certificate is usually needed to claim insurance, pension benefits and inheritance. Discuss how access to other benefits might potentially increase registration completeness.
An increasing number of countries have introduced obligatory identity cards for the adult population, and a birth certificate is often needed to prove identity to get the card. This has undoubtedly increased awareness among the population of the utility of registering birth.

B3.20 What social services or benefits are linked to birth registration?

For Kuwaitis, financial rewards for each baby and education facilities are offered free and social recognition of the baby (adding to his father's nationality file and issuing the national ID)

B3.21 What social services, insurance benefits or inheritance transfers are linked to death registration?

Knowing the number of adults who deserve the legal quorum
يتم حصر الراشدين وتحديد الأنصبة الشرعية للورثة الشرعيين

B3.22 If the country uses identity cards, how does that system affect vital events registration?

PACI: it facilitate calculating of deaths births denominators for vital statistics indicators

It is useful to list the main obstacles and deterrents that may discourage people from registering births and death, and to then discuss each of these and propose how each of these may be overcome or reduced.

B3.23 What are the main obstacles to improving civil registration? For example:

- **lack of registrars or places to register; No**
- **lack of access to health facilities; No**
- **lack of knowledge about the need to register births and deaths; No**
- **social stigma of illegitimate children; Yes**
- **cultural barriers; to some extent, for deaths due to suicide, drug problems etc.**
- **financial barriers; No**
- **illiteracy; No**
- **shortage of physicians and midwives; No**
- **other obstacles (please specify).**

Alternative electronic records in more than one place (Please specify) There are copies of records of births and deaths for the period before 1962 in the Archives House in Cairo and after this year they are present in the civil register		
22.4 Can individual birth or death records easily be retrieved if needed?	**Yes√**	**No**

23. Have there been instances of fraudulent or multiple registrations?	**Yes√**	**No**
23.1 What precautions are built into the system to avoid fraudulent or multiple registrations?		
(Please specify) By using National ID, and "log file" in the electronic version		

24. Using the flowcharts of data transmission prepared for birth and death records, explainwhere and how data are being consolidated before transmission.
For the Ministry of Health - Health Information System Health offices are merged in the Health Administration Health departments are merged in the health Directorate Governorates are merged at the central level For Civil Status Paper forms are compiled in the governorate Civil Registry Offices Electroinc data entery in the governorate Civil Status Information Center Governorates are merged at the central level

25. Reflecting on the data-flowchart prepared, is there a fixed schedule for transferring data in a timely manner?	**Yes√**	**No**
25-1 Is this schedule strictly adhered to?	**Yes√**	**No**
25-2 Is this schedule routinely monitored by those receiving the data?	**Yes√**	**No**
25.3 Are there procedures in place to deal with late or non-reporting from local civil registration offices?	**Yes√**	**No**
25-4 If there are procedures in place, what are they?		
(Please specify) Instructions have been issued from the central level with specific work procedures - the timing of data transmission from health offices to health departments, then to Directorate, then to the central level		

26. Is the information on the birth and death registration forms kept confidential?	**Yes√**	**No**

Subcomponent B4: Data storage and transmission

Supporting material to be prepared in advance:

- **Separate flowcharts of how data on birth and death registration are transmitted from the local level to higher levels and the central storage facility (include how often the data are transmitted and how the data are transmitted).**
- **A separate flowchart of how data from civil registration (and other sources recording vital events) are transmitted to the unit preparing vital statistics. (Note: the extent to which the civil registration and vital statistics systems are integrated or function as separate systems varies among countries and will determine whether many of the questions need to be duplicated to cover all the flows in both systems.)**

The UN has produced a series of handbooks to guide countries on civil registration; two of these handbooks are particularly relevant for data management and maintenance of civil registration records (20, 25).

B4.1 Do local registration offices record and store the collected information on births and deaths by:

- **registry books? Yes**
- **electronic files? Expected in the future plan of action**
- **other (please specify)?**

B4.2 Are birth and death records filed by:

- **date of registration?**
- **name?**
- **a numbering system or other numerical index? Yes by CID**
- **other (please specify)?**

There are different ways of storing and archiving records. A major requirement of any system is to ensure that registrars can retrieve individual records to make copies and issue certificates. Hence, a proper filing and archiving system is crucial. Long-term storage and preservation is usually best done at a national level and is easier to do with electronic records. However, where registration records are not computerized, copies also need to be stored at the local level so that local authorities and individuals have ready access. When records are computerized, daily backup of electronic files is recommended, to ensure that records are not lost if equipment fails.

B4.3 What method of record backup is used and how frequently is this done?

PACI + CRD …..eDB+Microfilm regular
VSD….. eDB
B4.4 How are birth and death records archived?
PACI + CRD ……eDB & Microfilm
VSD….. eDB
B4.5 Have records ever been lost or destroyed?
No

B4.6 How can the loss or destruction of records be avoided in the future?
NA

B4.7 Can individual birth or death records easily be retrieved if needed?
Yes

Because birth records in many countries are used for establishing identity cards and legal documents, they are more often subject to fraud. Vital records should not be treated as public documents, and certificates should only be issued to those with a legitimate right to ask for them. To avoid abuse, some countries have instituted a surveillance programme that requests information on the birth record that only the registrant would normally know; for example, maiden name of mother. Many countries also mark the birth records with the word "deceased" when the person dies.

B4.8 Have there been instances of fraudulent or multiple registrations?
Rare occasion (illegal +Judicial dispute)

B4.9 What precautions are built into the system to avoid fraudulent or multiple registrations?
Giving a unique reference number to each form (we suggest a speedy prove descent)
سرعة البت في قضايا إثبات النسب

Depending on the type of system and infrastructure available, there are many possible ways to consolidate and transfer data from the birth and death registration forms to create vital statistics. However, wherever data consolidation is performed – be it manually, mechanically or electronically – errors can occur; therefore, routine checking of data outputs is recommended.

B4.10 Using the flowcharts of data transmission prepared for birth and death records, explain where and how data are being consolidated before transmission.

In the CRD forms are gathered and distributed to VSD + PACI. However to save time, the yellow form is sometimes sent directly from hospitals to VSD

Reporting all vital events according to a fixed time schedule is a cornerstone of successful civil registration and vital statistics systems. Routine follow-up should be made to civil registration offices if the offices do not report on time. Every delay in reporting affects the timeliness of the national data and decreases the potential effectiveness of any query about the data in cases where information is missing or judged to be incorrect.

B4.11 Reflecting on the data-flowchart prepared, is there a fixed schedule for transferring data in a timely manner?
Yes

B4.12 Is this schedule strictly adhered to?

No

B4.13 Is this schedule routinely monitored by those receiving the data?
Yes

B4.14 Are there procedures in place to deal with late or non-reporting from local civil registration offices?
Yes

B4.15 If there are procedures in place, what are they?
Knowing the reason of delay &
معرفة أسباب التأخير و تحرير محاضر إدارية

People may be discouraged from registering births and deaths if the public perception is that the confidentiality of information reported on birth and death registration forms is not guaranteed. Also, doctors may not feel comfortable reporting accurate cause-of-death information if the record is not considered confidential.

B4.16 Is the information on the birth and death registration forms kept confidential?
Yes

B4.17 How is confidentiality maintained?

VSD: Anonymous data presentation

B4.18 Who can access the data and for what purposes?
VSD: only employers in VSD – papers are incinerated every 5 years and DB are kept anonymous.

Errors in the data can happen both at the time of registering the event and when data are consolidated, transcribed and transferred. Hence, it is recommended that the office receiving the statistics routinely checks the data. This is much easier if the data are computerized. In cases where there are queries with the transferred data, rapid feedback to local registration offices is essential, so allow the data to be corrected. This also encourages local offices to improve data quality.

B4.19 What checks are made on individual birth and death records to ensure that they are accurate and complete when transferred?

NA in Kuwait as the forms are carbon copies

B4.20 Are local registration offices routinely contacted for clarification about the statistics by the regional or central level?
Not routinely, but occasionally when needed

B4.21 If so, how frequently is clarification sought?
NA, **occasional**

Local offices should be able to provide the data they collect to local authorities for local planning; they should also know how the data compare with the national situation. Thus, the central office producing the country's vital statistics must keep the local offices informed about how their areas are performing in terms of birth and death rates, compared to the national context.

B4.22 Is there two-way communication and data transfer between central and peripheral offices?

Yes

B4.23 Do regional registration authorities routinely receive reports on how the characteristics of their populations compare with the national average?
NA

دولة الكويت
وزارة الصحة

بلاغ مولود حي

مسلسل البلاغ : ١

المستشفى / مركز صحي : ٢

مركز التسجيل .... ٣ نوع السجل .... ٤ تاريخ القيد : يوم — شهر — سنة ٥ رقم القيد : ٦

يستوفى في المستشفى / المركز الصحي (كاتب البلاغ)

١ / ٧ بيانات المولود

الرقم المدني المصدر للمولود ٨ اسم المولود : ٩ نوع المولود : ١٠

تاريخ الميلاد : أ - الميلادي بالأرقام .... يوم — شهر — سنة ١١ ب - الهجري بالأرقام .... يوم — شهر — سنة ١٢

ج - الميلادي بالحروف .... وقت الميلاد : الدقيقة .... الساعة .... صباحا / مساء

مكان الولادة : ١ - مستشفى حكومي ٢ - مستشفى خاص ٣ - مركز توليد ٤ - منزل بمساعدة ممرضة ٥ - منزل بدون ٦ - أخرى .... ١٣ للولادة التوأمية : عدد التوائم ١٤ ترتيب المولود ١٥

للولادة خارج الكويت : اسم الدولة .... ١٦ اسم القائم بالتوليد .... الصفة : ١ - طبيب ٢ - ممرضة ٣ - أخرى ١٧

٢ / ٧ بيانات الأب

الرقم المدني للأب

الاسم	الأول	الثاني (الأب)	الثالث (الجد)	الرابع (أب الجد / اللقب / العائلة)
الاسم				
تدقيق الاسم	١١	١٢	١٣	١٤

الجنسية ٨

المهنة ٩ ١٠

الديانة .... العمر بالسنوات ١٥ الحالة التعليمية : ١ - أمي ٢ - يقرأ ويكتب ٣ - شهادة ابتدائية ٤ - متوسطة ٥ - ثانوية ٦ - جامعية فما فوق ١٦ ١٧

٣ / ٧ بيانات الأم

الرقم المدني للأم

الاسم	الأول	الثاني (الأب)	الثالث (الجد)	الرابع (أب الجد / اللقب / العائلة)
الاسم				
تدقيق الاسم	١١	١٢	١٣	١٤

الجنسية ٨

المهنة ٩ ١٠

الديانة .... العمر بالسنوات ١٥ الحالة التعليمية : ١ - أمي ٢ - يقرأ ويكتب ٣ - شهادة ابتدائية ٤ - متوسطة ٥ - ثانوية ٦ - جامعية فما فوق ١٦ ١٧

محل الاقامة بالكويت : منطقة .... ١٨ قطعة ١٩ شارع / منزل .... ت : ٢٠

الاقرار/الادارية

أقر بأن المعلومات المذكورة بهذا البلاغ صحيحة وحقيقية بقدر معرفتي واعتقادي ، الاسم .... اسم كاتب البلاغ ....

إثبات الشخصية .... التاريخ .... التوقيع .... التاريخ .... التوقيع ....

يستوفى في مركز التسجيل

بيانات ثبوتية

للأب نوع الوثيقة : .... الرقم : .... التاريخ : .... جهة الاصدار : .... وثيقة العلاقة الزوجية ....

للأم نوع الوثيقة : .... الرقم : .... التاريخ : .... جهة الاصدار : ....

المبلغ/المدقق

الاسم الكامل للمبلغ .... العمر .... الصلة بالمولود .... الجنسية .... اسم المدقق ....

المهنة .... العنوان .... التوقيع .... التاريخ .... التوقيع ....

النسخة الثانية (اصفر) الاحصاءات الصحية والحيوية - الحاسب الآلي

تستوفى بمعرفة الطبيب المشرف على الولادة

٤ / ٣٦ بيانات طبية

١ - بيانات الخصوبة

مدة الحياة الزوجية منذ أول زواج — سنة ٥٦ مدة الحياة الزوجية مع الزوج الحالي بالسنوات — سنة ٥٧

عدد مرات الحمل السابق ٦٢ عدد الولادات المبكرة ٦١

أبناء لازالوا احياء ٦٥ أبناء ولدوا احياء وتوفوا ٦٤

مواليد موتى ٦٨ عدد مرات الاجهاض ٦٧

تاريخ آخر ولادة حية — شهر — سنة ٧١ مدة الحمل عند الولادة بالاسبوع ٦٩

٢ - الرعاية الطبية

عدد مرات الزيارة ٧٥

٣ - مضاعفات الحمل الطبية

القلب ٨٢ ضغط الدم ٨١ الكلى ٨٠ السكر ٧٩ مضاعفات اخرى ٧٨ لا يوجد ٧٧

٤ - مضاعفات مرتبطة بالحمل

ما قبل اكلامسيا ٨٧ اكلامسيا ٨٦ نزيف قبل الولادة ٨٥ مضاعفات اخرى ٨٤ لا يوجد ٨٣

٥ - بدء الولادة

بتحريض ٢٨ بدون ٢٧

٦ - طريقة الولادة

بدون تدخل ٣٣ بالشفاط ٣٢ جفت واطي ٣١ جفت متوسط ٣٠ جفت كيلاند ٢٩

مقعد بمساعدة أو بدون ٣٧ استخراج بمقعد ٣٦ قيصرية أولى ٣٥ قيصرية مكررة ٣٤

٧ - المضاعفات أثناء الولادة

استطالة الولادة أكثر من ٢٠ ساعة ٤١ مجيء معيب ٤٠ مضاعفات الحبل السري ٣٩ احتباس المشيمة ٣٨

نزيف بعد الولادة ٤٥ انفجار الرحم ٤٤ مضاعفات اخرى ٤٣ لا يوجد ٤٢

٨ - بيانات أخرى

وزن المولود (جرام) ٤٦

طول المولود (سم) ٥١ عيب خلقي ١ - نعم ٢ - لا ٥٠

بيان العيب الخلقي ٥٣

7540 HA0001288 بلاغ مولود حي

Rev. Date (12 / 2001)

دولة الكويت
وزارة الصحة

بــلاغ وفــاه

مسلسل البلاغ .... [ ]

المستشفى /مركز صحى /: .... [ ]

مركز التسجيل .... [ ] نوع الســجل : ..... [ ] تاريخ القيد [يوم | شهر | سنه] رقم القيد [ ]

يستوفى في المستشفى/المركز الصحي — بيانات المتوفى

الرقم المدني للمتوفى		الأول	الثاني (الأب)	الثالث (الجد)	الرابع (أب الجد/اللقب/العائلة)
	الاسم				
	تدقيق الاسم				

تاريخ الوفاه : أ ـ الميلادى بالارقام .... [يوم | شهر | سنة] ب ـ الهجري بالارقام .... [يوم | شهر | سنة]

جـ ـ الميلادي بالحروف ....

وقت الوفاه : دقيقه .... ساعه ...... [ ] صباحا / مساء ..... [ ] مكان الوفاه .... [ ]

الجنسية .... [ ] النوع .... [ ] الديانه .... [ ] المهنه .... [ ]

الحالة الاجتماعيه : .... [ ] الحاله التعليميه : ١ ـ أمى ٢ ـ يقرأ ويكتب ٣ ـ شهاده ابتدائيه ٤ ـ متوسطه ٥ ـ ثانويه ٦ ـ جامعيه فما فوق . [ ]

العمر : أ ـ للوفيات أقل من أسبوع دقيقة .... [ ] ساعه .... [ ] يوم .... [ ]

ب ـ للوفيات أسبوع فاكثر يوم .... [ ] شهر .... [ ] سنة .... [ ]

للوفيات خارج الكويت : اسم الدوله .... [ ] مكان الولاده (للوفيات أقل من ٢٨ يوم) .... [ ]

محل الاقامة بالكويت: منطقة .... [ ] قطعة .... [ ] ت : ....

شارع /منزل: ....

بيانات الأب

الرقم المدني للاب		الأول	الثاني (الأب)	الثالث (الجد)	الرابع (أب الجد/اللقب/العائلة)
	الاسم				
المهنه .... [ ]	تدقيق الاسم				

العمر بالسنوات [ ] الحاله التعليميه : ١ ـ أمى ٢ ـ يقرأ ويكتب ٣ ـ شهاده ابتدائيه ٤ ـ متوسطه ٥ ـ ثانويه ٦ ـ جامعيه فما فوق.......... [ ]

بيانات الام

الرقم المدني للام		الأول	الثاني (الأب)	الثالث (الجد)	الرابع (أب الجد/اللقب/العائلة)
	الاسم				
المهنه .... [ ]	تدقيق الاسم				

العمر بالسنوات [ ] الحاله التعليمية : ١ ـ امى ٢ ـ يقرأ ويكتب ٣ ـ شهاده ابتدائيه ٤ ـ متوسطه ٥ ـ ثانويه ٦ ـ جامعيه فما فوق .... [ ]

يستوفى في مركز التسجيل

ثبوتيه: نوع المستند .... الرقم .... التاريخ .... جهة الاصدار ....

المبلغ: الاسم .... العمر .... الصله بالمتوفى ....

العنوان .... التوقيع ....

المدقق: اسم المدقق : .... التاريخ .... التوقيع ....

الأصل (أبيض) مركز تسجيل المواليد والوفيات

يستوفى بمعرفة الطبيب — سبب الوفاة

للوفيات اقل من اسبوع

ا ـ مرض او حاله مرضيه اساسيه في الطفل .... [ ] ١٦

ب ـ امراض او حالات اخرى في الطفل ....

ج ـ مرض او حاله اساسيه في الام اثرت على وفاة الطفل .... [ ] ١٨

د ـ امراض او حالات اخرى في الام اثرت على وفاة الطفل . ...

هـ ـ احوال اخرى مرتبطه بوفاة الطفل ....

للوفيات اسبوع فاكثر

ا ـ السبب المباشر : .... [ ] ١٧

ب ـ السبب المتوسط : ....

ج ـ السبب الأصلي : .... [ ] ١٩

احوال مرضيه اخرى ساعدت على الوفاه ولا صله لها بالمرض او بالحاله التي سببت الوفاه ....

اقر بانني شاهدت المتوفى موضوع هذا البلاغ ◯ قبل الوفاه ◯ بعد الوفاه

الاسم .... الوظيفه .... التاريخ .... التوقيع ....

٣٤ ـ ٠٨ ـ ٣٠٣

بسم الله الرحمن الرحيم

بـــلاغ مولود ميت

دولة الكويت
وزارة الصحة العامة

مسلسل البلاغ : ....

المستشفى/مركز صحى : ....

مركز التسجيل : .... نوع السجل : .... تاريخ القيد : يوم — شهر — سنة رقم القيد :

بيانات المولود

تاريخ الميلاد : أ ـ الميلادي بالارقام .... يوم — شهر — سنة ب ـ الهجرى بالارقام .... يوم — شهر — سنة

جـ ـ الميلادى بالحروف .... نوع المولود ....

وقت الميلاد : الدقيقه .... الساعه .... صباحا / مساء للولاده التواميه : عدد التوائم ترتيب المولود

مكان الولاده :١ـ مستشفى حكومى ٢ ـ مستشفى خاص ٣ ـ مركز توليد ٤ ـ منزل بمساعدة ممرضه ٥ ـ منزل بدون ٦ ـ اخرى ....

بيانات الأب

الرقم المدنى للاب الاسم

الجنسيه .... الديانه .... المهنه ....

العمر بالسنوات.. الحاله التعليميه : ١ ـ امى ٢ ـ يقرا ويكتب ٣ ـ شهاده ابتدائيه ٤ ـ متوسطه ٥ ـ ثانويه ٦ ـ جامعيه فما فوق ....

بيانات الأم

الرقم المدنى للام الاسم

الجنسيه .... الديانه .... المهنه ....

العمر بالسنوات.. الحاله التعليميه : ١ ـ امى ٢ ـ يقرا ويكتب ٣ ـ شهاده ابتدائيه ٤ ـ متوسطه ٥ ـ ثانويه ٦ ـ جامعيه فما فوق ....

محل الاقامة بالكويت : منطقة .... قطعة .... ت : ....

شارع /منزل : ....

يستوفى في المستشفى/المركز الصحي (كاتب البلاغ)

اقر بان المعلومات المذكورة بهذا البلاغ صحيحة وحقيقية بقدر معرفتي واعتقادي، الاسم ....
اثبات الشخصية .... التاريخ .... التوقيع ....

اسم كاتب البلاغ ....
التاريخ .... التوقيع ....

سبب الوفاة

ا ـ مرض او حالة مرضية اساسية في الجنين. ....

ب ـ امراض او حالات اخرى في الجنين. ....

جـ ـ مرض او حالة اساسية في الام اثرت على وفاة الجنين. ....

د ـ امراض او حالات اخرى في الام اثرت على وفاة الجنين ....

هـ ـ احوال اخرى مرتبطة بوفاة الجنين. ....

وفاة الجنين : ١ ـ قبل الولادة. ٢ ـ اثناء الولادة ٣ ـ غير معروف ....

اسم القائم بالتوليد .... التوقيع .... الصفه: ١ ـ طبيب ٢ ـ ممرضه ٣ ـ اخرى

يستوفى بمعرفة الطبيب المشرف على الولادة

النسخة الأولــى (أصفر) الاحصاءات الصحية والحيوية ـ الحاسب الآلي

بيانات فنية

١ ـ بيانات الخصوبة

مدة الحياة الزواجية منذ اول زواج (سنة)

مدة الحياة الزواجية مع الزوج الحالي بالسنوات (سنة)

عدد مرات الحمل السابق

عـدد الـولادات المبكـرة

ابناء لازالـوا احيـاء

ابناء ولـدوا احيـاء وتـوفـوا

مـواليـد مـوتـى

عـدد مرات الاجـهـاض

تاريخ اخر ولادة حية (شهر — سنة)

مدة الحمل عند الولادة الاسبوع

٢ ـ الرعاية الطبية

عدد مرات الزيارة

٣ ـ مضاعفات الحمل الطبية

القلب — ضغط الدم — الكـلى

السكر — مضاعفات اخرى — لا يوجد

٤ ـ مضاعفات مرتبطة بالحمل

ما قبل اكلامسيا — إكلامسيا

نزيف قبل الولادة — مضاعفات اخرى — لا يوجد

٥ ـ بدء الولادة

بتحريض — بدون

٦ ـ طريقة الولادة

بدون تدخل — بالشفاط — جفت واطي

جفت متوسط — جفت كيلاند — مقعد بمساعدة او بدون

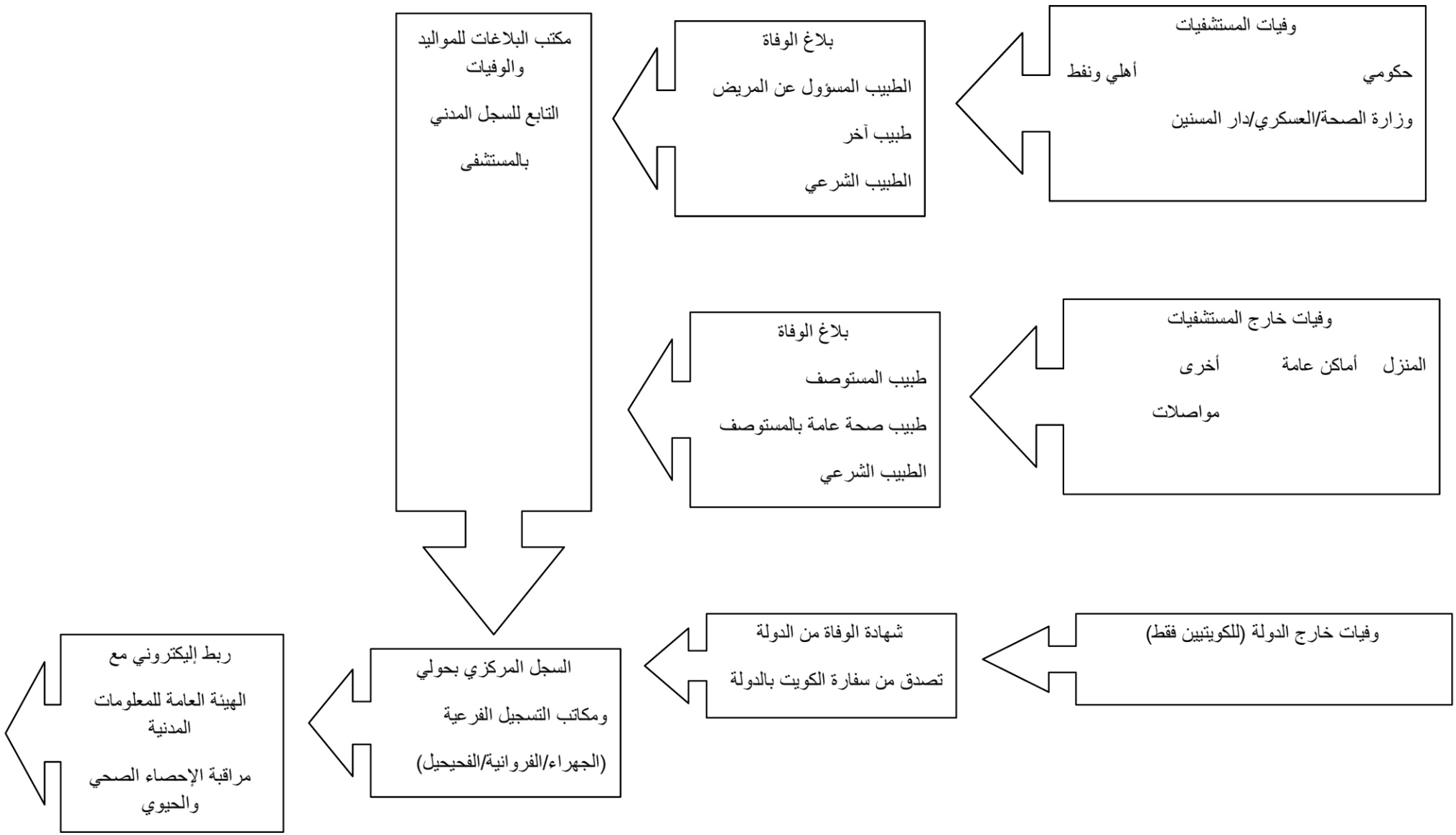
استخراج بمقعد — قيصرية اول — قيصرية مكررة

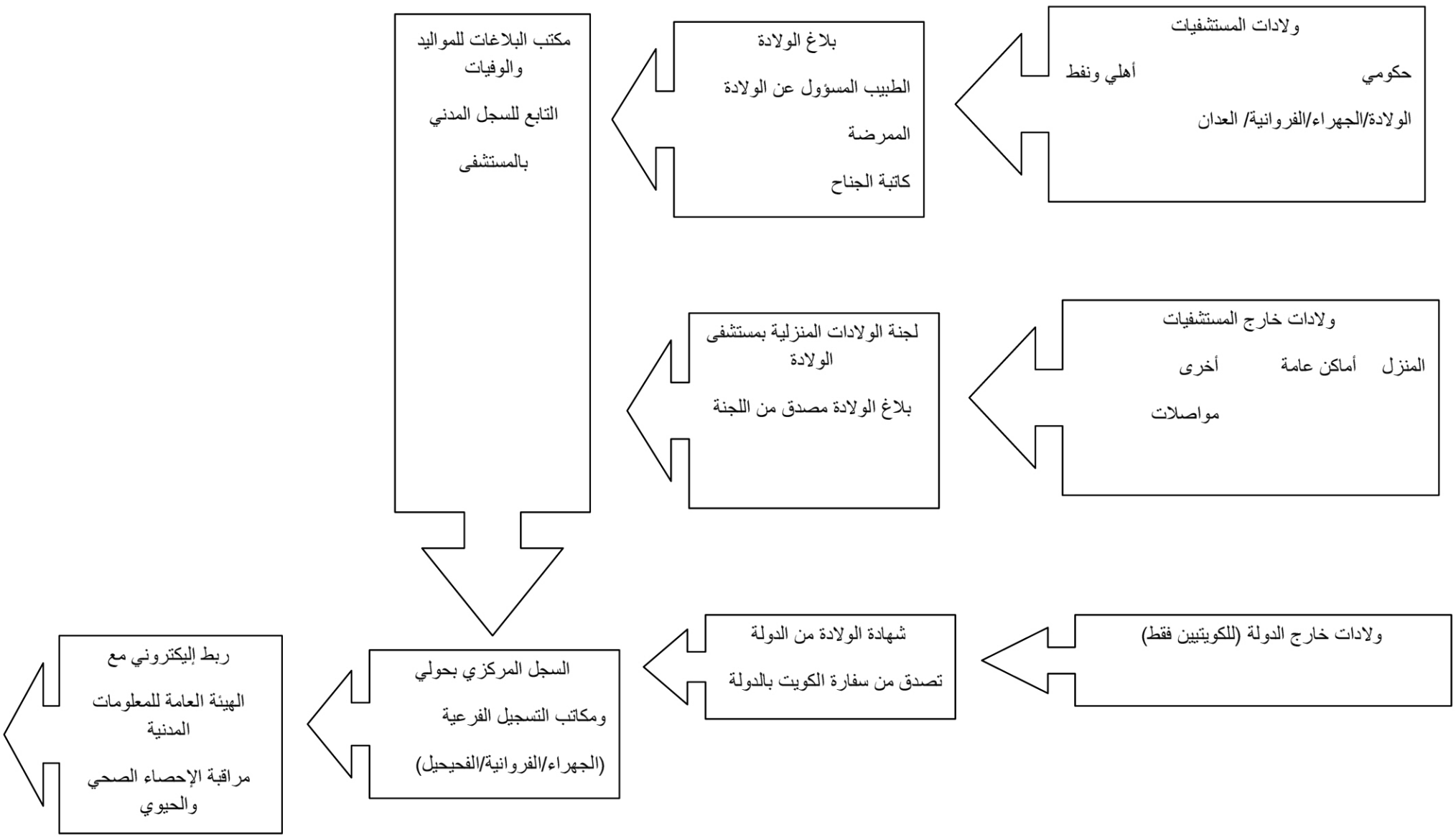
٧ ـ المضاعفات اثناء الولادة

استطالة الولادة اكثر من ٢٠ ساعة — مجيء معيب — مضاعفات الحبل السري

احتباس المشيمة — نزيف بعد الولادة — انفجار الرحم

مضاعفات اخرى — لا يوجد


وفيات المستشفيات
حكومي
أهلي ونفط
وزارة الصحة/العسكري/دار المسنين
بلاغ الوفاة
الطبيب المسؤول عن المريض
طبيب آخر
الطبيب الشرعي
مكتب البلاغات للمواليد والوفيات
التابع للسجل المدني
بالمستشفى
وفيات خارج المستشفيات
المنزل
أماكن عامة
أخرى
مواصلات
بلاغ الوفاة
طبيب المستوصف
طبيب صحة عامة بالمستوصف
الطبيب الشرعي
وفيات خارج الدولة (للكويتيين فقط)
شهادة الوفاة من الدولة
تصدق من سفارة الكويت بالدولة
السجل المركزي بحولي
ومكاتب التسجيل الفرعية
(الجهراء/الفروانية/الفحيحيل)
ربط إليكتروني مع
الهيئة العامة للمعلومات المدنية
مراقبة الإحصاء الصحي والحيوي


ولادات المستشفيات
حكومي
أهلي ونفط
الولادة/الجهراء/الفروانية/ العدان
بلاغ الولادة
الطبيب المسؤول عن الولادة
الممرضة
كاتبة الجناح
مكتب البلاغات للمواليد والوفيات
التابع للسجل المدني
بالمستشفى
ولادات خارج المستشفيات
المنزل
أماكن عامة
أخرى
مواصلات
لجنة الولادات المنزلية بمستشفى الولادة
بلاغ الولادة مصدق من اللجنة
ولادات خارج الدولة (للكويتيين فقط)
شهادة الولادة من الدولة
تصدق من سفارة الكويت بالدولة
السجل المركزي بحولي
ومكاتب التسجيل الفرعية
(الجهراء/الفروانية/الفحيحيل)
ربط إليكتروني مع
الهيئة العامة للمعلومات المدنية
مراقبة الإحصاء الصحي والحيوي

- غير ذلك (برجاء التحديد)

1-12 في حالة الاحتياج إلى طبيب، هل طالب هذا الشخص بالكشف على المتوفى قبل احتضاره؟ لا

نعم

لا

2-12 كيف تستخرج شهادة الوفاة في الحالات التي يختلف فيها الطبيب الذي يتولى كتابة شهادة الوفاة عن الطبيب المعالج؟

(برجاء التحديد) لا ينطبق

13. هل تتاح للممارسين في العادة، فرصة الاطلاع على السجلات الطبية للمستشفى والخاصة بأحد مرضاهم عند وفاته في المنزل؟
نعم , حيث لا يوجد قانون يمنع ذلك ولكن عادة تمنع المستشفيات العامه ذلك كنوع من البيروقراطية إلا ان المستشفيات الخاصة تمنع ذلك للحفاظ على السرية وتمنح الورثة فقط هذا الحق.

نعم

لا

14. هل يستخدم التشريح اللفظي بصورة روتينية لمعرفة سبب الوفاة لأي حالة وفاة لم تُعتَمَد طبياً في الدولة؟

لا , ولكن يستخدم روتينيا فى رعاية الطفوله والأمومه فقط حيث ينتدب مدير مكتب رعاية الطفوله والامومه لمقابله أقارب جميع حالات وفيات الإناث فى سن الإنجاب نتيجه أسباب متعلقه بالحمل أو الولادة أو النفاس (حتى سته اسابيع بعد الولادة) منذ 2001

نعم

لا

1-14 هل تستخدم إجراءات التشريح اللفظي، بصورة روتينية، وهل تتوافق مع معايير منظمة الصحة العالمية؟ لا

نعم

لا

2-14 هل أدخلت أية تعديلات على الإجراءت المعيارية لمنظمة الصحة العالمية بحيث يمكن تطبيقها بصورة أكبر في الدولة؟ لا

نعم

لا

(إذا كان الأمر كذلك، برجاء تحديد التعديلات)

لا ينطبق

ج4: الممارسات التي تؤثر على جودة المعلومات الخاصة بسبب الوفاة

15. لمن، سوى العائلة، تتوافر المعلومات الخاصة بسبب الوفاة (بما في ذلك توفرها عند الطلب)؟ تتوافر لدى مكتب الصحة ولا تتاح لاحد الا بامر محكمة وكذلك بجهاز الاحصاء والسجل المدنى ولكن لا تتاح .

1-15 ما هي المعلومات المتوافرة للعائلة في شهادة الوفاة: اسم المتوفى – تاريخ الوفاة – محافظة الوفاة – قسم الوفاة – عمر المتوفى – اسم الام – الرقم القومى منذ عام 2009 – الا ان المختص غالبا لا يسجل هذه البيانات.

ANS: NO DATA AVAILABLE HOWEVER A STUDY AND SAMPLING CAN BE DONE CENTRALLY AT THE DEPARTMENT

C1.11 What proportion of death certificates report the mode of death instead of the underlying cause of death?

ANS: no data available now, study in progress in the department with the approval of the MOH

C1.12 What proportion of death certificates do not indicate the interval between onset of disease and death?

ANS: 100%
This is irrelevant to local needs

Subcomponent C2: Hospital death certification

The quality of cause-of-death data will depend on the certifier's ability to diagnose diseases, knowledge of the patient's medical history, and ability to enter this information correctly on the death certificate. Certifying the correct cause of death takes experience; interns and junior doctors should only certify deaths when supervised by more experienced physicians.

C2.1 In hospitals, who completes the death certificate:

- **the attending doctor?**
- **another doctor who did not treat the deceased person before death occurred?**
- **a nurse?**
- **a medical records officer?**
- **other (please specify)?**

ANS: the death certificates are filled by any doctor available at the time of death, or by the doctor on call
Recommondations already suggested.

Attributing correct cause of death is difficult in cases when the deceased person was dead-on-arrival (DOA; i.e. was brought to the hospital but died before any medical intervention could take place). As a result, these deaths are often assigned to ill-defined causes. Some hospitals refuse to certify such deaths and refer them to coroners or special medical examiners. To assess data quality, it is important to know how hospitals certify DOA cases, and how common these cases are.

C2.2 How are cases of DOA certified?

ANS: these certified according to the hospital or the health clinics.
Either illdefine cause coded as R99 or if the death resulted from external cuses such
As RTA. In the case of suspession of criminal act referral is made to coroner.

C2.3 How common are DOA deaths in hospitals? Do they constitute:

- **less than 10% of deaths?**
- **10–20% of deaths?**
- **more than 20% of deaths?**

ANS: Less than 10%

In some countries, deaths can be registered at the hospital, either at hospital registration points or because the hospital forwards the completed registration papers to the civil registration office. These approaches are preferable to relying on individuals to go to the civil registration to register. Figure 3.2 illustrates this point, and demonstrates how certified deaths may not always be registered.

C2.4 Are the vital events that take place in hospitals registered in the country:

- **at civil registration points in hospitals?**
- **by the hospital sending forms to the civil registration office?**
- **by the individual family registering after the birth or death has occurred?**

ANS: hospitals register all vital event occurring which is done manually (hand written) and copies sent to the following:
Central registration office
The public authority for civil identification
Patients file
Relatives
The vital information section
Then relative or person concerned follow the rest of the process for issuing birth or death certificates.
The system is satisfactory but needs improvement.

Subcomponent C3: Deaths occurring outside hospital

The quality of cause-of-death data when deaths occur at home depends heavily on whether a doctor is the certifier. In some countries, family doctors certify death by writing the cause of death on plain stationery; this is not good practice. To standardize the cause-of-death information, all doctors should use the same form, which should be issued free-of-charge by the office with authority for collecting cause-of-death data.

C3.1 Is it mandatory to issue a death certificate with the cause of death indicated for people who die at home?

ANS: yes

C3.2 If so, are there any quality problems with these certificates and are they ever reviewed?

ANS: no problem specified and the reviewing in carried out centrally at the vital information division.

C3.3 Is the same cause-of-death form used for deaths in and outside hospital?

ANS: yes

C3.4 If a different form is used for deaths outside hospital, what information is recorded about the cause of death?

ANS: no difference

If cause-of-death forms can be completed by laypeople (such as village officials) or by doctors who may not have attended the deceased person, the reliability of the assigned cause-of-death will be questionable.

C3.5 Who prepares the death certificate and certifies the cause of death for people dying outside of hospital:

- **a general practitioner?**
- **a coroner or similar?**
- **a health official?**
- **a civil registrar?**
- **other (please specify)?**

ANS: either public health doctor or referred to the coroner

C3.6 If a doctor is needed, is that person required to examine the deceased person before they have died?

ANS: no, not applicable

C3.7 How are deaths certified in cases where the certifying physician is not the person who treated the patient?

Access to the deceased person's medical records will help doctors to more reliably diagnose the underlying cause of death, particularly for persons dying following long-term illness.

C3.8 Are hospital medical records usually accessible to general practitioners when one of their patients dies at home?

ANS : available upon request

When medical certification is not possible, "verbal autopsy" (see Box 3.6, below) is a viable way of obtaining information on important causes of death in parts of the country.

C3.9 Is verbal autopsy routinely used to obtain the cause of death for any non-medically certified deaths in the country?

ANS : NO

C3.10 If verbal autopsy procedures are routinely used, do they conform to the WHO standards (31)?

ANS : NO

C3.11 Has the WHO standard procedure been modified in any way to make it more applicable to the country? (If so, please specify the modification.)

ANS : NO

Subcomponent C4: Practices affecting the quality of cause-of-death data

Country practices vary as to who has access to cause-of-death information. Sometimes the part of the form containing the cause of death is sent straight to the vital statistics unit at the ministry of health or national statistics office for processing, and details are not kept by the civil registration offices. In other cases, the civil registration system records only broad causes of death, and forwards detailed data on causes of death to the office responsible for vital statistics. Countries also vary in the extent to which cause of death is considered confidential information. In some, it is considered an extension of the doctor–patient relationship and only shared with the closest family and medical authorities; in others, it is freely available.

C4.1 To whom, other than the family, is the cause-of-death information for individuals provided (including upon request)?

ANS : researchers and confidentiality guaranteed

C4.2 What information is provided to the family on the death certificate:

- **all the information on the cause-of-death form?**
- **an extract for laypersons about the cause of death?**
- **other (please specify)?**

ANS : an extract for laypersons about the cause of death

In many countries, some causes of death are widely viewed as unacceptable, either because of stigmatization, superstition or the risk of non-payment by insurance companies. Pressure from the family of the deceased may influence the doctor who certifies the death, particularly if that doctor is also the family doctor. While these influences may be difficult to prevent, it is important to understand how they might affect the quality of cause-of death data.

C4.3 Is it likely that many cases with a sensitive or stigmatizing cause of death (e.g. suicide or HIV/AIDS) would be assigned to a more socially acceptable cause of death?

ANS: YES

Infant mortality and maternal mortality are widely used indicators for assessing a country's health status and the performance of its health system. Maternal mortality is particularly difficult to measure accurately, because deaths during pregnancy are relatively rare and are often missed or misclassified to other causes. This is particularly likely to happen when the death occurs early in pregnancy (before the fact that the women was pregnant is known), or sometime after delivery (when the fact that the women had been pregnant may not be entered in the records).To avoid missing such deaths, the death certificate should include a checkbox prompting the certifying doctor to indicate whether a woman of reproductive age who died was pregnant at the time of death or had recently been pregnant. The Glossary includes definitions of "maternal mortality" and "maternal death".

C4.4 Does the death certificate state whether a woman was pregnant, or had recently been pregnant?

ANS: not on the death certificate but it is written on the death notification.

In some countries, the death registration system provides a starting point for special reviews of deaths among women of reproductive age, to identify all such deaths that might have been associated with pregnancy but were not classified as such in the death certificate. Reviews of medical records and interviews with care providers and family members are used to build a more complete picture of the circumstances leading to the death, and to permit reclassification of some deaths of reproductive women to maternal causes (32). In many hospital settings, detailed clinical audits of all maternal deaths are conducted to investigate the causes and circumstances surrounding maternal deaths, and to identify possible failings in the availability or quality of care. These audits have been effective in identifying maternal deaths and their causes; they also provide important information to guide national programmes to reduce maternal mortality. Because maternal mortality and perinatal mortality are closely linked, measurement of maternal deaths has also led to strengthened procedures to measure perinatal mortality.

C4.5 Are maternal deaths reviewed separately from other deaths?

ANS : yes in the mortality committee in each hospital.

C4.6 Are perinatal deaths monitored using a special form, as recommended by the WHO?

ANS : YES

If doctors have received little training in how to correctly complete the death certificate, and are not aware of its importance for public health purposes, they will be unable to certify deaths reliably and accurately.[5]

C4.7 What training and practice do doctors receive in certifying the cause of death:

- **none?**
- **one lecture in medical school or at the hospital?**
- **an ICD-compliant training course on certification?**
- **on-the-job training?**
- **other (please specify)?**

C4.8 Would most doctors be aware of the important public health uses of the information they provide on the death certificate?

ANS: not known.

One way of assessing the quality of death certification is to select a random sample of about 1% of hospital death certificates, and conduct an independent verification of the cause of death using the full set of hospital medical records for the deceased persons. If there are significant differences in the underlying cause of death between the original and the later sources, this indicates the need for retraining of doctors and stricter hospital processes for certifying cause of death. Such evaluations should always be accompanied by an analysis of types of error, so that they can be targeted in the follow-up training.

C4.9 Has the country evaluated the quality of medical certification?

C4.10 If yes:

- **When was the evaluation done?**
- **How was it done?**
- **What did it conclude?**
- **What follow-up was undertaken to improve certification practices?**

Because there is often more than one condition present at the time of death, doctors need full access to the patient's medical records, as well as technological and other diagnostic aids in order to be able to correctly diagnose the underlying cause of death.

C4.11 Are hospital medical records generally:

- **complete?**
- **reliable?**
- **easily accessible to the certifier?**

ANS : YES

C4.12 Are other health records, such as from health clinics, general practitioners or family doctors:

- **complete?**
- **reliable?**
- **easily accessible to the certifier?**

ANS : YES

Although the ICD provides special instructions on the classification of unnatural deaths, individual countries decide who should be responsible for their certification. Because certification of these deaths is often delayed through judicial investigations (see Box 3.5), they may be missed by the vital statistics system. The diagram prepared on this topic (see subcomponent C1) should be used for the discussion.

C4.13 Who certifies whether the cause of death is unnatural (i.e. accident, suicide or homicide)?

ANS : MUST BE A MEDICAL DOCTOR BY LAW

C4.14 If there is a special system for certifying these deaths, please describe how this works and how well it works.

ANS: only if there is a criminal suspicion referral is made to coroner or coroner called to the scene of event

When injury, poisoning or certain other consequences of external causes is the cause of death, the certifier must also describe the circumstances of the incident or accident that led to death. Moreover, the certifier should select this original incident or accident as the underlying cause of death and code it according to Chapter XX of the ICD (V01-Y89). The type of injury or poisoning (Chapter XLX of the ICD Codes S00-T98) may be used as an additional code but should not be reported as being the underlying cause. Some countries have a separate box on the death certificate to report on the circumstances surrounding such violent or unnatural deaths.

C4.15 Are certifying doctors aware of how to report deaths from injuries and external causes according to the ICD rules?

ANS : no special training is needed.

Component D – ICD mortality coding practices

Subcomponent D1: Mortality coding practices

Countries are strongly advised to use the alphanumeric codes of the ICD classification for coding and classifying deaths, and to use the latest version of the ICD, which is currently the 10th revision, 2nd edition (ICD-10) (28). If this ICD version is not being used, it is important to discuss the specific steps required to upgrade to ICD-10. Correct application of the ICD will be easier if a version is available in one (or more) of the national languages. It is particularly important to compile a list of locally used medical terms, and include this in the alphabetical index volume (see Volume 3 of ICD-10).

D1.1 Is the ICD used for cause-of-death statistics?
Yes

D1.2 If so, which revision and edition is currently being used?
Revision ICD 10 edition 2

D1.3 Is a national-language version of the ICD used?
No we use the English, it is the second spoken language in Kuwait.

D1.4 Who is responsible for coordinating the implementation of the ICD?
Centrally at Health and vital statistics division, Health information and medical record department, Ministry of Health.

D1.5 Who is responsible for training ICD coders?

Centrally at Health and vital statistics division, Health information and medical record department, Ministry of Health.

The basic ICD classification is a list of three-character categories, each of which can be further divided into up to 10 four-character subcategories. When coding skills and resources are limited, it is useful and sometimes necessary to code to a less detailed summary list of categories. Although summary lists reduce the precision of coding (because each category represents a group of diseases rather than a single disease or injury entity), using these larger aggregates tends to diminish the public health impact of diagnostic and coding errors, and improve comparability. Volume 1 of the ICD-10 contains recommended tabulation lists intended for use in circumstances where the three-character list is too detailed.

D1.6 Are the codes selected for cause-of-death reporting chosen from the complete ICD list, or is coding done from a summary tabulation list of the ICD?
Complete ICD list.
D1.7 If a summary list is used, which list is it?
Not applicable.

In-depth knowledge and understanding of the purpose and structure of the ICD are vital for statisticians, analysts and coders if they are to interpret and code the information on the cause-of-death certificate correctly. Application of the ICD principles and correct use of the selection rules by all coders is crucial to accurately identify the main causes of death in populations and allow international comparisons.

D1.8 Are coding and ICD selection rules for underlying cause-of-death data applied?

Yes

In some countries, mortality coding is done centrally, often in the ministry of health or national statistical office; in other countries, coding is done in hospitals where the death occurred. Centralized coding of cause of death facilitates the application of common standards and procedures, it is also likely to make error detection and correction easier. In decentralized coding systems used in hospitals, it is easier to access the patient records in case of doubt about the certification, but it is difficult to avoid a certain amount of local interpretation, which could well result in national data inconsistencies.

D1.9 Is mortality coding centralized or decentralized?
Centralized and it is of great advantage since Kuwait is a small country.
D1.10 If coding is decentralized, what quality measures and procedures are in place to ensure national consistency in the application of ICD coding rules?
Not applicable.

To verify and select the correct underlying cause of death, coders should have access to all the information provided on the death certificate. It is not good practice to provide coders only with the cause of death reported by the certifier. Rather, the coder should have access to the original death certificate form, and to all the diseases and injuries reported on the form. This facilitates the selection of the underlying cause of death, and makes it possible to apply the modification tables from the Automated Classification of Medical Entities (ACME). It also allows multiple-cause-of-death analysis.

D1.11 Is cause-of-death coding done from a copy of the original death certificate or from a transcribed list provided by the civil registration office, or from some other summary document?
It is done using (Death Notification Form) and not from original death certificate or from a transcribed list provided by the civil registration office in fact there is no transcribed list provided by the civil registration.

D1.12 Is all the information on the death certificate coded, or only the presumed underlying cause of death?
All information present in the notification of death are coded beside the presumed underlying cause of death.

In cases where the death certificate does not provide enough information for the coder to select the underlying cause of death, or where the information reported is incorrect, a system for querying doctors for further information is needed.

D1.13 Is there an established mechanism to query the certifier (doctor) in cases where the coder cannot understand or interpret the reported causes of death on the certificate?
Yes there is.

D1.14 If so, please describe these procedures and discuss their efficacy.
In case of any queries Health and vital statistics division will call the questioned hospital (statistics department) and wait for the feedback and this procedure work mostly all the time.

Subcomponent D2: Mortality coder qualification and training

Compile a list of the ICD training courses that have been offered in the last 3 years. As far as possible, include a summary list of the subject matter taught (see Box 3.7).

In some countries, coding is done by the same physicians who certify the cause of death. More commonly, coding is done by administrative clerks and statisticians who have been specially trained for this task; this is preferable because it fosters the development of a specific cadre of specialized coders who have in-depth knowledge of the ICD rules and procedures.

D2.1 What categories of staff (e.g. physicians, statisticians, and health professionals) are doing mortality coding in the country?
Physicians with public health qualifications in the central office.

D2.2 What level of education do mortality coders typically have?

Post graduate training in **Public Health (specialist)**

All coders should follow a formal training course on correct coding of death certificates. On-the-job training is important, but training courses with standardized curricula ensure consistency of knowledge transfer. It is useful to compare the country's coder training with the sample curriculum shown in Box 3.7. The material on training prepared in advance should be used in the discussion of these questions.
To ensure consistency in levels of skills, training curricula and courses should be standardized nationally. Senior ICD trainers are required for local sustainability of coding skills.

D2.3 Are specific training courses provided for mortality coders or do they learn on-the-job?
learn on-the-job (In fact they are WHO trainers) currently the mortality coding is being done by public health specialists who receive academic and professional training
D2.4 If coders are specifically trained to code:

- **Are there sufficient local ICD trainers to meet the needs?**
- **Who is responsible for delivering the training?**
- **What is the length of training and is there a standard curriculum?**
- **How often is coder training conducted?**

As mentioned, above our coders are public health consultants.

To avoid a high turnover of coders, their skills and qualification should be formally recognized, with diplomas issued for the professional titles bestowed as a result of successful training. Career paths are important for retaining trained coders.

D2.5 Is there a high turnover among coders?
No

D2.6 Are coders recognized within staffing structures as a separate cadre, and are coding qualifications recognized separately to other administrative officers?

No

The WHO Collaborating Centers Network for the Family of International Classifications[6] ("WHO-FIC") regularly offers training courses in ICD coding. Additional training in medical terminology and medical science can improve the skills of coders. Training is also required for coders when applying new versions of the ICD, or when the local adaptation of the ICD has been changed.

D2.7 Are there local senior trainers who have been trained at WHO-FIC supported training courses?
No

D2.8 Do coders have opportunities for ongoing education?
Note they are already of high level in their field

Box 3.7 Summarized training curriculum for coders

As a result of collaboration between WHO-FIC and the International Federation of Health Records Organizations (IFHRO), a core international curriculum has been developed for use in training coders. The curriculum provides a standard basis for education in all countries. A nine-module training course is recommended, as outlined below.

Module	Intent
1–Knowledge of basic medical science	To develop an understanding of the medical terminology that will be encountered in cause-of-death statements, of the structure and function of the human body, and of the nature of disease.
2–Legal and ethical issues relevant to the country in which coding is being conducted	To introduce the legal and ethical issues applicable to health information, its collection and release.
3–General use of underlying cause-of-death data	To explain the purpose for which underlying cause-of-death data are collected and how they are used.
4–Specific use of underlying-cause-of-death data	To introduce the specific use of coded mortality data.
5–Users of mortality data	To explain the different groups and stakeholders who are users of mortality data.
6–Sources of mortality data	To explain the roles of all the different people responsible for reporting data on the deceased, and the sources of that data.
7–The ICD	To develop an understanding of the ICD and to develop the knowledge and skills that are necessary to assign valid codes for. cause of death.
8–How to code	To provide detailed instruction and practice on how to apply the coding rules and assign codes.
9–Quality assurance	To raise awareness of the various factors that influence the quality of coded data, and to describe techniques for ensuring the highest quality data possible.

Subcomponent D3: Quality of mortality coding

Having the right tools is vital for good coding. Coders should work from a copy of the three ICD volumes – Tabular list, Instruction manual and Alphabetical index – to ensure proper code allocation. Many countries also use the ACME decision tables to help coders to select the correct underlying cause. Use of these tools also ensures that all coders consistently assign the same code to the terms used on the death certificates.

D3.1 Do all coders have a complete set of ICD volumes available to them when they code?
Yes
D3.2 Do all coders have a set of the ACME decisions tables?
No

Annual updates to the ICD codes and coding practices are determined by WHO-FIC and routinely posted on the WHO web site for the ICD. Keeping up-to-date with these revisions helps to ensure international comparability of the data.

D3.3 Do you regularly check:

- **the ICD web site[7] for updates to codes and coding practices?**

Yes

- **the department of health's web site for updates on coding practices?**

Yes

Poor coding practices detract from the utility of cause-of-death data and are a waste of resources. To ensure good quality coding, the work of coders should be systematically and periodically evaluated, to identify and correct any systematic errors or problems with coding practices.

D3.4 What processes are in place to assess the quality of cause of death coding, and how frequently is this assessed?

Causes of death are cross checked with gender, age, marital status, etc. This is done quarterly and annually (5 times/ year)

D3.5 Has the quality of mortality coding ever been evaluated?

It is evaluated by using the percentage of ill defined causes and the R codes.

D3.6 If so, was the level of accuracy deemed satisfactory? What systemic issues were identified?

Yes, R codes represented less than 2% during the last 10 years, ongoing we are exploring the ill defined causes.

D3.7 What mechanisms are in place to provide feedback to coders on the quality of coding, and to correct the problems and issues identified through evaluation and practice?

It is not applied to Kuwait as coding is centrally done by qualified public health physicians.

Component E – Data access, use and quality checks

Subcomponent E1: Data quality and plausibility checks

Supporting material to be prepared in advance:

- **Tabulations of relevant vital event data from other sources (e.g. censuses with birth and death questions, demographic and health surveys (DHS) and other national surveys). Calculations of birth and death rates from these sources compared with birth and death rates derived from civil registration (see Box 3.8).**
- **Calculations of the percentage distribution of deaths for the latest available year according to three broad cause-of-death groups I, II and III, as shown in Box 3.10.**
- **Calculations of the percentage distribution of deaths for the latest available year according to cause of- death groups I, II and III within 5-year or 10-year age intervals (see Box 3.11).**
- **Calculation of the percentage of deaths by age and sex being assigned to ill-defined cause-of-death categories.**

Subcomponent E1 (A): Levels of fertility and mortality

The best way to check the plausibility of vital statistics is to convert them into birth and death rates or ratios. Consistency checks should always be carried out both on the raw data and on key indicators (e.g. birth and death rates) before they are used or made more widely available. This can be done simply by comparing the raw data, and the rates derived from them, to corresponding figures from previous years. Major changes in numbers or rates are unlikely from year to year and should be investigated.

E1.1 Are fertility indicators (e.g. crude birth or fertility rate, age-specific fertility rate and total fertility rate) routinely calculated from the civil registration and vital statistics data?

Yes, calculated by both C.R. (population)and V.S. (Rates) CBR, CDR, TFR, MMR, GRR, LE, ASFR.

E1.2 If so, which indicators are calculated?

All morbidity and mortality rates (Kuwait health indicators) (

E1.3 Are mortality indicators (e.g. crude death or mortality rate, age-specific mortality rate, infant mortality rate, neonatal mortality rate and maternal mortality rate) routinely calculated from the civil registration and vital statistics data?

Yes, calculated by both C.R. and V.S.

E1.4 If so, which indicators are calculated?

All morbidity and mortality rates (Kuwait health indicators) LB,SB,ID, D all ages, according to nationality and gender, PMR, MMR.

EXCEPT.....Neonatal survival rate need to be updated (suggested survival starting from 25 weeks instead of 28 weeks)

E1.5 What data sources are used as the denominators to calculate these rates?

PACI, MOH, Statistical Regional Offices

E1.6 Describe the plausibility and consistency checks that are carried out on the data and indicators before they are released for use (see Box 3.9).

All data are consistent, plausible, more correct (e.g. mother pregnancy age previously was <15 yrs but now No female ages <15 yrs) CR, VS

It should not be assumed that, just because a country has a vital statistics system, the data the country produces are accurate. There are many potential sources of error in the vital statistics, including under-registration, age misreporting of deaths, and incorrect certification and coding of the underlying cause of death. Therefore, countries should carry out a range of consistency checks to identify possible sources of error in the data. This knowledge (e.g. about under-registration of deaths) will guide efforts to redress the problems.

E1.7 Are the civil registration and vital statistics data used to investigate variations in fertility and mortality within the country? If so, describe how this is being done.

Yes, very consistent/correct history data since 1993 by which health policy & decision making was accurate and supportive to improve Kuwait public health

E1.8 Are fertility rates derived from civil registration and vital statistics compared with rates derived from other sources?

Yes; total population for MO, PACI is different by 0.5 million higher than Central Census calculation

E1.9 Are mortality rates derived from civil registration and vital statistics compared with rates derived from other sources?

Yes; total population for MOH,PACI, CSB

In countries lacking reliable vital statistics systems the investigation of fertility and mortality is particularly important. If the completeness of vital registration data is less than about 90%, the UN advises countries to include both fertility and mortality questions in the census. Estimates of fertility and mortality derived from census data, however, are approximate and subject to various errors, and should be adjusted using standard demographic techniques (19). Nonetheless, these data can be useful for estimating the completeness and overall performance of vital registration.

E1.10 Did the last census include a question on births or deaths; for example:

- **Number of children ever born alive and still alive?**
- **Date of birth of last child born alive?**
- **Whether the last birth was registered?**
- **Whether the last death was registered?**
- **Deaths in the household in the past 12–24 months?**

NO (ALL answers can be observed from MoH and C.R.)

E1.11 If so, have the data been analysed and compared with the vital statistics data?

--

Other sources (e.g. church, cemetery, police, village records and different administrative databases) can be used to complete and verify vital registration data, through matching of births and deaths.

E1.12 Are other sources used to complete and verify birth and death data?

--

E1.13 If so, describe these. --

Box 3.9 Standard plausibility and consistency checks

It is useful to carry out standard plausibility or consistency checks on the vital statistics by combining or aggregating the data into standard 5-year age groups. For fertility, births should be grouped according to age of mother, namely <15 years, 15–19 years, 20–24 years, … , 45–49 years and 50+ years.

For mortality, deaths should be aggregated into the following age groups: <1 year (i.e. died before reaching the first birthday), 1–4 years, 5–9 years, 10–14 years, …. , 80–84 years and 85+ years. Wherever possible, deaths should be tabulated up to age 100 in 5-year age groups.

Age-specific fertility rates (for ages of the mother shown above) and age-specific mortality rates (for the ages at death shown above) should be calculated separately for males and females. An estimate of the mid-year population by age and sex is required to calculate the rates.

Based on these aggregate numbers of deaths (and births) by age, and on the age-specific birth and death rates, countries should calculate the metrics listed below from their vital statistics data, and should carefully review their findings to make a preliminary assessment of the quality of their vital statistics data.

Calculate the ratio of male births (B (m)) to female births (B (f)). This ratio should be about 1.05. Significant departures indicate underreporting of births for either males or females, with the latter being the more likely. The pattern of age-specific fertility rates should show a peak level for women aged 25–29 or 30–34 years, and decline thereafter.

Calculate the crude death rate (reported deaths × 1000/total population size). The rate should be about 5–10 per 1000. Crude death rates below 5 per 1000 should be viewed with suspicion. (Note: the crude death rate should not vary by more than about 3–5% each year. Annual variations greater than this amount should be investigated.)

Plot the log of the age-specific death rate at each age. The graph should show a high rate at ages 1 year and 1–4 years, a trough at ages 5–14 years, a small bump at ages 15–34 years (due to accidents in males, and to maternal mortality and accidents in females), and a consistent increase (seen as a straight line) from about the age of 35 years onwards. Departures from this linear trend with age suggest underreporting or misreporting of age at death.

For comparisons of fertility and mortality rates within and between countries, it is important to standardize for differences in age distributions (*24*).[6]

All opportunities should be used to further check the plausibility of the vital statistics data, by comparing the fertility and mortality rates from civil registration data with those derived from other sources. Major differences in rates or ratios should be investigated. Rates derived from other sources (such as DHS or UNICEF's multiple indicator cluster surveys (MICS) or some other health or demographic survey) should be used as comparators (see Box 3.8).

Subcomponent E1 (B): Cause of death

A frequently used indicator of the quality of cause-of-death data is the percentage of all deaths for which the cause is classified as ill-defined (Chapter XVIII of the ICD-10). Ill-defined causes are of no public health value. Also, where they are common, they will make the cause-of-death distribution unreliable, because true causes of death are hidden and hence underestimated. Generally, the percentage of deaths for which the cause is ill-defined should be less than 10% at ages 65 years and over, and less than 5% at ages below 65 years. If the percentage of ill-defined causes has declined significantly, caution must be exercised when interpreting trends in specific causes (such as cancers or heart disease), because changes in death rates from these causes may be largely or entirely due to a redistribution effect from ill-defined to more-specific causes. The need to reduce ill-defined causes of death should not force the certifying doctor to give a defined cause in all instances: there will inevitably be occasions when a cause of death cannot be indicated with precision. Such, "unknown" causes (code R99) should be measured and tabulated separately, and should not constitute more than about 2–3% of all deaths.

E1.14 What is the proportion of all deaths allocated to ill-defined categories? (See Annex 1 of Volume 2 of ICD-10 and Section 4.1.10 of ICD-10, Rule A on Senility and other ill-defined conditions.)

R code (< 2%) (reference=end of table 40; Kuwait, Health 10)

E1.15 Has the proportion of deaths allocated to the ill-defined categories changed over time?

~ 2.1 - 2.5% within the last 10 years

E1.16 What is the proportion of unknown causes of death among all deaths?

R 99 (< 1%)

Apart from exceptional cases (e.g. HIV/AIDS or other high-mortality epidemics), national cause-of-death patterns do not change significantly in the short term. Simple percentage distributions of deaths by cause

will reveal unexpected deviations in patterns of causes of death that should be further investigated. Breaks in series due to ICD version changes may also cause variations, and need to be noted. There is little that can be done to correct for discontinuities caused by changes to the ICD other than conducting in-depth comparability studies, but care should be exercised when interpreting such changes because they are unlikely to be due to real increases (or decreases) in disease rates.
Checking the annual numbers of deaths assigned to specific causes can be sufficient to identify major changes in the use of cause-of-death categories from one year to another. Such changes should not occur without a good reason (e.g. a natural disaster) and should be investigated. It is also important to carry out this consistency check at different levels of data aggregation, particularly for major administrative groups of the country. This will enable users to detect whether the quality of reporting at a local level has changed from one year to another. If so, this should be investigated.

E1.17 Is the consistency of the national cause-of-death pattern checked over time, including disaggregation comparisons?

Yes (checked over time)

There is a close and predictable relationship between causes of death and life expectancy, which has been validated by long time-series from many different settings. As life expectancy increases, the proportion of communicable, maternal and perinatal causes decreases, while the proportion of noncommunicable diseases (such as heart disease and cancer) increases. These relationships should be used to check the plausibility of the cause-of-death pattern provided by the vital statistics system.

E1.18 Does the overall cause-of-death distribution seems plausible, e.g. does it fit the expected disease and injury patterns given current national levels of life expectancy (see Box 3.10)?

Yes (analyzed at hospital levels e.g. Razi Hosp)

Broad causes of death, such as communicable or non-communicable diseases and injuries, show a predictable pattern at different ages. Significant departures from this pattern suggest problems with the quality of vital statistics and can be used to check for plausibility.

E1.19 Is the age pattern of causes of death obtained from civil registration for major disease groups and injuries consistent with expected patterns? (see Box 3.11)

No comment (Dr Ali Sadek)

It is common for deaths to be certified to vague causes within broad-cause categories. For example, a death may be certified as due to heart failure, arteriosclerosis or some other vague diagnosis. Cancer deaths may be certified to an ill-defined primary site of cancer or to no specified primary site. Understanding the dimensions of such certification practices is important. Both certifying doctors and coders frequently use the three categories referred to below in E.1.20, but they are of limited public health value. In such circumstances, it is important to consult the patient records or to check with the treating physician, to obtain additional information that can be used to correctly certify and code the death.

E1.20 Further checks on the quality of cause-of-death data can be made using the three measures below. In properly functioning systems with good death certification, the percentage of all cardiovascular, cancer or injury deaths assigned to these codes should not exceed about 10–15%.
No comment (Dr Ali Sadek)

- **What is the proportion of cardiovascular disease deaths assigned to heart failure and other ill-defined heart-disease categories (ICD-10 codes I472, I490, I46, I50, I514, I515, I516, I519, I709)?**
- **What is the proportion of cancers with an ill-defined primary site (ICD-10 codes C76, C80, C97)?**
- **What is the proportion of injury deaths that are of undetermined intent (ICD-10 codes Y10- Y34, Y872)?**

Box 3.10 Percent of deaths expected from three broad cause-of-death groups (I–III) as a function of increases in life expectancy

	Broad cause-of-death groups			
Life Expectancy (years)	Group I (%)	Group II (%)	Group III (%)	Total (%)
55	22	65	13	100
60	16	70	14	100
65	13	74	13	100
70	11	78	11	100

Group I: Communicable diseases, maternal, perinatal and nutritional conditions (ICD-10 codes A00–B99, G00–G04, N70–N73, J00–J06, J10–J18, J20–J22, H65–H66, O00–O99, P00–P96, E00–E02, E40–E46, E50, D50–D53, D64.9, E51–64)

Group II: Noncommunicable diseases (ICD-10 codes C00–C97, D00–D48, D55–D64 (minus D 64.9) D65–D89, E03–E07, E10–E16, E20–E34, E65–E88, F01–F99, G06–G98, H00–H61, H68–H93, I00–I99, J3–J98, K00–K92, N00–N64, N75–N98, L00–L98, M00–M99, Q00–Q99)

Group III: Intentional and non-intentional injuries (including homicide and suicide)(ICD-10 codes V01–Y89)

The table above shows how the relative importance of different broad causes of death changes as the average life expectancy of a population increases. Three broad cause groups are shown:

- Group I – Infectious and parasitic diseases, maternal and perinatal and nutritional causes.
- Group II – Cancers, heart disease, stroke, chronic lung, liver and other noncommunicable diseases, and mental health conditions such as schizophrenia.
- Group III – Injuries, such as accidents, homicides and suicides.

At each level of life expectancy, the typical distribution (as a percentage) of deaths that one might expect to find is shown in the table above. For example, a country with an average life expectancy of 55 years would typically have about 22% of deaths due to group I diseases, and about 65% due to group 2 (i.e. noncommunicable diseases such as cancer, heart disease and stroke). A country with lower mortality and higher life expectancy (e.g. 65 years) would expect a smaller percentage of deaths from group I causes (13%) and a higher percentage from group II causes (74%). In other words, as the life expectancy in a country improves, the relative importance (percentage of deaths) of group I diseases declines, due to better infectious diseases control; hence, more people can be expected to die from noncommunicable diseases or even injuries.

In using this table, first situate the country according to the most recent life expectancy estimates, then interpolate between the percentage distributions in the table to estimate the expected percentage of deaths from groups I, II and III. The expected distribution should be compared to the observed distribution of deaths as calculated from the vital statistics to determine the plausibility of the observed cause-of-death pattern across the three groups. All ill-defined causes should be ignored when making comparisons.

Subcomponent E2: Data tabulation

The UN recommends that vital statistics be compiled according to date of occurrence. However, in many countries, birth and death statistics are compiled according to date of registration because this is simpler than re-allocating events to the year of occurrence. Vital statistics tabulated by date of registration can be misleading, particularly if a large number of delayed births and deaths are registered as a result of periodic registration campaigns.

E2.1 Are births and deaths compiled according to date of occurrence or to date of registration?

Yes (date of occurrence or event-based)

Place of occurrence is usually the geographical location (locality/town) where the birth or death took place. For policy and services planning, it is also important to know the place of usual residence of the parents, or of the deceased in case of death registration.

E2.2 Are births and deaths compiled according to place of occurrence as well as place of usual residence?

Yes (place of occurrence or event-based)

All mortality data should be tabulated separately by age, sex and underlying cause of death. The probability of dying varies substantially at different ages for men and women but can also vary substantially within a country between different regions. Each country should decide what geographic disaggregation of birth and death statistics is appropriate for its policy and planning needs.

E2.3 At what level of disaggregation are the birth data tabulated? Report separately for:

- **sex;**
- **sex, and age of mother;**
- **sex, age of mother and subregion, PACI**

E2.4 At what level of disaggregation are the deaths and cause-of-death data tabulated? Report separately for deaths and cause of death for:

- **sex;**
- **sex and age;**
- **sex and subregion;**
- **sex, age of mother and subregion cause of death, ICD-10 (103 causes).....PACI**

The risk of death varies significantly by age, and death statistics should always be complied according to the age at which death occurred. Countries should use the WHO standard age groupings to do this.

E2.5 Are standard WHO age groups used to tabulate mortality and cause-of-death data?

Yes (different WHO age-groups can be used e.g. <1month, <1yr, 1-**5yr,...etc.)**

Subnational tabulations are important for revealing geographical inequalities in heath status with implications for health-services planning.

E2.6 What is the smallest subnational level used for tabulating vital statistics? Is this appropriate given the potential uses for disaggregated data?

- **Households (also blocks, governorates)**
- **Yes, such tabulated vital statistics by which can analyze/assess/compare/improve community public health in Kuwait**

Standard tabulation lists are useful for comparing trends in diseases and health status across different populations and time periods.[9] WHO requests countries to report data according to the four-character ICD level.

E2.7 Are any of the four standard mortality tabulation lists suggested by the ICD used for data presentation purposes? Yes (?)

E2.8 If not, which condensed list is used? How was this list derived?

Public health authorities usually want information on the diseases that cause the most premature deaths. Statistics on leading causes of death should always be shown separately for men and women.
The level of disaggregation used for the cause-of-death database will influence the ranking of selected diseases and injuries. Comparisons between countries should only be made using comparable ranking lists. Ill-defined causes should not be included when ranking causes of death but shown separately and not included with the residual or other causes category.
Some countries include deaths of nationals currently residing outside the country who die overseas in tabulations. If this is the current practice, these deaths and all nationals should be included in the national population estimates when calculating rates.

E2.9 Are data compiled into 10 leading causes (separately for men and women and children)?

Yes

E2.10 From which list are the 10 leading causes selected?
ICD-10 Disease Classification

E2.11 Are ill-defined causes included in the ranking as a category?
ICD-10 Disease Classification table 40-41 (1-103)

E2.12 What proportion of deaths is accounted for by the 10 leading causes of death?
< 2%

Subcomponent E3: Data access and dissemination

Supplementary material to be prepared in advance:

- **Compile a list of publications and information products available that use the vital statistics.**

The main data users should be involved in determining the most appropriate cross tabulations and regional breakdowns of the vital statistics data that are relevant to their needs. It is important to solicit feedback from users about the relevance, utility and quality of vital statistics. There is little point in producing data that are not used, or are regarded as unnecessary.

E3.1 Who are the main users of the vital statistics:

- **within government?**
  MOH, PACI, Cabinet Council, KISR, University, Public Institutes, MOI, MO of Planning

- **outside the government?**
  WHO, EMRO

E3.2 Is there an engagement strategy to regularly discuss data needs with the main data users? If so, describe this.
Yes, according to any new medical/health disabilities

E3.3 Is it possible to provide an example of how vital statistics have been used to guide policy and practice?
Used in ASSESSMENT of old and PLANNING of new Medical Care and Health System Programmes

Timeliness of data is one of the quality criteria that users rate most highly. This is particularly important for local level and small-area data. Data-release dates are important both for producers and users. Keeping to release dates allows users to plan their work around availability of vital statistics.
Understanding of vital statistics can be facilitated by issuing brief analytical reports based on the data. For example, reports that give a brief account of significant changes in mortality levels, or differences by sex, or trends in leading causes of death are extremely useful. The principal purpose of such reports is to summarize the key messages from the vital statistics for policy use.

E3.4 What is the time from the end of the reporting period (e.g. end of calendar year in which births and deaths occurred) to the dissemination of:

- **birth and death statistics?**
- **cause-of-death statistics?**

Every March/annually (PACI & MOH)

E3.5 Are analytical reports about birth, deaths and causes of deaths derived from vital registration produced? If so, include examples.
Yes (MOH) Health, Kuwait

E3.6 Is there a data-release schedule?
Annual & Quarterly (Q1 – Q4)

To be useful, data have to be accessible to as many legitimate users as possible, preferably in both print and electronic form. Every effort should also be made to ensure that data are available to users at minimal cost. The more the data are used, the more feedback will be received about their quality.

E3.7 Are vital statistics made available to users as:

- **print?**
- **electronic files?**
- **web sites?**
- **pdfs?**
- **interactive tables?**

MOH & C.R.

E3.8 Are the vital statistics available free of charge or at a cost? Please explain.
Booklet hardcopy = 3 K.D.
Online = free

Official vital statistics should be published annually by a trustworthy government source. The correct use and understanding of the data depends on supplying information about the data ("metadata") along with the data themselves. These metadata ensure that the data are interpreted appropriately by the end users.

E3.9 What agency publishes the official vital statistics?
MOH & PACI

E3.10 How regularly are the data published or released?
Annual & Quarterly (Q1 – Q4)

E3.11 Are all definitions and concepts used in vital statistics publications clearly explained?
Yes

It is important for producers of the data to also be users of the data. As well as building essential analytical capacity (and providing quality checks), producers who are also users will help to build the case for improving the quality of vital statistics as their potential value will be better appreciated by those who collect them.

E3.12 What analyses are being routinely carried out on the data (e.g. fertility patterns, mortality differentials, disease mapping, etc.)?
Yes (PACI is processing GIS disease mapping for routine use)

E3.13 Along with the statistical tables, are analyses of the data published regularly?
Yes

E3.14 How are these data being used at various levels?
Policy makers, Health care planning (through MOH, PACI)

E3.15 Is there any attempt to build analytical capacity among staff who collect and compile vital statistics to perform basic analyses of the data to help them better understand the value and purpose of the data which they collect? If not, how could this be achieved?
Still none; need highly qualified statisticians (linked to WHO and experiences from developed countries field experts)

e.g. Regular meeting between PACI, MOH, Census CSP, University researchers,…followed by presenting results/recommendations to WHO for progress follow-ups.