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Reproductive Health Indicators for Global Monitoring:

Report of an interagency technical meeting

9–11 April 1997

Division of Reproductive Health (Technical Support)
UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
World Health Organization

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EXECUTIVE SUMMARY

The number of indicators proposed by a range of agencies for monitoring goals and targets in reproductive health has, in recent years, increased rapidly. In order to bring some order to this proliferation of indicators and facilitate interagency dialogue, the Working Group on Reproductive Health of the ACC Task Force on Basic Social Services for all (BSSA) held a meeting specifically on reproductive health indicators. This meeting in September 1996 concluded that WHO should host this follow up technical meeting to:

1. achieve consensus on a minimal list of reproductive health indicators for global monitoring.
2. agree on criteria for the identification and selection of indicators at district and national levels.
3. define research needs in areas for which indicators have not yet been identified or tested.
4. share country experiences on identifying and selecting indicators and generating the needed data.

The meeting started with a review of country experiences in strengthening health information systems for monitoring reproductive health. This was followed by an analysis of agency work in global monitoring of health status and programmes. In particular, UNICEF experiences in monitoring the goals of the World Summit for Children (WSC) and lessons learned by WHO in the evaluation of progress towards Health for All were presented.

The group then discussed a guideline directed at district level health managers which describes a process of identifying reproductive health indicators according to specific criteria including feasibility and scientific soundness. The basic underlying premise of this guideline is that indicator selection and related data collection should serve to assist programme management at the level at which data are collected.

Finally, the meeting discussed a draft set of indicators for global monitoring. These indicators were chosen on the basis of explicit criteria, of which feasibility and usefulness for programme management were considered particularly important. After much discussion the meeting reached consensus on a list of 15 indicators. Research needs were defined for areas where appropriate indicators have not yet been identified or tested.

The meeting concluded by making a number of recommendations, foremost among which were that WHO should develop guidelines for regions and countries on the collection and interpretation of these indicators and that follow-up work should be undertaken to identify indicators in those areas where currently none are available.

In conclusion, WHO undertook to convene a broader task force bringing together technical experts, representatives of multi-lateral and bilateral agencies, NGOs and women’s groups to continue work on this important topic.

INTRODUCTION

Following a number of international conferences, in particular the 1990 World Summit for Children (WSC), the 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women (FWCW), there has been an increase in demand for monitoring goals and targets in reproductive health. An unwanted effect, however, has been the proliferation of indicators currently proposed by a range of agencies on which countries are asked to report, in addition to nationally agreed indicators.

In September 1996 the Working Group on Reproductive Health of the ACC Task Force on Basic Social Services for All (BSSA) held a meeting to facilitate interagency dialogue and cooperation on the issue of reproductive health indicators.

The principal conclusion of this meeting was that WHO should host a follow up technical meeting to reach consensus on a minimal list of reproductive health indicators that would support monitoring and evaluation at the global level, without compromising the time spent collecting the information at the peripheral level.

The working group also recommended that the technical meeting:

- finalise guidelines on the principles for identifying and selecting reproductive health indicators at the district and national levels.
- define a research agenda for the development of new indicators and related data collection tools.
- share country experiences, specifically to analyse country “best practices” in the area of generating and using reproductive health indicators.
- provide technical guidance on data collection for existing reproductive health indicators and advise on the analysis and interpretation of such indicators.

In line with these specific recommendations WHO convened an interagency meeting comprising agency technical staff, technical experts from developing and developed countries, and key WHO staff with responsibilities in different aspects of health monitoring and evaluation. The key objectives of this interagency technical meeting were as follows:

1. To achieve consensus on a minimal list of reproductive health indicators for global monitoring.

2. To agree on criteria for the identification and selection of indicators at district and national levels.

3. To define research needs in areas for which indicators have not yet been identified or tested.

4. To share country experiences on identifying and selecting indicators and generating the needed data.

The meeting started with a discussion of country perspectives on strengthening national health information systems in order to monitor aspects of reproductive health. This was followed by a sharing of experiences of international agencies. WHO presented a summary of

lessons learned in the global evaluation of progress towards the achievement of Health for All. UNICEF summarised its experiences in monitoring the goals of the World Summit for Children.

The meeting then examined a draft guideline for district health planners on criteria for identifying reproductive health indicators. These criteria were then adapted for application at the global level to reach consensus on a minimal list of reproductive health indicators for global monitoring.

COUNTRY PERSPECTIVES ON REPRODUCTIVE HEALTH INDICATORS

Sharing country experiences on identifying and selecting indicators and generating the needed data was listed as one of the main objectives of this technical meeting. Case studies carried out in France, Iran, Senegal and Zimbabwe were compared, to identify country “best practices” in the area of generating and using reproductive health indicators.

Despite vast differences in the status of the countries health statistics and information systems and a broad range of indicators currently in use, the overview highlighted notable commonalities and differences from which valuable lessons can be learned. These provide a sound base for developing global level indicators and guidelines for identifying and selecting indicators at the district level.

Essential lessons to be learned from country case studies

- *There is a need to rationalise and select indicators, and to support the development of information and research systems to generate these indicators*
  Country level health statistics and information and surveillance procedures have evolved in parallel with the development of health systems and health programme areas. At the same time numerous indicators have been created in an ad hoc manner. Therefore, there is an urgent need to rationalise the selection of indicators and to support the development of information and research systems to generate and report on the indicators.

- *It is critical to consolidate and build on the health information systems already in place*
  When selecting both a minimal list of indicators for global monitoring and developing new tools for selecting indicators at the district level, it is important to consider and consolidate what is already in place. Any new tools must be integrated with the existing health information system.

- *Programmes must not be indicator driven*
  When addressing the problems of reproductive health, the problem should first be clearly defined before the most appropriate indicators available to monitor the programmes can be effectively identified. Also, care must be taken to ensure indicators serve to identify possible problem areas and contribute to decision making, rather than being ends in themselves.

- *It is important to make the maximum and most appropriate use of information provided by indicators*
  Tools must be developed on how best to utilise the information gathered, and a feed back process must be established to ensure the information is internalised. Mechanisms must be set in place to drop inappropriate indicators which are not used to improve programme management and which are collected out of bureaucratic need rather than management and diagnostic purposes.

- *The promotion and use of health indicators in reproductive health must also be supported by adequate analysis for monitoring and evaluating reproductive health programmes at all levels of the health system*
  Donor and technical support agencies have a key role to play in supporting national health information systems that are sustainable in the long term. In general, special surveys should be used to supplement routine health information or to derive information that cannot be made available through the health information system.

- *Emphasis should be placed on capacity building for reproductive health programme monitoring and evaluation within country information systems as well as reproductive health programmes*
  With the current focus on health sector reform and decentralization, and significant regional, geographical and epidemiological differences within countries, there is a need for ownership of the selection of indicators and development of information systems to be placed firmly at the district level.

INTERNATIONAL EXPERIENCE OF GLOBAL MONITORING

For the past fifteen years WHO has been monitoring and evaluating progress in implementing the global strategy for health for all adopted by its Member States in 1979. Consequently it has gained considerable experience in selecting, and using global health indicators for the purpose of monitoring global health development. The primary objectives of this monitoring and evaluation process are:

- to follow all aspects of the implementation of the global health for all strategy and to report on progress made and problems encountered to WHO governing bodies
- to foster, induce and support, at national level, the practice of periodically evaluating the implementation of national strategies for health for all with the aim of strengthening the managerial process for national health development
- to collect, validate, analyse and disseminate national data of international significance.

In practice, the coverage of data received to generate global indicators has been disappointing. For 58% of the indicators selected for the third monitoring (1994) data were only received from countries representing less than 25% of the world population. Several reasons are given for these poor returns. Some indicators were obsolete and others were poorly defined, with no internationally accepted definition. Insufficient resources were mobilized, both nationally and internationally, for such an important exercise. The lack of political support and visibility may have lead some national counterparts to consider the exercise as an administrative duty rather than as an opportunity to learn from the past in order to plan better for the future.

In light of the above WHO revised and reduced the indicators for the third evaluation (1997) according to strict selection criteria which included the need for indicators that are:

- robust, relevant and useful - that is they can and will be used by policy makers and are acceptable as national indicators
- generated through data collection methods which do not require efforts from institutional levels that have no use for them
- generated through procedures which are sustainable by the national and international administrations responsible.

Several UN institutions have shown keen interest in identifying suitable indicators for the purpose of monitoring various aspects of health development. WHO’s mandate is to act as the directing and coordinating authority on international health work. In WHO’s experience indicators proposed by UN institutions for the purpose of health development, monitoring or evaluation should be:

- defined and selected according to strict criteria paying particular attention to their usefulness to national decision-makers
- supported by methodology sheets
- reviewed and discussed with sister organisations
- promoted as part of strengthening national health information systems
- proposed to information specialists with the active participation and support of national decision-makers

- put in perspective with indicators needed to monitor different aspects of health development.

UNICEF's experiences with monitoring progress towards the goals and objectives set out in the World Summit for Children Declaration and Plan of Action provide additional insights into selecting and using global indicators.

The Plan of Action called for each country to, "establish appropriate mechanisms for the regular and timely collection, analysis and publication of data required to monitor social indicators related to the well-being of children." Sixty indicators were developed to monitor the goals, 11 were related to reproductive health.

The burden of collecting such a volume of information soon became apparent, particularly considering the paucity of reliable, current national data for goal-indicators. To reduce the information needs to specific areas critical to the survival and development of each child, 13 mid-decade goals were adopted. Prompted by the need to report progress towards these goals by mid-decade UNICEF, in collaboration with other agencies including WHO, UN Statistical Office, and the U.S. Centers for Disease Control, developed and promoted national sample household surveys world-wide to collect the required data. These surveys, which have come to be known as Multiple-Indicator Cluster Surveys (MICS), were intended to produce nationally representative and statistically robust estimates, of sufficient quality to withstand international scientific scrutiny. They were designed as an integral component of national capacity building for programmatic action and policy review in each of the goal areas. They were also intended to foster inter-sectoral collaboration in the process.

A standardized questionnaire and survey methodology, including sampling guidelines, were developed in late 1994 and were documented in *A Practical Handbook for Multiple Indicator Surveys* (*Monitoring Progress Toward the Goals of the World Summit for Children*).

The guidelines in the *Handbook* are flexible and framed in a way to be relevant to a range of country situations; but they are only guidelines. Thus the surveys have been adapted locally, with respect to sample size and design, the number of modules included, and other areas of inquiry.

As of July 1997, some 59 countries had conducted MICS surveys. Forty-six final reports and 5 preliminary reports are currently available at UNICEF headquarters. Nearly half of the MICS surveys were conducted in Sub-Saharan Africa (29 surveys), with seventeen in West Africa. In Latin America, only two MICS surveys were conducted. Some countries, such as China and India have implemented these surveys at the sub-national level. In India some 200 MICS have been conducted at the state level.

The level of survey activity is a good indication of the poverty of current data on these important indicators. The MICS initiative has gone a long way to redressing this problem. Quite apart from international goal monitoring, the survey results are expected to be extremely useful at the level of national policy reviews, mobilization of action and national capacity building in programme monitoring.

CRITERIA FOR IDENTIFYING AND SELECTING INDICATORS AT THE DISTRICT LEVEL

Many reproductive health indicators advocated at the global level are not appropriate for programmatic use at the district level.

At the district level, indicators summarise data collected to answer questions relevant to the planning and management of health programmes. In order to promote a more critical approach to the selection of indicators at this level, encouraging health managers to take into account the practicalities of data collection, the Informal Consultation on Indicators for Reproductive Health in May 1996 recommended that guidelines be developed for identifying and selecting reproductive health indicators at the district level. These guidelines are set out in the background document, *Selecting reproductive health indicators: A guide for district managers* (WHO/RHT/HRP/97.25). The task of this technical meeting was to appraise and finalise these guidelines.

The main steps for identifying and selecting a set of indicators to assess need, monitor the implementation and evaluate the impact of reproductive health programmes in a district are outlined in Annex B.

The selection process is based on the principal of maximum utilisation of existing data and data sources, so as to avoid overloading health workers with data collection activities. The guidelines also highlight the need for co-ordination both between district managers and health managers at the national level. The comparison and reconciliation of indicators selected by different districts is essential to the selection of national level indicators. Thus a core set of indicators should be gathered across all districts to enable a valid national picture to be constructed.

The general view at the meeting was that the guidelines were a useful and necessary tool, particularly since they used explicit and clearly defined selection criteria. However, there may be differences in how criteria are applied at national and district levels. The group recommended a clearer definition of the ethical criterion which should not be open to interpretations that hinder data collection on sensitive topics. The criterion was revised accordingly.

The group highlighted that selecting indicators is not the end point and that more emphasis should be placed on using and analysing the information. They also stressed the need for a constant review process, with a step for eliminating indicators no longer in use.

The group strongly recommended that the guidelines be field tested and highlighted a number of issues that should be addressed during field testing:

- What would be the best approach to providing support on how the selection process should be carried out, e.g. workshop?
- Who is actually going to carry out the indicator selection process - are programme managers empowered to make these decisions?
- Are the number of forms overwhelming and is this consistent with not overburdening district health managers?

MINIMAL LIST OF REPRODUCTIVE HEALTH INDICATORS FOR GLOBAL MONITORING

The primary objective of this interagency technical meeting was to reach consensus on a minimal list of reproductive health indicators for global monitoring. Order needs to be brought to the proliferation of indicators being advocated by different agencies for international comparison, global monitoring and follow-up to the international conferences. The *implementation* of the agreed list by all agencies will ensure a more harmonised approach to monitoring and evaluating reproductive health issues at the global level and will provide a comparable “snapshot” of the reproductive health situations in countries.

The selection process

The document *Monitoring reproductive health: selecting a short list of national and global indicators* (WHO/RHT/HRP/97.26) provided the basis for discussion. This document outlines the process and outcome of a short list of indicators for global monitoring.

Here, 148 indicators were identified from existing lists[1] and reviewed according to strict selection criteria. These are the same criteria as those recommended for district level indicator selection. The criteria which were used by the authors are outlined below.

The selection criteria

- *Scientifically robust* - the indicator must be a valid, specific, sensitive and reliable reflection of that which it purports to measure.
- *Valid* - an indicator must actually measure the issue or factor it is supposed to measure.
- *Reliable* - the indicator must give the same value if its measurement was repeated in the same way on the same population and at almost the same time.
- *Sensitive* - the indicator must be able to reveal important changes in the factor of interest.

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1 **Maine *et al*, (1995)** *Maternal Mortality: Guidelines for Monitoring Progress*. UNICEF. New York
The Evaluation Project (1995) *Indicators for reproductive health programme evaluation*. Carolina Population Centre/Tulane University/The Futures Group.
UNFPA (1996) *Indicators for monitoring the performance of reproductive health programmes: a discussion paper.* Draft December 1996. New York
WHO and UNICEF (1993) *Indicators for monitoring health goals of World Summit for Children 1993.* Geneva
WHO (1993) *Third Monitoring of Progress of Strategies for Health For All by the year 2000.* Geneva
WHO (1994) *Indicators to monitor maternal health goals*. Report of the Technical Working Group, 8-12 November 1993. Geneva
WHO (1994) *Evaluation of a National AIDS Programme: A Methods Package. 1. Prevention of HIV Infection*. Geneva
WHO (1996) *WHO Catalogue of Indicators for Health Monitoring*. Geneva

- *Specific* - the indicator must only reflects changes in the issue or factor under consideration.

- *Useful* - at the national level, the indicator must be able to act as a "marker of progress" towards improved reproductive health status, either as a direct or proxy measure of impact or as a measure of progress towards specified process goals. Since computation of national level indicators usually requires aggregation of data collected at a local level, the data should also be useful locally, i.e. follow-on action should be immediately apparent.

- *Representative* - the indicator must adequately encompass all the issues or population groups it is expected to cover; for national level indicators the group of interest is the population as a whole including minority groups and adolescents.

- *Understandable* - the indicator must be simple to define and its value must be easy to interpret in terms of reproductive health status.

- *Accessible* - the data required should be available or relatively easy to acquire by feasible data collection methods that have been validated in field trials.

- *Ethical* - An ethical indicator is one for which the gathering, processing and presentation of the data it requires are ethical in terms of the rights of the individual to confidentiality, freedom of choice in supplying data, and informed consent regarding the nature and implications of the data required.

None of the 148 indicator collected managed to fulfill all the criteria outlined above. However, by a process of elimination 16 "strong" indicators were identified. Reproductive health areas not covered by the "strong" list were then flagged and the least problematic of the "weak" indicators were proposed for these programme areas. The result was a "working" minimal list of 17 indicators (Annex 1).

The general consensus was that the above selection process was well defined and comprehensively conducted. The group highlighted a number of additional key issues that should be kept in mind when selecting and using global level indicators. These are summarised below.

Key issues concerning the selection and use of global level indicators

- *Indicators play an important advocacy role*
  Global level indicators play an important advocacy role, drawing attention to serious problem areas within reproductive health.

- *Indicators have inherent limitations*
  Indicators are not specific diagnostic tools. They should be regarded as *indicative or suggestive* of problems or issues needing action. A number of more detailed diagnostic, action-oriented tools are available such as maternal/perinatal audits. In general, such tools are qualitative in nature.

- *Indicators should be based on readily available information*
  In selecting indicators it is important to consider what information is already being generated, rather than burdening health services with requests for additional information. Emphasis should be placed on refining existing indicators rather than creating new ones.

- *Indicators should be action-oriented*
  No indicator should be requested to be reported at the global or national level that is not relevant and useful for programme or case management at the level of data collection.

- *Qualitative and quantitative approaches should be considered*
  Other methodologies, in addition to those providing numeric information, should not be neglected in monitoring and evaluating strategies. They are important complements to quantitative indicators.

- *More than just scientific criteria for selection*
  In addition to scientific characteristics, criteria relevant to the use of the indicator, its weaknesses, and collection methodology must be considered.

- *Indicators must be clearly defined*
  Each indicator should be clearly defined both textually or in the case of proportions, rates or ratios, by specifying the numerator and denominator. With each indicator clear recommendations of data collection methods and formats of presentation, as well as appropriate uses of the indicator should also be provided.

- *Disaggregation of indicators*
  The indicators should allow for disaggregation by sex, age, urban/rural areas, special groups etc. as appropriate.

- *Periodicity of reporting*
  The periodicity of reporting is an issue that must be addressed. If significant changes are likely to occur from one year to the next, the indicator should be collected annually. If, however, the change is not statistically significant then an appropriate frequency of collection must be identified.

- *Stratification of indicators*
  There are many different bases on which indicators can be categorised, such as:
  organisational level - individual, community, country
  variable of primary interest - disease case, person, health programme
  function - priority setting, planning, implementation
  type of phenomenon - health status, health services
  logical framework approach - inputs, direct outputs, intermediate effects, impact
  The categorisation of indicators into groups such as those cited above can be useful for ensuring a balanced spread of indicators.

- *New and emerging issues in reproductive health*
  Suitable indicators for new and emerging issues in reproductive health must be identified. Information systems providing information on these areas must be developed and improved.

- *The identification of indicators should be an ongoing process*
  The selected minimal list of indicators should not be finite. Changes in our understanding of what we mean by reproductive health, in epidemiological situations and in health care and service delivery, are inevitable. Therefore, there will be a need to periodically up-date the list as new indicators are tested and found useful. Also, there needs to be a mechanism for dropping indicators that are not useful or that require unrealistic and unsustainable resources for their collection.

The minimal list of indicators for global monitoring

The technical group assessed each of the 17 indicators in the "working" minimal list, paying particular attention to definition, the numerator and denominator, the feasibility of data collection and issues of interpretation. Some of the indicators were discarded, some were modified and others were added to the list. This process, and the rational for the selection of the final list of 15 indicators, is described in detail in, *Monitoring reproductive health: selecting a short list of national and global indicators* (WHO/RHT/HRP/97.26). The final agreed upon list is outlined below.

1. **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.

2. **Contraceptive prevalence rate (any method)**
   Percentage of women of reproductive age who are using (or whose partner is using) a contraceptive method** at a particular point in time.*
   * Contraceptive method includes female and male sterilisation, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and condoms, natural family planning and lactational amenorrhoea where cited as a method.
   ** Women of reproductive age here refers to all women aged 15-49, who are at risk of pregnancy, i.e. sexually active women who are not infecund, pregnant or amenorrhoeic.

3. **Maternal Mortality Ratio**
Annual number of maternal deaths per 100 000 live births.

4. **Antenatal care coverage**
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.*
* Skilled health personnel refers to doctor (specialist or non-specialist), and/or persons with midwifery skills who can manage normal deliveries and diagnose or refer obstetric complications. Both trained and untrained TBAs are excluded.

5. **Births attended by skilled health personnel**
Percentage of births attended by skilled health personnel (excluding trained or untrained traditional birth attendants).*
* Skilled health personnel refers to doctor (specialist or non-specialist), and/or persons with midwifery skills who can manage normal deliveries and diagnose or refer obstetric complications. Both trained and untrained TBAs are excluded.

6. **Availability of *basic* essential obstetric care**
Number of facilities with functioning basic essential obstetric care per 500 000 population.*
* Basic essential obstetric care should include parenteral antibiotics, oxytocics and sedatives for eclampsia, and the manual removal of placenta and retained products.

7. **Availability of *comprehensive* essential obstetric care**
Number of facilities with functioning comprehensive essential obstetric care per 500 000 population.*
* Comprehensive essential obstetric care should include basic EOC plus surgery, anaesthesia and blood transfusion.

8. **Perinatal mortality rate**
Number of perinatal deaths per 1000 total births.*
* Deaths occurring during late pregnancy (at 22 completed weeks gestation and over), during childbirth and up to seven completed days of life.

9. **Low birth weight prevalence**
Percentage of live births that weigh less than 2500 g.

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

11. **Prevalence of anaemia in women**
Percentage of women of reproductive age (15-49) screened for haemoglobin levels with levels below 110 g/l for pregnant women, and 120 g/l for non-pregnant women.

12. **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).

13. **Reported prevalence of women with FGM**
Percentage of women interviewed in a community survey, reporting themselves to have undergone FGM.

14. **Prevalence of infertility in women**
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.

15. **Reported incidence of urethritis in men**
Percentage of men (15-49) interviewed in a community survey, reporting episodes of urethritis in the last 12 months.

An additional indicator, ***HIV prevalence in pregnant women aged 15-24***, was also discussed. This indicator has been proposed by UNAIDS where it has been under development.[2] The group, however, felt that there are a number of problems with this indicator. These are outlined in the document (WHO/RHT/HRP/97.26). Nonetheless, in some settings, particularly where HIV prevalence is high, it may be considered important to collect this information. Where this is the case, extreme caution is urged, both with regard to the operational aspects and to issues of interpretation.

Research issues

This final list of 15 global level indicators may appear to be somewhat long on safe motherhood and perinatal issues and rather short on other aspects of reproductive health. This is in part a reflection of the fact that it is in these areas that there is greatest experience in selecting and generating indicators. Other aspects of reproductive health were identified as in need of further research before appropriate indicators can be identified. These are listed below:

- Abortion
- Violence against women
- Quality of care
- Access to care
- Antenatal care
- Post-partum care
- Adolescent reproductive health
- "Male factor"
- Reproductive health policy
- HIV/AIDS
- Reproductive Tract Infections
- Preventative behaviour
- Cervical cancer.

[2] World Health Organization, (1994) Global Programme on AIDS. *Evaluation of a national AIDS programme*. WHO/GPA/SEF/94.1.

Where next?

Consensus was reached on a minimal list of indicators for global monitoring, but further groundwork is needed in order to implement this minimal list successfully. The meeting recommended that the following steps be taken to finalise the minimal list of global indicators.

1. *The short-listed indicators must be reviewed to identify potential improvements.*
   Points highlighted during the meeting include:
   - Clear recommendations / guidelines are needed for countries to generate, analyse and interpret the indicators adequately. Therefore, WHO will be developing detailed guidance notes, describing the data collection methods and their strengths and weaknesses, and how the data should be interpreted, noting in particular some of the common pitfalls.
   - Where appropriate the indicators should be disaggregated (e.g. by age or sex)
   - The appropriate frequency of collection must be ascertained

2. *A strategy must be devised to identify / develop new indicators, not only for the research issues pinpointed during the meeting, but also for the new and emerging issues in reproductive health.*
   These must pass through the same rigorous selection process, based on the selection criteria outlined on page 10, used to select the minimal list.

To successfully implement the minimal list of indicators the following steps were recommended:

3. *A strategy must be devised to introduce these indicators to the national statistical offices, programme managers and agency representatives.*
   This could be achieved through a series of workshops to provide guidance on the generation, analysis and interpretation of the indicators.

4. *International databases, such as those maintained by the WHO Family and Reproductive Health Division (FRH), should begin systematically collecting the selected minimal list of indicators for global monitoring, to ensure their effective retrieval.*
   WHO's FRH data bases currently cover:
   - Maternal mortality
   - Perinatal mortality
   - Low birth weight
   - Coverage of care
   - Unsafe abortion
   - Anaemia in women
   - Infertility.

5. *Country-specific case-studies should be used to appraise the implementation of the indicators.*
In particular, their integration within reproductive health programme review processes, the training needs, the deletion of redundant indicators and their successful interpretation.

WHO is currently setting up a task force, involving a broader group of people in the ongoing work mentioned above, including technical experts, NGOs and women's groups.

RECOMMENDATIONS AND CONCLUSIONS

This Interagency Technical Meeting on Reproductive Health Indicators for Global Monitoring achieved all its objectives set out in section 3 of this document.

- Consensus was reached on a minimal list of 15 indicators for global monitoring
- Research needs were defined for areas where appropriate indicators have not yet been identified or tested
- Criteria were agreed upon for the identification and selection of indicators at district level

Also all agencies present acknowledged the need for continued inter-agency collaboration and the importance of limiting the proliferation of indicators, particularly for global monitoring.

Recommendations on how to proceed

In order to successfully implement the agreed upon minimal list of indicators the group set out a number of recommendations on how to proceed.

- Continued inter-agency dialogue and collaboration is crucial.
- WHO should consider establishing a task force, involving a broad group of people - technical experts, NGOs and women's groups - to continue and co-ordinate the ongoing work.
- A series of regional and intercountry workshops should be developed to introduce the minimal list of indicators to participants.
- WHO should develop detailed guidelines on collecting, analysing, interpreting and acting on reproductive health indicators.
- A strategy is needed for developing new indicators which meet the proposed criteria.
- WHO should expand its data bases, to cover the selected minimal list of indicators for global monitoring, to ensure their effective retrieval.
- Country-specific case-studies should be carried out to appraise the implementation of the indicators. In particular to examine their integration within reproductive health programme review processes, the training needs, the deletion of redundant indicators and their successful interpretation.
- Field trials of district level guidelines should be undertaken

ANNEX 1
"WORKING" MINIMAL LIST OF REPRODUCTIVE HEALTH INDICATORS

The following list is taken from the background document, *Reproductive health indicators for national and international monitoring: selection of a short list* and was the basis for discussion.

1. Total fertility rate
2. Fertility rate of women 15-19 years old
3. Contraceptive prevalence rate (modern contraception)
4. Maternal Mortality Ratio
5. Proportion of women attended at least once during pregnancy for reasons related to pregnancy
6. Proportion of births attended by trained health personnel (excluding trained and untrained traditional birth attendants)
7. Number of health centres per 500 000 population with functioning basic essential obstetric care (basic EOC)
8. Number of hospitals per 500 000 population with functioning comprehensive essential obstetric care (comprehensive EOC)
9. Proportion of babies under four months old who are exclusively breast fed
10. Perinatal mortality rate
11. Proportion of live births of low birth weight
12. Positive syphilis serology prevalence in pregnant women
13. Proportion of pregnant women routinely screened for haemoglobin levels who are anaemic
14. Facility-based case fatality rates for post-abortion complications
15. Estimated prevalence of women who have been genitally mutilated
16. Proportion of service delivery points offering PAP smear tests
17. Proportion of women aged 20-44 years who are sexually active, are not using contraception or lactating, who want a pregnancy and have not become pregnant during the last two years

ANNEX 2
STEPS FOR SELECTING INDICATORS AT DISTRICT LEVEL

STEP 1
List the reproductive health programme areas which are functioning in your district

STEP 2
Locate all the relevant sources of data in your district, and identify the indicators available from these according to programme area

STEP 3
Take each programme area separately and decide which of the indicators listed are:
Useful
Accessible
Ethical
Robust
Representative
Understandable

STEP 4
Select available indicators for each programme area

STEP 5
Select new indicators for each programme area

STEP 6
Assess the extent to which the data collection system currently in place enables the selected indicators to be generated

STEP 7
Review the complementarity of the selected indicators across the programme areas and identify gaps

ANNEX 3
AGENDA

1. Opening of the meeting
2. Agency activities in the area of reproductive health indicators
3. Country case studies: generating health information and identifying indicators
4. Selecting reproductive health indicators at district level
5. Reproductive health indicators that meet essential requirements for national and global monitoring
6. Lessons learned about the use of “Health for All” indicators
7. Research needs in areas where indicators have not yet been identified or tested
8. Recommendations and next steps
9. Closure of meeting

ANNEX 4
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