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Measuring Access to Reproductive Health Services

Summary Report
of a WHO/UNFPA
Technical Consultation
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Department of Reproductive Health
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Contents

Background

The International Conference on Population and Development (ICPD) was convened in 1994 under the auspices of the United Nations (UN). It was the largest intergovernmental conference on population and development ever held, with participants from governments, UN specialized agencies, international, intergovernmental and non-governmental organizations, and the media. Delegations from 179 countries took part in negotiations to finalize a Programme of Action for improvements in the area of population and development for the next 20 years.

The Programme of Action, adopted on 13 September 1994, endorsed a new strategy that emphasized the close links between population issues and development and focused on meeting the needs of individual women and men, rather than on achieving demographic targets. A number of population and development goals, related to, *inter alia*, education, reduction of infant and maternal mortality, gender equity and equality, and universal access to reproductive health care, were recommended to the international community. The goal related to universal access to reproductive health care called on countries to make reproductive health accessible through the primary health care system "to all individuals of appropriate ages as soon as possible and no later than 2015" (Annex 1).

In 1999, the UN General Assembly convened a special session to review progress towards the ICPD goals. The session, commonly known as ICPD+5, agreed on a set of targets, including two related to the goal of universal access to reproductive health care (Annex 1).

In September 2000, the UN organized a Millennium Summit, during which countries reaffirmed their commitment to work towards development and the elimination of poverty by unanimously adopting the United Nations Millennium Declaration. The General Assembly recognized the Millennium Development Goals (MDGs) as part of the road map for implementing the Millennium Declaration (Annex 2).

The MDGs are derived from agreements and resolutions of previous UN conferences, including ICPD and ICPD+5, and provide a framework for reporting progress on health and development by 2015. Goals, targets and indicators on maternal health, child survival and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) are included in the framework of MDGs. However, the ICPD goal of universal access to reproductive health care is not included in this framework. A possible reason for this could relate to the fact that although some reproductive health indicators reflect access to and utilization of care and services, a reporting mechanism for this goal was not identified to date.

WHO and UNFPA identified a need for a small number of indicators, to facilitate reporting on progress towards achievement of the goal of universal access to reproductive health care, both for monitoring the ICPD Programme of Action and as part of reporting on MDGs. They therefore convened a technical consultation in December 2003 to define such a set of indicators.

Discussions and recommendations

Participants from WHO, UNFPA, international partner agencies and nongovernmental organizations, technical experts and national reproductive health programme managers (Annex 5) reviewed 17 reproductive health indicators already shortlisted for global monitoring (Annex 3) as well as the MDG framework.

The consultation discussed and reviewed methodological issues in measuring access to and use of health care, as well as equity of access. In order to cover all the main areas of reproductive health, indicators for key components of family planning, maternal and newborn health, reproductive tract infections (RTIs) and HIV/AIDS were reviewed separately.

It was agreed that indicators on the use of reproductive health care services should serve as a proxy for access to reproductive health care. Four indicators were chosen, drawing on existing indicators, and taking into account both supply side and demand side issues. Two of the indicators fully or partially reflect the MDG indicators, the third is related to behaviour change and young people, and the fourth addresses male reproductive health issues.

Consensus was reached on the following points.

- The consultation reaffirmed support for the ICPD goal on access to reproductive health care, reiterated the target, and selected four indicators for measuring and reporting on this goal, as follows:

  Goal. Improve access to reproductive health care

  Target. Ensure access to reproductive health care for all by 2015

  Indicators (see also Annex 4).
  1. Percentage of births attended by skilled health personnel.
  2. Contraceptive prevalence (stratified by method and age).
  3. Knowledge of HIV-related prevention practices (stratified by age and sex).
  4. Percentage of men aged 15–49 years reporting receipt of treatment for urethritis.

- The group was mindful of requirements for appropriate indicators detailed in earlier reports, and chose indicators that are either available or could be added to existing systems without much difficulty. Data for the above indicators could be derived from surveys such as the Demographic and Health Surveys (DHS), Reproductive Health Surveys (RHS), Knowledge, Attitudes and Practice (KAP) surveys on sexually transmitted infections (STIs), the World Health Survey (WHS) conducted by WHO, and other similar studies.

- Indicators should be able to show differences among subgroups of the population (e.g. by age, sex, socioeconomic status or geographical location) as appropriate, and thereby provide a measure of equity.

- It is hoped that all countries will collect and report data on the suggested four indicators, so that reporting on progress towards the goal of universal access to reproductive health care will be both standard and consistent across countries.

- There is a simultaneous need for commitment of resources towards reproductive health.

- The agreed set of indicators for the ICPD goal of universal access to reproductive health care needs to be integrated into the 5-year review process of the MDGs.

- New knowledge is required in the following two areas:
  1. the usefulness of different data sources for the agreed indicators;
  2. evaluation of equity of reproductive health care among subgroups within countries.

Annex 1. The ICPD goal on universal access to reproductive health care and related targets

ICPD Programme of Action Chapter 7: Reproductive rights and reproductive health. Paragraph 7.6

"All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, *inter alia*, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should also be an integral component of primary health care, including reproductive health-care programmes."

Source: <http://www.unfpa.org/icpd/summary/htm#chapter7>.

Key Actions for the Further Implementation of the Programme of Action of the ICPD—ICPD+5: Section IV: Reproductive rights and reproductive health

" ... Governments should strive to ensure that by 2015 all primary healthcare and family planning facilities are able to provide, directly or through referral, the widest achievable range of safe and effective family planning and contraceptive methods; essential obstetric care; prevention and management of reproductive tract infections, including sexually transmitted diseases, and barrier methods (such as male and female condoms and microbicides if available) to prevent infection. By 2005, 60 per cent of such facilities should be able to offer this range of services, and by 2010, 80 per cent of them should be able to offer such services." [para. 53]

"Where there is a gap between contraceptive use and the proportion of individuals expressing a desire to space or limit their families, countries should attempt to close this gap by at least 50 per cent by 2005, 75 per cent by 2010 and 100 per cent by 2050. In attempting to reach this benchmark, demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment of clients." [para. 58]

Source: <http://www.unfpa.org/icpd5/icpd5/htm>.

Annex 2. Millennium Development Goals, targets and indicators

Goals and targets	Indicators
Goal 1: Eradicate extreme poverty and hunger	
• Target 1. Halve, between 1990 and 2015, the proportion of people whose income is less than US$1 a day.	1. Proportion of population below US$1 a day 2. Poverty gap ratio 3. Share of poorest quintile in national consumption
• Target 2. Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	4. Prevalence of underweight (children under-five years of age) 5. Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
• Target 3. Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.	6. Net enrolment ratio in primary education 7. Proportion of pupils starting grade 1 who reach grade 5 8. Literacy rate of 15–24-year-olds
Goal 3: Promote gender equality and empower women	
• Target 4. Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015.	9. Ratios of girls to boys in primary, secondary and tertiary education 10. Ratio of literate females to males among 15–24-year-olds 11. Share of women in wage employment in the non-agricultural sector 12. Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
• Target 5. Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.	13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of one-year-old children immunized against measles
Goal 5: Improve maternal health	
• Target 6. Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria, and other diseases	
• Target 7. Have halted by 2015, and begun to reverse, the spread of HIV/AIDS.	18. HIV prevalence among 15–24-year-old pregnant women 19. Condom use rate of the contraceptive prevalence rate 20. Number of children orphaned by HIV/AIDS

Goals and targets	Indicators
Goal 6: Combat HIV/AIDS, malaria, and other diseases (contd.)	
• Target 8. Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases.	21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures 23. Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)
Goal 7: Ensure environmental sustainability	
• Target 9. Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.	25. Proportion of land area covered by forest 26. Ratio of area protected to maintain biological diversity to surface area 27. Energy use (kg oil equivalent) per US$1 GDP [1] 28. Carbon dioxide emissions (per capita) and consumption of ozone-depleting CFCs (ODP tons) 29. Proportion of population using solid fuels
• Target 10. Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.	30. Proportion of population with sustainable access to an improved water source, urban and rural 31. Proportion of urban population with access to improved sanitation
• Target 11. Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers.	32. Proportion of households with access to secure tenure (owned or rented)
Goal 8: Develop a global partnership for development	
• Target 12. Develop further an open, rule-based, predictable, non-discriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction—both nationally and internationally). • Target 13. Address the special needs of the least developed countries (includes tariff- and quota-free access for exports enhanced program of debt relief for HIPC[5] and cancellation of official bilateral debt, and more generous ODA for countries committed to poverty reduction.	33. Net ODA[2], total and to LDCs[3], as percentage of OECD/DAC[4] donors' gross national income 34. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services 35. Proportion of bilateral ODA of OECD/DAC donors that is untied

2 ODA—Overseas development assistance.
4 OECD/DAC—Organisation for Economic Co-operation and Development/Development Assistance Committee.
5 HIPC—Heavily indebted poor countries.
1 GDP—Gross Domestic Product.
3 LDC—Least developed countries.

Goals and targets	Indicators
Goal 8: Develop a global partnership for development (contd.)	
• Target 14. Address the special needs of landlocked countries and small island developing States.	36. ODA received in landlocked countries as proportion of their GNIs[6] 37. ODA received in small island developing States as proportion of their GNIs
• Target 15. Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term.	38. Proportion of total developed country imports from developing countries and LDCs, admitted free of duties 39. Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 40. Agricultural support estimate for OECD countries as percentage of their GDP 41. Proportion of ODA provided to help build trade capacity 42. Total number of countries that have reached their HIPC completion forms (cumulative) 43. Debt relief under HIPC initiative, USD 44. Debt service as a percentage of exports of goods and services
• Target 16. In co-operation with developing countries, develop and implement strategies for decent and productive work for youth.	45. Unemployment rate of 15–24-year-olds, each sex and total
• Target 17. In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries.	46. Proportion of population with access to affordable essential drugs on a sustainable basis
• Target 18. In co-operation with the private sector, make available the benefits of new technologies, especially information and communications.	47. Telephone lines and cellular subscribers per 100 population 48. Personal computers in use per 100 population and Internet users per 100 population

Source: <http://www.unmillenniumproject.org/html/dev_goals1.shtm>

[6] GNI–Gross National Income.

Annex 3. Seventeen reproductive health indicators shortlisted for global monitoring

Total fertility rate. Total number of children a woman would have by the end of her reproductive period if she experienced the currently prevailing age-specific fertility rates throughout her childbearing life.

Contraceptive prevalence. Percentage of women of reproductive age (15–49) who are using (or whose partner is using) a contraceptive method[1] at a particular point in time.

Maternal mortality ratio. The number of maternal deaths per 100 000 live births.

Percentage of women attended at least once during pregnancy by skilled health personnel for reasons relating to pregnancy. Percentage of women attended at least once during pregnancy, by skilled health personnel (excluding trained or untrained traditional birth attendants) for reasons relating to pregnancy.

Percentage of births attended by skilled health personnel[2]. Percentage of births attended by skilled health personnel (excluding trained and untrained traditional birth attendants).

Number of facilities with functioning basic essential obstetric care[3] per 500 000 population. Number of facilities with functioning basic essential obstetric care per 500 000 population.

Number of facilities with functioning comprehensive essential obstetric care[4] per 500 000 population. Number of facilities with functioning comprehensive essential obstetric care per 500 000 population.

Perinatal mortality rate. Number of perinatal deaths[5] per 1000 total births.

Percentage of live births of low birth weight. Percentage of live births that weigh less than 2500 g.

Positive syphilis serology prevalence in pregnant women attending for antenatal care. Percentage of pregnant women (15–24) attending antenatal care clinics, whose blood has been screened for syphilis, with positive serology for syphilis.

Percentage of women of reproductive age screened for haemoglobin levels who are anaemic. Percentage of women of reproductive age (15–49) screened for haemoglobin levels with levels below 110 g/l for pregnant women, and below 120 g/l for non-pregnant women.

Percentage of obstetric and gynaecological admissions owing to abortion. Percentage of all cases admitted to service delivery points, providing in-patient obstetric and gynaecological services, which are due to abortion (spontaneous and induced, but excluding planned termination of pregnancy).

Reported prevalence of women with female genital mutilation (FGM). Percentage of woman interviewed in a community survey, reporting themselves to have undergone FGM.

[1] Contraceptive methods include female and male sterilization, injectable and oral hormones, intrauterine devices, diaphragms, implants, spermicides and condoms, natural family planning and lactational amenorrhoea where cited as a method.

[2] A skilled attendant is a health professional–such as a midwife, doctor or nurse–who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns (*The critical role of the skilled attendant: a joint statement by WHO, ICM and FIGO*. Geneva, World Health Organization, in press).

[3] Basic essential obstetric care should include parenteral antibiotics, oxytocics, and sedatives for eclampsia and the manual removal of placenta and retained products.

[4] Comprehensive essential obstetric care should include basic essential obstetric care plus surgery, anaesthesia and blood transfusion.

[5] Perinatal deaths are deaths occurring during late pregnancy (at 22 or more completed weeks of gestation), during childbirth and up to seven days after birth.

Percentage of women of reproductive age at risk of pregnancy who report trying for a pregnancy for two years or more. Percentage of women of reproductive age (15–49) at risk of pregnancy (not pregnant, sexually active, non-contracepting and non-lactating) who report trying for a pregnancy for two years or more.

Reported incidence of urethritis in men. Percentage of men aged 15–49 interviewed in a community survey reporting episodes of urethritis in the last 12 months.

HIV prevalence among pregnant women. Percentage of pregnant women aged 15–24 attending antenatal clinics, whose blood has been screened for HIV, who are seropositive for HIV.

Knowledge of HIV-related prevention practices. Percentage of all respondents who correctly identify all three major ways[6] of preventing the sexual transmission of HIV and who reject three major misconceptions about HIV transmission or prevention.

[6] The three major ways of preventing transmission of HIV are: having no penetrative sex, using condoms, and having sex only with one faithful uninfected partner.

Annex 4. Agreed indicators for reporting on the ICPD goal of access to reproductive health care: definitions and data sources

1. Percentage of births attended by skilled health personnel

Numerator: births attended by skilled health personnel during a specified period
Denominator: total number of live births during the specified period

Skilled health personnel refers to a health professional, such as a midwife, doctor or nurse, who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.

Live birth is the birth of a fetus of more than 22 weeks gestation, or weighing 500 g or more, that shows signs of life (breathing, cord pulsation or audible heart beat). Adapted from *International Classification of Diseases*, 10th edition, Geneva, World Health Organization, 1994.

Data sources

For most countries, the main sources of information on skilled health personnel at delivery are *routine health service data* and *household survey data*. As a point of contact with women, health services are the main and most obvious routine source of information for the numerator. However, routine health service information generally excludes information on the private sector. Household surveys are an important source of information on maternity care, but are only available on an *ad hoc* basis.

2. Contraceptive prevalence

Proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time.
Numerator: number of women of reproductive age (15–49 years) at risk of pregnancy who are using (or whose partner is using) a contraceptive method at a given point in time.
Denominator: number of women of reproductive age (15–49 years) at risk of pregnancy at the same point in time.

Contraceptive methods include clinic and supply methods (or modern methods) and non-supply (or traditional) methods. Clinic and supply methods include female and male sterilization, intrauterine devices (IUDs), hormonal methods (oral pills, injectables, implants), condoms and vaginal barrier methods (diaphragm, cervical cap, and spermicidal foams, jellies, creams or sponges). Traditional methods include the rhythm method, withdrawal, abstinence, and lactational amenorrhoea.

Women of reproductive age includes all women aged 15–49 years. "At risk of pregnancy" refers to women who are sexually active, not infecund, not pregnant and not amenorrhoeic. Technically speaking, the denominator should relate to the population at risk of pregnancy as cited above; however, in practice, information is generally only available for women who are either currently married or in a stable union.

Data sources

Population-based sample surveys provide the most comprehensive data on contraceptive practice, since they show the prevalence of all methods, including those that do not require supplies or medical services. Estimates may also be obtained from small-scale or more focused surveys, or by adding relevant questions to surveys on other topics (e.g. surveys of health programme prevalence or coverage).

3. Knowledge of HIV-related prevention practices.

Proportion of survey respondents who correctly identify all three major ways of preventing sexual transmission of HIV, and who also reject three major misconceptions about HIV transmission or prevention.
Numerator: Number of women/men (15–49 years) who correctly identify all three major ways of preventing sexual transmission of HIV, and who also reject three major misconceptions about HIV transmission or prevention.

Denominator: total number of women/men (15–49 years) included in the survey.

The *three major ways of preventing sexual transmission of HIV* are: (1) not having penetrative sex; (2) using a condom; and (3) limiting sexual activity to one faithful uninfected partner.

Three *major misconceptions about HIV transmission* should be determined according to the local cultural context, but should include "a person who is infected with HIV does not look healthy", i.e. the lack of understanding that a person who looks healthy can be infected with HIV.

This indicator is a composite of two sets of questions, relating to correct knowledge and incorrect knowledge or misconceptions. In calculating the estimates (for women and men), all survey respondents aged 15–49 years are included in the denominator; only those who satisfy the definitions for complete knowledge and lack of misconceptions are included in the numerator.

Data sources

The principal source of information on HIV prevention knowledge has been population-based household surveys. Any well designed and implemented population-based survey of sufficient size can potentially yield high-quality data on HIV prevention knowledge. Currently the most commonly available source of such data for developing countries is the Demographic and Health Surveys (www.measuredhs.com). Another population-based household survey instrument designed for this specific indicator is the UNAIDS/MEASURE *Evaluation* model.

4. Percentage of men aged 15–49 reporting receipt of treatment for urethritis

Numerator: number of men (15–49 years) reporting treatment for episodes of urethritis in the past 12 months.
Denominator: number of men (15–49 years) reporting episodes of urethritis in the past 12 months.

Urethritis: presence of discharge from the penis with or without presence of a burning sensation or pain while passing urine.

Discharge: discharge may be thick or thin and either clear (like mucus) or coloured (green, yellow or white). A discharge that contains blood is usually not indicative of urethritis.

Episode: the occurrence of symptoms either for the first time ever or at least five days after the disappearance of previous symptoms. The recall period of 12 *months* refers to the previous 12 months and not the last calendar year.

Data sources

There are no readily available data for this indicator. The indicator requires data to be collected at a population or subpopulation level. The most appropriate source of data is a community survey, such as the Demographic and Health Survey (DHS), or a study undertaken for the specific purpose. Community surveys can be conducted either at national level or in specific population groups or specific geographical areas.

Annex 5. List of participants

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