Measuring Access to Reproductive Health Services

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Contents

Reproductive health is fundamental to the social and economic development of communities and nations and is at the core of human development. The Programme of Action adopted by consensus at the 1994 International Conference on Population and Development (ICPD) brought in a paradigm shift from actions aimed at achieving specific demographic targets, to those focused on attainment of reproductive health, through a holistic and coherent framework, guided by the principles of human rights, equality, and gender equity. At ICPD and at the 5-year follow-up session (ICPD+5) convened by the United Nations, governments committed themselves to providing access to reproductive health care to all individuals of appropriate age no later than 2015. The adoption of the Programme of Action marked a the beginning of a new era in which governments and international agencies would advocate for reproductive health and rights and for improved quality of care.

Since then, some countries have formulated new policies and developed programmes specifically to improve reproductive health through attainment of internationally agreed goals and targets. The overarching objective of ICPD is to raise levels of sexual and reproductive health in all populations and to reduce inequities. Actions necessary to achieve this objective include: strengthening the capacity of health systems to provide appropriate, affordable and accessible sexual and reproductive health care; creating a supportive economic, political, social, legal and regulatory environment; and promoting health-seeking behaviour in families and communities, including support for use of formal health care.

Access to reproductive health care is a multidimensional concept with multiple determinants. The ICPD affirmed the need to ensure access, declaring:

"All countries should strive to make accessible through the primary health care system, reproductive health care to all individuals of appropriate ages as soon as possible and no later than 2015."

The Millennium Development Goals (MDGs) provide a framework for reporting progress on health and development by 2015 (Annex 1). Although a specific reproductive health goal was not included in the framework of MDGs, goals and targets on maternal mortality, child survival and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) were included. The World Health Assembly, in resolution WHA55.19, adopted in May 2002, declared that "increased access to good quality primary health care information and services, including reproductive health, is critical for attainment of the development goals contained in the United Nations Millennium Declaration". Therefore, measuring access to reproductive health care remains a global priority.

"Access" consists of at least five components of service provision: availability, affordability, acceptability, appropriateness and quality. All these five components are applicable to the key elements of reproductive health care: family planning; maternal and newborn care; prevention and management of unsafe abortion; prevention and management of reproductive tract and sexually transmitted infections (RTI/STIs), including HIV/AIDS; and promotion of healthy sexuality. The multidimensional nature of reproductive health care could make it difficult to ensure consistent and harmonized reporting of progress towards universal access.

1.1 Rationale for the consultation

At the forefront of the development agenda, and central to the mission of the United Nations

system, the MDGs constitute a global partnership to progressively eradicate poverty, as well as a framework for accountability regarding progress. They capture the multidimensional nature of poverty and support a rights-based approach to development. Although many ICPD goals, such as access to primary schools, and reduction of maternal, infant and under-five child mortality, are incorporated in the MDG framework, the goal of universal access to reproductive health care is not explicitly included. However, since poverty, education and reproductive health are intricately interconnected, achieving the ICPD goal of universal access is a precondition for meeting the MDGs. Moreover, the inclusion of ICPD-related goals in the MDGs will be important in promoting discussions and influencing decisions concerning reproductive health.

Despite the consensus at ICPD and the commitments of countries to the goal of universal access, no specific set of indicators to measure access has been identified to date. In two previous interagency meetings, 17 reproductive health indicators were shortlisted for global monitoring (Annex 2). However, some of these indicators have been difficult to implement, leaving a crucial gap in the monitoring of the ICPD goal. There is a need to review these indicators for their usefulness in monitoring access to reproductive health care.

This review should take into account the fact that the criteria used previously for selecting indicators did not include considerations of equity, potentially creating a situation where some targets could be achieved without bringing benefits to the most vulnerable groups. Thus, the indicators need to be reconsidered not only in terms of existing criteria, but also in relation to equity. In addition, indicators should be able to respond to the needs of programme managers in countries, as well as meeting the need for global advocacy. Some reproductive health issues, e.g. female genital mutilation, are relevant only for certain countries. Therefore, countries should not be obliged to measure or report on all the items under reproductive health care, but only those that are relevant. In view of the difficulties encountered in implementing programmes to reach the ICPD goal of universal access, there is also a need to consider what is required to improve existing knowledge in this field.

During a meeting of the agency heads, WHO and UNFPA agreed that it was important to develop and implement approaches for measuring and monitoring access to reproductive health care. The two agencies therefore convened a technical consultation on 2–3 December 2003 to:

- agree on a set of indicators to provide an MDG-type framework for reporting on progress towards the goal of universal access to reproductive health care;

- review strategies for measuring and monitoring those indicators and potential sources of data;

- agree on a programme of activity for the further development of the work.

2.1 Approaches to measuring access to reproductive health care

Measuring access is not as straightforward as it might appear at first sight. Many indicators of access focus on the physical characteristics of the service delivery system, such as the distribution and proximity (travel time or distance) of health facilities and health care providers, and are often measured through geographical and health information systems. However, the absence of physical barriers is not necessarily equivalent to full accessibility. There is often a need to examine other aspects, including the affordability and cultural acceptability of the services being offered, the availability of information about the services, and client satisfaction with them. In many low-income countries, the poor quality of services and inappropriate treatment of patients serve as major deterrents to service utilization. It follows that an adequate study of accessibility of services will require a number of indicators.

Several approaches to measuring accessibility have been attempted to date:

- direct measures of physical accessibility alone, with the possible under-representation of affordability, acceptability, and quality of care. These direct measures are normally based on health information systems, occasionally supplemented by surveys;

- direct measures of physical accessibility coupled with direct measures of affordability and acceptability, typically derived from occasional surveys;

- indirect, or proxy, measures (use of services or health status) of physical accessibility, affordability and acceptability.

2.2 Reproductive health indicators

Since ICPD in 1994, a plethora of reproductive health indicators have been developed and tested. Different indicators are needed for different purposes, e.g. for district level planning, for projects (outcome and process indicators), and for national and global monitoring. In 1996, WHO took the lead in organizing an interagency meeting,[1] which led to the selection of 15 global indicators for monitoring progress towards reproductive health targets. In a later consultation,[2] two HIV/AIDS-related indicators were added and the 17 indicators were shortlisted for national and global monitoring.

Experience so far has revealed several shortcomings of these 17 indicators for global monitoring. For many of the indicators, there are no routinely collected data and standard measurement techniques are lacking. National estimates are computed using subnational data, but the validity of these calculations is questionable. Finally, little is known about the cost-benefit for countries of data collection on these indicators. Collecting and reporting the data represent a financial burden for countries and resource-poor countries in particular need to be convinced of the benefits.

2.3 Reproductive health differentials and equity

Many indicators of use of reproductive health care services and reproductive health status show variations among subgroups of populations. Maternal deaths, skilled attendance at birth, contraceptive prevalence, antenatal care, and teenage pregnancies have been shown to vary

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[1] *Monitoring reproductive health: selecting a short list of national and global indicators*, Geneva, 1996.

[2] *Reproductive health indicators for global monitoring*, Geneva, 2000.

according to urban/rural residence, education, ethnicity and income. Gender differentials have been reported in the treatment and knowledge of HIV/AIDS. Differential use of reproductive health care could be linked to differences in need, supply-side factors, demand-side factors or inappropriate use by certain groups. The extent to which existing variations are inequitable needs to be disentangled in order to intervene appropriately for universal access to reproductive health care.

Equity encompasses notions of fairness, justice and equality, and implies that everyone should have an equal opportunity to attain their full potential for health. It should be distinguished from the related concept of equality. Equality is assessed in terms of comparisons between the level of health, or ability to obtain health care, of individuals and communities. Some inequalities may be unavoidable, and therefore not generally considered unfair, while others could be avoided and so are considered inequitable. Natural, biological and genetic variations may have unavoidable (though very important) health inequalities related to them. However, inadequate access to health care because of a lack of transport, or restricted access to information because of language differences, is inequitable as well as unequal.

Study of inequalities in health care access and use requires all subgroups of the population (defined by, for example, age, socioeconomic status, sex, geographical location, ethnic group and disability) to be systematically considered, even if only some are of local importance. Different levels of need for health care should also be taken into account in studies of health care inequalities.

Prior to proceeding with working group discussions, the Consultation reached consensus on the following issues:

- The MDGs and ICPD goals are fixed and agreed, and this Consultation should not suggest changes, modifications or additions. The focus should be on reaching consensus on the appropriate indicators for the ICPD access goal. The indicators should be selected primarily from the 17 indicators shortlisted for global monitoring, and efforts should be made to avoid introducing new indicators.

- It would be useful to contemplate the broader concept of reproductive health care rather than a narrow definition of physical access.

- In general, use of care should be measured rather than access to care, because the first includes both demand- and supply-side factors, while the latter is only a measure of supply. Equity of use should also be of concern.

In order to cover all main areas of reproductive health, working groups were arranged according to the key components of family planning, maternal and newborn health (including unsafe abortion), and RTIs and HIV/AIDS. The Consultation was mindful of the relevance of other components of reproductive health, albeit within regional contexts, but considered that the above-mentioned were globally applicable.

3.1 Family planning

The group initially discussed reconciliation of potential indicators with the family planning targets set by ICPD, i.e. 60% of primary health care/family planning (PHC/FP) facilities providing reproductive health services by 2005 and 80% by 2010. However, direct indicators of physical access for monitoring of these targets were found to be difficult to operationalize because of:

● the lack of a standard definition of PHC,

● the lack of a standard definition of provision (staff, supplies, etc.),

● the extent of the role of private sector,

● problems regarding availability and quality of data

Therefore, it was decided to focus on indicators of use rather than physical access.

The existing 17 indicators were reviewed and contraceptive prevalence was chosen as the most appropriate, because:

● data on contraceptive prevalence exist for previous years, which allows trends to be assessed;

● in most cases, data on contraceptive prevalence are available disaggregated according to urban/rural residence, geographical area, income level, education and age;

● the different roles of the public, private and nongovernmental sectors in the provision of this aspect of care can be identified.

Rates of teenage pregnancy and unwanted or mistimed pregnancy were suggested as additional key indicators; however, if only one indicator were to be chosen for this thematic area, it should be contraceptive prevalence.

The group discussed the integration of need into the format of reporting contraceptive prevalence in order to be able to recognize unmet need. Unmet need refers to women who are not practising contraception, but who do not want any more children (limiting) or who want to postpone the next birth for at least two years (spacing). Currently the main tool for measuring unmet need is the Demographic and Health Survey (DHS), in which women are asked whether and when they would like to become pregnant. These responses are linked to the current use of contraception in order to estimate a figure for unmet need. However, there are some shortcomings of these figures; unmarried women are often excluded, and women using ineffective methods or who are not satisfied with their methods are not taken into account.

Finally, the group emphasized that data contraceptive prevalence need to be disaggregated by important variables, such as method, age, residence and socioeconomic status.

3.2 Maternal and newborn health (including unsafe abortion)

The group reviewed the existing indicators related to maternal health care. It was decided to keep the percentage of births attended by skilled health personnel in the first place, because this indicator already exists in the MDG framework and is generally available. The second option would be antenatal care coverage, because it is related to socioeconomic characteristics and attitudes of the community towards health care, and because antenatal care represents a good opportunity for interventions related to HIV/AIDS and malaria control. The percentage of obstetric and gynaecological admissions owing to abortion was chosen as the third option.

The group recommended that a standard definition of "skilled attendant" be developed (based on the proposed joint statement by international organizations on essential competencies of skilled attendants). Governments should then be encouraged to use the definition in relation to the different categories of health personnel in their national health system. The results of this process would be shared with DHS and other relevant household survey groups, to ensure that questions about carers during childbirth identify appropriate cadres of personnel as skilled attendants.

The importance of providing the enabling conditions for the skilled attendant to deliver appropriate care was also discussed. A skilled attendant's ability to provide the care needed in the event of an emergency depends on the environment in which he or she works. It was suggested that a number of supplies for obstetric care (e.g., blood, intravenous fluids, oxytocin) could be included in checklists for assessment of the preparedness of health facilities. The presence of these supplies could serve as a proxy indicator of the capacity of health facilities to provide emergency obstetric care, and would thus provide some indication of whether skilled attendants are, in fact, in an environment where they can provide skilled, life-saving care.

The suggested indicators would be reported at national level. However, it is possible to improve maternal health overall—as measured by these indicators—without reaching those most at need; such an occurrence would increase the gap between rich and poor. If the indicators are to be of use for countries, they should be able to indicate where the problems lie and which populations or regions are most affected. The group agreed to advocate for disaggregation of data by age, region,

socioeconomic status and educational level, so that equity issues are not overlooked.

3.3 Reproductive tract infections and HIV/AIDS

The group suggested that the target for this thematic area should be: "proportion of men and women aged 15–49 receiving preventive and treatment services for RTIs and STI/HIV increased by 50% in low-income countries, and by 25% in middle-income countries, from their national baseline levels by 2015". The levels of 50% and 25% were chosen arbitrarily.

The indicators related to RTIs and HIV/AIDS among the shortlisted 17 indicators were reviewed. Some of the indicators were rephrased to reflect the use of care. Three indicators were considered appropriate to monitor this aspect of reproductive health care:

- the percentage of pregnant women aged 15–49 having a syphilis test;

- knowledge of HIV-related prevention practices;

- the percentage of men aged 15–49 reporting treatment for urethritis.

There could be problems with the first indicator, related to differences in the types of tests provided and the difficulty of obtaining data from the private sector. Similar concerns were raised regarding the indicator related to receipt of treatment for urethritis: variations in the type of treatment and the provider could be problematic. Nevertheless, it is more appropriate to select indicators of health care use rather than of the health status of the population (prevalence estimates), because health status could be influenced by many other factors.

The indicators proposed by the working groups were reviewed and discussed. Consensus was reached on the following points:

- The Consultation reaffirmed support for the ICPD goal on access to reproductive health care, specified 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 repro ductive health care for all by 2015

  Indicators (see also Annex 3):

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 ap- propriate 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 DHS, reproductive health surveys, knowledge, attitudes and practice surveys on STIs, the World Health Survey conducted by WHO, and other similar studies.

- Indicators should be able to show differences among subgroups of the population (e.g. by age, ethnic group, sex, socioeconomic status, 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 coun- tries.

- 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:

  (i)   the usefulness of different data sources for the agreed indicators,

  (ii) evaluation of equity of reproductive health care among subgroups within countries.

Annex 1: 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).

33. Net ODA[2], total and to LDCs[3], as percent age 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

◉ 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.

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

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[6] GNI–Gross National Income.

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 child bearing 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 below 110g/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

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[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 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, 2004).

[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 (15-24) attending antenatal clinics, whose blood has been screened for HIV, who are sero-positive for HIV

Knowledge of HIV-related prevention practices. The 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

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[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.

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 or prevention should be determined according to the local context, but should include 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 4: List of participants

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Dr Fatma Mrisho	UNFPA, Addis Ababa, Ethiopia
Dr Rosalind Raine	London School of Hygiene and Tropical Medicine, London, United Kingdom
Dr Khama Rogo*	World Bank, Washington, DC, USA
Dr Harshad Sanghvi	JHPIEGO, Baltimore, MD, USA
Dr Ann Starrs	Family Care International, New York, NY, USA
Dr Petra Tenhoope-Bender	International Confederation of Midwives, Amsterdam, Netherlands
Dr Budi Utomo	Population Council, Jakarta, Indonesia

United Nations Population Fund (UNFPA), New York

Dr Nick Dodd	Chief, Inter-Country and Field Support Branch, TSD
Dr France Donnay	Chief, Reproductive Health Branch, TSD
Dr Allan Keller	Consultant

World Health Organization, Regional Offices

Dr Jafaar Hussain	WHO Regional Office for the Eastern Mediterranean, Cairo, Egypt
Dr Ardi Kaptiningsih	WHO Regional Office for South-East Asia, New Delhi, India
Dr Doyin Oluwole	WHO Regional Office for Africa, Brazaville, Zimbabwe
Dr Ernest Pate	WHO Regional Office for the Americas/Pan American Health Organization, Washington, DC, USA

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Dr Paul Van Look	Director, Department of Reproductive Health and Research
Dr Mike Mbizvo	Department of Reproductive Health and Research
Dr Metin Gülmezoglu	Department of Reproductive Health and Research
Dr Herbert Peterson	Department of Reproductive Health and Research
Dr Ana Betrán	Department of Reproductive Health and Research
Dr Lale Say	Department of Reproductive Health and Research
Dr Veronica Lippuner	Department of Reproductive Health and Research
Ms Harriet Kabagenyi	Department of Reproductive Health and Research
Ms Barbara Kayser	Department of Reproductive Health and Research
Dr Bedirhan Üstün	Evidence and Information for Policy
Mrs Carla Abou-zahr	Evidence and Information for Policy

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Dr Vincent Fauveau	Senior Adviser, Maternal Health
Dr Wilma Doedens	Technical Officer, Humanitarian Response Group
Ms Ana Angarita	Adviser, Gender and Reproductive Rights