

AN ADVOCATE'S GUIDE:

Strategic Indicators
for Universal Access
to Sexual and
Reproductive Health
and Rights



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Strategic Indicators
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to Sexual and
Reproductive Health
and Rights

Developed by TK Sundari Ravindran

Based on indicators agreed to by ARROW and partners- Likhaan, RHAC, RUWSEC, Shirkat Gah and Yayasan Kesehatan Perempuan- at the Strategic SRHR Indicators' Workshop on 21 – 22 August 2013, Kuala Lumpur, Malaysia.

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Preface

The year 2014 marks the 20th anniversary of the International Conference on Population and Development's Programme of Action, one of the landmark consensus documents in which governments agreed to and signed off on commitments towards improving women's sexual and reproductive health and rights (SRHR). Monitoring government achievements and performance is a powerful exercise in holding governments and development stakeholders accountable to those international commitments on SRHR.

ARROW and her partners have been actively and consistently monitoring the implementation of the ICPD Programme of Action at the +5, +10, +15 and +20 intervals at community, national, regional and Global South levels. At strategic intervals we review and renew the indicators we use in order to enable better monitoring of government performance.

This strategic set of indicators was derived from the indicators used in the +15 regional and +20 Global South monitoring work done by ARROW and her partners. These indicators were then discussed and refined in close consultation with lead partners in our European Union (EU) supported project, to enhance the monitoring of the key issues we work on. The combination of both quantitative and qualitative indicators presented here enables NGOs to present an improved analysis of the situation on the ground to influence and guide policy- and decision-makers.

ARROW and the 15 partners of the EU project are working to ensure that universal access to SRHR remains high on the development agenda in the Asia-Pacific region and that national and international policy- and decision-makers are improving SRHR policies and investments to benefit the underserved and most marginalised groups, especially women and girls. These partners are all women's rights organisations, and have been chosen because they have a direct stake in the issues around women's SRHR. This will enable the rights aspects—women's rights, sexual and reproductive rights, and health rights—to be emphasised.

ARROW recognises the contributions of TK Sundari Ravindran who has been working in close collaboration with ARROW to develop and refine this set of strategic indicators through the years. Her dedication to mentoring and guiding ARROW staff and partners in understanding data and analysis has really enriched our ability to monitor governments.

It is our greatest hope that this contribution helps create the momentum to ensure that the SRHR agenda stays on track for inclusion within the post-2015 development framework.

Sivananthi Thanenthiran
Executive Director

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This publication, *An Advocate's Guide: Strategic Indicators for Universal Access to Sexual and Reproductive Health and Rights*, was developed by TK Sundari Ravindran. It is based on the Strategic SRHR Indicators workshop, where she served as a resource person and where five national partners in the Asia-Pacific region together with ARROW identified the core set of indicators to take the SRHR agenda forward in the project, "Strengthening the Networking, Knowledge Management and Advocacy Capacities of an Asia-Pacific Network for SRHR," supported by the EU. Sundari has been working with ARROW for a long time in fine-tuning our monitoring work with regards the International Conference on Population and Development (ICPD).

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We also acknowledge the contribution from ARROW staff: Sivananthi Thanenthiran, Maria Melinda Ando, and Nadia Rajaram for their feedback on the draft which was incorporated into the final version.

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Finally, this publication is made possible with the assistance from the EU, under the project "Strengthening the Networking, Knowledge Management and Advocacy Capacities of an Asia-Pacific Network for SRHR."

About this Guide

This guide was prepared to enable advocates to use data when advocating for universal access to SRHR at the national, regional and global levels. It is a direct outcome of the Strategic SRHR Indicators workshop held in Kuala Lumpur, Malaysia on 21-22 August for the project “Strengthening the Networking, Knowledge Management and Advocacy Capacities of an Asia-Pacific Network for SRHR” supported by the EU.

One of the major objectives of the project is to develop a comprehensive monitoring framework of indicators for measuring government performance to fulfil their international commitments, particularly to the ICPD and the MDGs, both in the Asia-Pacific region and globally. It is a timely objective to aim at, to monitor the progress and performance thus far, when the international development community, as well as national governments and civil society organisations, are reviewing the ICPD goals and MDGs. It is also a critical moment for advocating SRHR at all levels to ensure that universal access to SRHR remains important in the development agenda after 2015.

Building on past experiences in monitoring the progress of ICPD+15/20, ARROW and her partners have identified the core set of indicators that are internationally cross-comparable, measurable, and where the existing data is available from credible sources in the time series. The primary purpose of this rigorous exercise was to develop country and regional profiles based on these indicators, which will be used for advocacy in the 15 countries in the region where the project operates, as well as globally.

However, we believe that this guide will also be of great use for SRHR advocates at various levels, as well as anyone interested in SRHR, to better understand the process of concrete evidence generation on universal access to SRHR. It is not meant to be a full set of indicators nor a comprehensive guidebook/textbook for indicators. If you think your country or region needs other indicators to address specific issues, it would certainly make sense to include them in addition to the indicators listed here. There are already a lot of different sets of SRHR indicators available. In selecting the indicators, what the author, the ARROW team and her partners kept in mind was their usefulness in promoting human rights, and in pushing for accountability of governments and the international development community.

We also had foremost in mind the inequity in country and within the region: how to address the needs within SRHR policies of marginalised populations, including women, poor people, young people, indigenous people, migrant populations and people with diverse sexual orientations and gender identities, with the minimal set of indicators across the Asia-Pacific region. Other than being meant for practical use for advocacy, this special attention to marginalised populations with human rights perspectives, characterises this set of indicators. We sincerely hope that our attempt will contribute to the policy change in the area of universal access to SRHR.

SECTION I

AN ADVOCATE'S GUIDE TO INDICATORS FOR MONITORING PROGRESS IN UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

What are health indicators?

Health indicators:

- Are pointers which lets one know how things are, how they have changed over time;
- Can alert one to the possibility that there is a problem; and
- A single indicator is like one piece of a puzzle; one has to use reasoning to look for other pieces to get a more complete picture.

A piece of a puzzle

The following data is about the proportion of births attended by skilled birth attendants in three Asian countries. Delivery by skilled birth attendants is known to be highly correlated with lower maternal mortality ratios (MMRs), and this is the reason why this indicator matters. What we gather from this is that Cambodia fares much better than Nepal and Bangladesh. But this is only one piece of the story.

Proportion of births attended by Skilled Birth Attendants:

Bangladesh	31.7% (2011)
Cambodia	71.0% (2010)
Nepal	36.0% (2011)

However, the picture changes if you include Maternal Mortality Ratio as another indicator.

	MMR	SBA
Bangladesh	240 (2010)	31.7% (2011)
Cambodia	250 (2010)	71.0% (2010)
Nepal	170 (2011)	36.0% (2011)

Source: Millennium Development Goals Indicators Database

When we look at data on maternal mortality ratios for the same countries, what we find is that Nepal and Bangladesh have much lower ratios compared to Cambodia. Despite having the highest percentage of skilled personnel attending to births, Cambodia has the highest mortality rate among the three. On the other hand, the maternal mortality ratio in Nepal is not as high, though the proportion of births attended by skilled personnel is much lower. Here, one must ask about the underlying causes of maternal deaths in Cambodia. Why do women die despite having skilled birth attendance? Is it because the quality of delivery care is

poor? Or are the women in such poor health that it would be difficult to save them in case of obstetric emergencies? In the cases of Nepal and Bangladesh, are maternal deaths being reported accurately? If yes, it is important to learn how and why the maternal mortality ratio declined rapidly without a higher proportion of births attended by skilled personnel.

Categories of indicators

Indicators are usually categorised into two.

- **Quantitative indicators** can be defined as a measure of quantity- usually as a rate or a ratio. For example, the infant mortality rate is a quantitative indicator, which involves counting the number of infants who died before they reached one year of age, and expressing this as a proportion of all infants who were born.
- **Qualitative indicators** include:
 - People's judgements or perceptions about a situation (e.g., Proportion of people who feel that the consultation time with the physician was adequate).
 - 'Yes/No' indicators, which refer to the adoption of policies and creation of mechanisms and structures for achieving a specific objective (e.g., Is there a Reproductive Health Policy in the country? Yes/No).

What can health indicators measure or point to?

- **Existence of policy commitment:** e.g., existence of a law against domestic violence; a policy which makes maternal death reviews mandatory.
- **Health System characteristics:** e.g., percentage of health spending by government; emergency obstetric care facilities per 100,000 population.
- **Utilisation indicators:** e.g., contraceptive prevalence rate, percentage of births attended by skilled attendants.
- **Health Status:** e.g., total fertility rate, maternal mortality ratio.
- **Health equity in utilisation and status:** e.g., births attended by skilled birth attendants among poorest 20% as a proportion of births attended by skilled birth attendants among richest 20%; maternal mortality ratio among immigrant population as compared to the same among the local population.

What makes a good health indicator?

The Health Council Canada (2011) notes that a good health indicator:

- Measures what it claims to measure;
- Allows you to make apple-to-apple comparisons; and
- Provides all technical details about how it was collected.

When selecting an indicator, one should bear in mind that a good health indicator should *measure what it claims to measure*. For instance, antenatal care is sometimes used as a measure of maternal health care.

However, there are some instances where maternal mortality ratios are very different across places that have almost the same proportion of women receiving antenatal care. This means that antenatal care is not a good enough indicator of maternal healthcare in this case because it does not differentiate between places that are likely to have high and moderate or low maternal mortality ratios.

Similarly, some might think that education is a good indicator of utilisation of contraception. However, if both educated and uneducated women are found not using contraception, then education is hardly a good indicator of contraception use. Secondly, a good indicator should also allow us to make apple-to-apple comparisons.

For example, when comparing two provinces, a province could have a higher prevalence of non-communicable diseases than the other because that province has a higher proportion of persons above 50 years in its population. Therefore, the two provinces should first be made comparable in terms of its age distribution (i.e., 'age standardisation') before the indicators for these two provinces can be compared.

Thirdly, a good indicator should also provide all the technical details of how the data was collected. It is important to look at the sources of data included in the numerators and denominators of indicators. For example, in a morbidity survey, reproductive morbidity was found to be much lower than all other types of morbidity. But when one examined the data-collection method, it was found that the men as heads of the households were answering the surveys.

The male head of household may not know about the reproductive health problems experienced by all women in the household, or may not be willing to disclose such information to a data collector who is male. Surveys in which women investigators ask women directly are more likely to get a higher number of reported reproductive health problems.

The anatomy of an indicator

What are the essential details that should come with an indicator?

1. **Indicator title and value, and the time period it represents.**
For example: "Antenatal coverage rate Bangladesh"- 54.6% in 2011

2. Definitions of both numerator and the denominator. For example:

The numerator includes “proportion of pregnant women with at least one antenatal visit by a skilled health provider,” while the denominator is “all pregnant women.”

Terms used in the numerator and denominator also need to be defined. For example, how is “antenatal visit” defined? Who is a “skilled health provider”?

3. Data source. Were the numbers from a special survey, which would cover all pregnant women in a community? Or is it routine service delivery data from a clinic, which will only report on those who came to the clinic? There should also be some explanation of the limitations of the source of data; for example, whether there is possibility of under- or over-estimation or of being non-representative of the general population (Health Council Canada, 2011).

Caution! Use with care

- When comparing indicators from two different sources, make sure that they are defined in the same way.
- When comparing indicators over time, make sure definitions have not changed and the boundaries of the geographic area have remained the same.
- Averages may mask extreme inequalities. For example, there are large variations across income groups in deliveries attended by skilled birth attendants or in contraceptive prevalence rates.
- When examining health-seeking behaviour, ‘proportion seeking treatment’ may be high. However, if the nature of treatment sought (medical, traditional) and/or the delay after which treatment was sought (how many days after symptom appeared) are examined, we may find that inequalities appear across population sub-groups. Therefore, while an almost equal proportion of women from two ethnic groups may be seeking treatment, the more disadvantaged group may be seeking treatment from informal and not fully qualified health providers while the more privileged group may be going to hospitals with qualified health providers. It may also be that the more disadvantaged group may delay treatment for several days before seeking treatment from a qualified source due to lack of information, time or having to mobilise money for treatment.
- As already indicated, more than one health indicator may need to be examined before drawing conclusions. For example, while there may be low prevalence of a health problem, further examination may show that this is not because people are not falling ill, but that the condition is so serious that there is high incidence and high and immediate mortality.

Indicators are the means, not the end

- Indicators are only a tool to assess whether there is a problem, and whether we are moving in the right direction towards addressing these problems.
- Unless acted upon, they remain useless.

Using Indicators for Advocacy for Universal Access to SRHR

The ARROW project for which this guide was produced aims to use indicators as a means to advocate for universal access to SRHR. Before we look at some principles that may guide the selection of indicators for advocacy purposes, let us first define universal access.

Universal access means that no one is deprived of being able to use appropriate services when needed. This is usually interpreted to mean that no one has to incur a large out-of-pocket expenditure at the time of seeking services; that services are geographically and socially accessible; and that service delivery points have the necessary personnel, supplies and equipment. This is also interpreted to mean that suitable policies and budgetary allocations are in place.

We have examined in detail how to understand and use indicators in general. However, when our aim is to advocate for universal access to SRHR and more importantly, to hold governments accountable for taking necessary steps towards universal access to SRHR, then it is important that the indicators we use are able to tell us something about whether or not governments are taking necessary action towards universal access.

Criteria for Choosing Indicators for Accountability

Yamin and Falb (2012) have suggested the following criteria for choosing quantitative health indicators to promote human rights accountability of governments:

- Objective;
- Continuously or frequently measurable;
- Programmatically relevant;
- Susceptible to disaggregation to show disparities and discrimination within countries; and,
- Susceptible to audit by affected population groups (p. 358).

Objective: This means that the indicator should be transparent about data sources and calculation methods, and also assumptions made. For example, estimates that are made on the basis of several assumptions, which are not made known to readers, will not qualify as being 'objective' according to this criterion.

Continuously or frequently measurable: Indicators for which data can be collected only once in ten years or so do not tell us much about whether the current administration is fulfilling its commitments. The indicators chosen for advocacy or accountability should therefore be such that data on these are collected at least once in two years, and better still, for which routine data are available.

Programmatically relevant: A programmatically relevant indicator is one which is able to tell us whether or not a programme is doing better (or worse) now as compared to earlier, so that we know whether the government has or has not taken appropriate action. Some examples of programmatically relevant indicators are budgetary allocation, deployment of human and other resource, and service utilisation disaggregated by relevant population subgroups.

Susceptible to disaggregation to show disparities and discrimination within countries: The indicator should have data for various vulnerable subgroups of the population, so that one can assess whether or not the objective of universality and equity are being achieved.

Susceptible to audit by affected population groups: The indicators chosen should lend themselves to verification by affected populations through small-scale audits. For example, let us take the indicator "proportion of deliveries by skilled birth attendants." It would be possible for a rural community to carry out a rapid assessment of the proportion of deliveries by skilled birth attendants in their community during the past one year, and alert authorities if this was vastly lower than the official figures quoted by government.

Practical criteria: Choice of indicators for advocacy purposes has also to be governed by some practical considerations. For example, indicators chosen should be readily available, and at least a core-set of indicators should be comparable across countries participating in the project for the purpose of getting a regional picture.

SECTION II

DEFINITION, INTERPRETATION AND DATA SOURCES FOR CORE INDICATORS OF UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Sexual and Reproductive Rights Indicators

1. Difference between Median Age at Marriage and Legal Minimum Age at Marriage

The purpose of this indicator is to examine the extent to which legal age at marriage is adhered to. This is viewed as an indicator of sexual rights under the assumption that adolescent girls are less likely to be able to exercise the right to choose their husbands or sexual partners.

INDICATORS

$$\frac{(\text{Median age at marriage for women at a given point in time})}{\text{Minus}} \\ (\text{Legal Age at marriage as specified by law})$$

Median age at marriage is defined as follows:

$$\frac{\text{Number of women age 20-49 years who have married}}{\text{Number of women of all marital statuses age 20-49 years}} \times 100$$

Median age at marriage for women age 15-49 years may be understood to indicate the age by which 50% of women in this age group have been married.

Definitions

'Marriage' as used by most surveys refers to unions that are recognised by civil and religious laws, as well as by the community. Only heterosexual unions are considered in these definitions. Unless otherwise specified, the age under consideration is for *first marriage*, i.e., the age at which the respondent began living with her/his first spouse or partner (Measure Evaluation PRH). The specific age category considered is usually 20-49 years, and sometimes, 25-49 years.

Points to Remember

Another commonly used indicator of age at marriage is 'singulate mean age at marriage.' When the indicator says 'age at marriage,' check to see whether it refers to median age at marriage for women. Median age at marriage is preferable because the median tells us the 50% mark, while the mean is influenced by extreme values and does not tell us what percentage of the population would have married by that age.

Sometimes the median age is disaggregated by five-year age groups, e.g., 15-19 years, 20-24 years, 25-29 years and so on. (See Table 1, pg. 18 for an example.)

Table 1: Age at first marriage

Percentage of women age 15-49 who were first married by specific exact ages and median age at first marriage, according to current age, Cambodia 2010

Percentage first married						Percentage never married	Number	Median age at first marriage
Current age	15	18	20	22	25			
					Women			
15-19	0.9	na	na	na	na	89.1	3,734	a
20-24	2.1	18.4	37.3	na	na	43.1	3,155	a
25-29	1.8	21.2	41.4	58.2	76.8	16.4	3,262	21.0
30-34	4.8	27.1	48.1	66.5	79.8	8.6	2,167	20.2
40-44	3.8	22.4	44.5	63.4	80.7	5.1	2,300	19.8
20-49	2.9	23.7	44.9	na	na	16.3	15,020	a
25-49	3.1	25.1	46.9	63.9	79.3	9.2	11,865	20.3

Source: National Institute of Statistics, Ministry of Planning; Directorate General for Health, Ministry of Health, Cambodia; and MEASURE DHS. (2011.) Cambodia Demographic Health Survey Final Report 2010.

In the table, the median age at marriage for women aged 15-19 years and 20-24 years is not calculated since fewer than 50% of the cohort are married or lived in a consensual union.

If we want to know about marriage trends for the younger age groups, it would be more useful to use the indicator “*percentage married before age 15*” for those ages 15 to 19 years and “*percentage married before age 18*” for those ages 20 to 24 years (Measure Evaluation PRH).

Data Sources

The main sources of median age at marriage data is the Demographic and Health Surveys (<http://measuredhs.com/Where-We-Work/Country-List.cfm>). Most other UN sources, such as the World Marriage Data and the World's Women, give data on Singulate Mean Age at Marriage. Information for all countries on the legal minimum age at marriage can be found in the UN Statistical Division's database (<http://unstats.un.org/unsd/demographic/products/indwm/default.htm>).

2. Grounds under which Abortion Is Legal

The purpose of this indicator is to assess the extent of legal restrictions placed on the availability of safe abortion services.

INDICATORS

Legal grounds on which abortion is permitted:

To save a woman's life	Yes/No
To preserve a woman's physical health	Yes/No
To preserve a woman's mental health	Yes/No
In case of rape or incest	Yes/No
Because of foetal impairment	Yes/No
For economic or social reasons	Yes/No
On request	Yes/No

Definitions

In the present context, ‘abortion’ refers to ‘induced’ abortion, which is the intentional termination of a pregnancy before the foetus can live independently. An abortion may be elective (based on a woman's personal choice) or therapeutic (to preserve the health or save the life of a pregnant woman) (Abortion, induced, 2013).

In most countries of the world, induced abortion is regulated by law which spells out the grounds under which abortion is legal in a country, i.e., the circumstances under which a woman approaching a health facility to have a pregnancy terminated may be legally provided abortion services according to the laws of the land. While national laws may present this information in an elaborate form, inter-country comparison is facilitated by summarising the 'grounds' to the seven given above.

In many countries where induced abortion is permitted only on one or two therapeutic grounds, the general perception may be that abortion is illegal. However, most countries permit legal abortion on at least one of the above grounds. This means that safe abortion services ought to be made available in the health system, and medical colleges ought to train providers for performing abortion so that women who satisfy the legal requirements are not denied abortion services.

In countries with a federal structure, there may be differences across states/provinces in the existence and contents of policies. This has to be captured when assessing the policy situation on induced abortion.

Data Sources

The latest information for all UN Member countries is available from the publication, *World Abortion Policies 2013*, published by the United Nations Department of Economic and Social Affairs, Population Division (http://www.un.org/en/development/desa/population/publications/pdf/policy/WorldAbortionPolicies2013/WorldAbortionPolicies2013_WallChart.pdf). This is a periodic publication, and comparison with earlier versions may give information on changes over time. Data may be cross-checked against the latest legal sources for each country to take into account any recent changes and amendments that may have been introduced to the law governing abortion.

3. Legislation and Policies on Sexual Orientation

Here, we consider a set of commonly used indicators, which provide an understanding of the extent to which the human rights of people with non-heterosexual sexual orientation are respected, protected and fulfilled by governments.

INDICATORS

- a) Legal status of same-sex sexual activities between consenting adults: *Legal/Illegal/Illegal and punishable with death penalty/Unclear or uncertain*
- a) Legal or policy prohibition of discrimination in employment based on sexual orientation: *Yes/No*
- b) Constitutional prohibition of discrimination based on sexual orientation: *Yes/No*
- c) Is incitement to hatred on the basis of sexual orientation prohibited by law: *Yes/No*
- d) Is marriage between same-sex couples legal: *Yes/No*
- e) Are rights of marriage offered to same-sex couples (as compared to heterosexual couples): *Most or all/Some/None*
- f) Is joint adoption by same-sex couple legal: *Yes/No*

Definitions

Sexual orientation covers sexual desires, feelings, practices and identification. Sexual orientation can be towards people of the same or different sexes: same-sex, heterosexual or bisexual orientation (Amnesty International).

In countries with a federal structure, there may be differences across states/provinces in the existence and contents of policies. This has to be captured when assessing the policy situation on sexual orientation.

Data Sources

The International Lesbian Gay Bisexual Trans and Intersex Association (ILGA) publishes an annual report, *State-sponsored Homophobia; A World Survey of Laws: Criminalisation, Protection and Recognition of Same-sex Love*, with data for 110 countries (www.ilga.org). Information on national legislations and policies may be available from websites of national governments and from organisations working for sexual rights.

4. Legislation and Policies on Gender Identities

Here, we consider a set of commonly used indicators, which provide an understanding of the extent to which the human rights of trans-people or gender-variant people are respected, protected and fulfilled by governments.

INDICATORS

- Existence of law criminalising 'so-called' cross-dressing or other activities of trans or gender-variant people: *Yes/No*
- Change of name legally possible: *No/Yes - on request/Yes - on the basis of psychiatric diagnosis of Gender Identity Disorder/Yes - only following a Gender Reassignment Surgery/Yes - conditional on undergoing sterilisation*
- Change of gender legally possible: *No/Yes - on request/Yes - on the basis of psychiatric diagnosis of Gender Identity Disorder/Yes - only following a Gender Reassignment Surgery/Yes - conditional on undergoing sterilisation*
- Legal or policy prohibition of discrimination in employment based on gender identity: *Yes/No*
- Incitement to hatred on the basis of gender identity prohibited by law: *Yes/No*
- Constitutional prohibition of discrimination based on gender identity: *Yes/No*
- Granting asylum on grounds of discrimination based on gender identity authorised by law or policy: *Yes/No*
- Gender reassignment treatment/surgery or body modifications available: *No/Yes - on request/Yes - only on the basis of psychiatric diagnosis of Gender Identity Disorder*

Definitions

Gender identity refers to the complex relationship between sex and gender, referring to a person's experience of self-expression in relation to social categories of masculinity or femininity (gender). A person's subjectively felt gender identity may be at variance with their sex or physiological characteristics (Amnesty International).

The terms 'trans-people' or 'gender-variant' people include those with a gender identity that is different from the gender they were assigned at birth, and those who wish to portray their gender in a way that differs from the gender they were assigned at birth. These include, among many others, transsexual and transgender people, transvestites, cross-dressers, as well as intersex people who relate to or identify as any of the above (Balzer et al, 2012).

In the Asia-Pacific region, there is a wide range of groups of various gender and sexual identities. These include the *akava'ine* in Cook Islands; the *arovanis*, *hijras* and *kothis* in India; the *baklas* in the Philippines; the *fa'afafine* in Samoa; the *fakafafine* in Tonga; the *mak nyahs* in Malaysia; the *metis* in Nepal; the *warias* in Indonesia; the *vakasalewalewa* in Fiji; and the butch/femme identities that are so strongly ingrained in same-sex desiring women in China, Indonesia and the Philippines

(Chandiramani, 2007; New Zealand Human Rights Commission). In countries with a federal structure, there may be differences across states/provinces in the existence and contents of policies. This has to be captured when assessing the policy situation on legislation and policies on gender identities.

Data Sources

Transgender Europe publishes a periodic report on the legal and health care situation of gender-variant people from about 54 countries, including several in Asia, *Transrespect versus Transphobia Worldwide: A Comparative Review of the Human Rights Situation of Gender-variant/Trans People* (http://www.transrespect-transphobia.org/uploads/downloads/Publications/TvT_research-report.pdf).

Information on national legislations and policies may be available from websites of national governments and from organisations working on sexual rights and the rights of gender-variant people.

5. Policies on Sexual and Reproductive Health

The existence of a sexual and reproductive health (SRH) policy in a country is taken as an indication of SRH being on the political agenda and supported by the government. The expectation is that with a policy in place, budgetary allocations and programmes will follow. An SRH policy also gives advocates the leverage to hold their government accountable for its implementation.

We consider here a series of indicators on the existence, scope and implementation status of policies on SRH.

INDICATORS

- Is there a policy or strategy document issued by the government on SRH? *Yes/No*
- If yes, does it address issues beyond sexually transmitted infections and HIV? *Yes/No*
- If yes, does it address sexuality education? *Yes/No*
- If yes, status of its implementation: *Not implemented/Implemented in some locations or some parts of the policy implemented/Implementation progressing as scheduled*
- If no, is there a policy or strategy document issued by the government on reproductive health (RH)? *Yes/No*
- If yes, areas of reproductive health addressed by it: Family planning (FP) and maternal health (MH) only/Other reproductive health issues (besides FP/MH) addressed/Comprehensive (ICPD-defined) range of reproductive health issues addressed
- If yes (no SRH policy but RH policy), status of implementation: *Not implemented/Implemented in some locations or some parts of the policy implemented/Implementation progressing as scheduled*
- If no (no SRH policy or RH policy), is there a policy/strategy on sexuality education? *Yes/No*

Definitions

'Sexual and reproductive health' includes:

- Contraceptive services and safe abortion services within the parameters of the country's laws
- Pregnancy-related services, including skilled attendance at delivery, emergency obstetric care and post-abortion care
- Infertility diagnosis and treatment
- Sexually transmitted infections (STI) and HIV prevention, diagnosis, treatment and care
- Early diagnosis of, treatment, care and support for reproductive cancers, including breast and cervical cancers
- Prevention of gender-based violence and care of survivors
- Sexuality education
- Adolescent sexual and reproductive health

This definition is derived from the ICPD Programme of Action and subsequent interpretations.

In countries with a federal structure, there may be differences across states/provinces in the existence and contents of policies. This has to be captured when assessing the policy situation on SRH.

Data Sources

Information on government policies and programmes may be available from government websites and publications. Additionally, *Women of the World: Laws and Policies Affecting Their Reproductive Health; East and South-east Asia*, a 2005 publication by the Centre for Reproductive Rights in collaboration with Asian-Pacific Resource & Research Centre for Women (ARROW) gives information up to 2005 for China, Malaysia, Philippines, Thailand and Vietnam (<http://reproductiverights.org/en/document/women-of-the-world-laws-and-policies-affecting-their-reproductive-lives-east-and-southeast->). This could be a starting point which may then be updated.

Information on policies related to sexuality education for Asian countries is available from *Sexuality Education in Asia and the Pacific: Review of Policies and Strategies to Implement and Scale up*, Bangkok: UNESCO Bangkok, 2012 (<http://unesdoc.unesco.org/images/0021/002150/215091e.pdf>).

6. Extent of Gender-based Violence

This includes a set of indicators that point to the extent to which women's autonomy, including in matters related to sexuality and reproduction, may be constrained because of existence of violence or the threat of violence.

INDICATORS

Life-time prevalence of intimate partner violence

- a) $\frac{\text{Proportion of women age 15-49 who have ever been in a partnership, reporting physical violence by a partner ever in their life time} \times 100}{\text{All women age 15-49 who have ever been in a partnership}}$

All women age 15-49 who have ever been in a partnership

- b) $\frac{\text{Proportion of women age 15-49 who have ever been in a partnership, reporting sexual violence by a partner ever in their life time} \times 100}{\text{All women age 15-49 who have ever been in a partnership}}$

All women age 15-49 who have ever been in a partnership

- c) $\frac{\text{Proportion of women age 15-49 who have ever been in a partnership, reporting physical and/or sexual violence by a partner ever in their life time} \times 100}{\text{All women age 15-49 who have ever been in a partnership}}$

All women age 15-49 who have ever been in a partnership

Life-time prevalence of non-partner violence

- a) $\frac{\text{Proportion of women age 15-49 reporting physical violence by a person other than a partner ever in their lifetime} \times 100}{\text{All women age 15-49}}$

All women age 15-49

- b) $\frac{\text{Proportion of women age 15-49 reporting sexual violence by a person other than a partner ever in their life time} \times 100}{\text{All women age 15-49}}$

All women age 15-49

- c) $\frac{\text{Proportion of women age 15-49 reporting physical and/or sexual violence by a person other than a partner ever in their life time} \times 100}{\text{All women age 15-49}}$

All women age 15-49

- d) $\frac{\text{Proportion of women age 15-49 reporting forced first sex} \times 100}{\text{All women age 15-49}}$

All women age 15-49

Rape

- a) Number of cases of rape reported to the police in the most recent year (Crime Bureau Statistics)

- b) $\frac{\text{Proportion of women age 15-49 who have ever been in a partnership, reporting physical violence by a partner ever in their life time} \times 100}{\text{All women age 15-49 who have ever been in a partnership}}$

All women age 15-49 who have ever been in a partnership

Definitions

Gender-based violence is a broad term that includes all forms of violence and threat of violence against women. We have considered here specific categories of gender-based violence, which are most prevalent and on which data are now being collected and reported by many countries.

According to the US Centres for Disease Control (CDC), 'intimate-partner violence' or IPV describes physical, sexual, or psychological harm by a current or former partner or spouse (CDC, 2010).

The *WHO Multi-Country Study on Women's Health and Domestic Violence against Women* (Garcia-Moreno et al, 2005) defined a person as having experienced 'physical violence' if she was:

- slapped or had something thrown at her that could hurt her;
- pushed or shoved;
- hit with fist or something else that could hurt;
- kicked, dragged or beaten up;
- choked or burnt on purpose; and/or
- threatened by the perpetrator with the use of a gun, knife or other weapon, or if the weapon was actually used against her.

Sexual violence has been defined as, "[a]ny sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (WHO, 2011).

A person has experienced sexual violence by an intimate partner (Garcia-Moreno et al, 2005) if she:

- was physically forced to have sexual intercourse when she did not want to;
- had sexual intercourse when she did not want to because she was afraid of what the perpetrator might do; and/or
- was forced to do something sexual that she found degrading or humiliating.

A person has experienced forced first sex if her sexual initiation was coerced. Typically, questions which ask whether sexual initiation was 'non-consensual' or 'unwanted' find much higher proportion reporting this to be the case.

Data Sources

The Demographic and Health Surveys provide data on life-time prevalence of physical and sexual violence by an intimate partner. Information on non-partner physical and/or sexual violence may be available from special national surveys on violence against women.

UN Women has compiled all available surveys by country in the publication, *Violence against Women Prevalence Data: Surveys by Country, as of March 2011* (http://www.endvawnow.org/uploads/browser/files/vaw_prevalence_matrix_15april_2011.pdf). This publication provides information on intimate partner violence and prevalence of first forced sex.

Rape statistics may be available from the National Crime Bureau of Statistics or its equivalent at the country level.

The UN Secretary General's Data Base on Violence against Women (<http://sgdatabase.unwomen.org>) gives information for each UN country on what kind of country level statistics and survey data are available on violence against women.

7. Legislation related to Gender-based Violence

This set of indicators reveal the extent of policy commitment to prevent all forms of violence against women and the kind of legal recourse women have when they experience one or more forms of gender-based violence, ranging from intimate partner violence to non-partner violence, sexual violence within and outside marriage, female genital mutilation and sexual harassment in the work place.

INDICATORS

- | | | |
|----|---|--------|
| a) | Is there legislation on intimate partner violence against women? | Yes/No |
| b) | If yes, what forms of intimate partner violence does the law address? | |
| | - Physical violence | Yes/No |
| | - Sexual violence | Yes/No |
| | - Emotional abuse or controlling behaviour | Yes/No |
| c) | Is there legislation against rape? | Yes/No |
| d) | If yes, how does the legislation define rape? (Only vaginal penetration or beyond that?) | |
| e) | If there is a law on rape, does the burden of proof lie on the complainant or the alleged perpetrator? | |
| f) | Does the law on rape include marital rape as a crime? | Yes/No |
| g) | Is there a law or statutory provisions to address sexual harassment in the workplace? | Yes/No |
| h) | Does the health sector have specific statutory provisions to address sexual harassment in the work place? | Yes/No |
| i) | Is there a law prohibiting female genital mutilation? | Yes/No |
| j) | What are other laws prohibit violence against women? List these. (e.g., laws against dowry-related violence, acid throwing, honour killing) | |

Definitions

Intimate partner violence and sexual and physical violence have been defined earlier.

Sexual harassment is “any unwelcome sexual advance, request for sexual favour, verbal or physical conduct or gesture of a sexual nature, or any other behaviour of a sexual nature that might reasonably be expected or be perceived to cause offence or humiliation to another, when such conduct interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment. While typically involving a pattern of behaviour, it can take the form of a single incident. Sexual harassment may occur between persons of the opposite or same sex. Both males and females can be either the victims or the offenders” (UN Women).

WHO (2013) defines female genital mutilation as comprising of “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.”

Data Sources

The UN Secretary General's Data Base on Violence against Women (<http://sgdatabase.unwomen.org>) provides for each UN member country, information related to laws, policies and interventions to prevent all forms of violence against women ranging from intimate partner violence and rape to sexual harassment and trafficking.

8. Policy on Adolescent Sexual and Reproductive Health Services

The right of adolescents to appropriate services to meet their SRH needs was acknowledged in a special section of adolescents in the ICPD Programme of Action. Countries were called upon to protect and promote the rights of adolescents to reproductive health education, information and care (7.44 and 7.46, ICPD PoA). The purpose of this indicator is to assess the extent to which countries have acted on this recommendation and the barriers that adolescents continue to face in accessing SRH services.

INDICATORS

Is there a policy or strategy document issued by the government on provision of SRH services to adolescents? *Yes/No*
If there is a policy or strategy document on SRH services for adolescents:

- Does it specify that services will be available irrespective of marital status? *Yes/No*
- Does it require guardian or parental consent for accessing services for adolescents? *Yes/No*
- Does it permit minors to give informed consent on their own behalf? *Yes/No*
- What is the status of implementation? *Not implemented/ Implemented in some locations or some parts of the policy implemented/Implementation progressing as scheduled*

Definitions

Adolescent SRH services include “at a minimum... gender sensitive life-skills based SRH education and a package of social protection services for adolescents and youth, including psychosocial counselling, contraception, HIV-prevention, STI-prevention/ treatment and maternal health services” (UNFPA, 2008).

Data Sources

Information on policies related to SRH services for adolescents is usually available from government sources, such as publications of the section responsible for SRH of the Ministry of Health.

9. HIV and AIDS Policies

The principle of non-discrimination enshrined in the Universal Declaration of Human Rights and other human rights instruments prohibit discrimination based on race, colour, sex, language, religion, political or other opinion, property, birth or other status. In 1996, the UN Commission on Human Rights resolved that the term 'or other status' used in several human rights instruments 'should be interpreted to include health status, including HIV/AIDS', and that discrimination on the basis of actual or presumed HIV status is prohibited by existing human rights standards. The following set of indicators assess whether the government has put in place policies to uphold non-discrimination on the basis of HIV status.

INDICATORS

- a) Is there a legislation issued by the government prohibiting arbitrary discrimination on the basis of HIV status of an individual? *Yes/No*
- b) If there is a law prohibiting arbitrary discrimination on the basis of HIV status of an individual, which of the following areas does it cover?
 - Health care *Yes/No*
 - Employment *Yes/No*
 - Education *Yes/No*
 - Reproductive and family life *Yes/No*
 - Insurance and other financial services *Yes/No*
- c) Are there non-discrimination laws or regulations that specify protections for vulnerable subpopulations? *Yes/No*
- d) What is the status of implementation of the law? (For each law that exist)
Not implemented/ implemented in some locations or some parts of the law implemented/ implementation progressing as scheduled
- e) Is there evidence of arbitrary discrimination on the basis of HIV and AIDS in the internal regulations and procedures of public and private bodies, organisations or groups? (Irrespective of whether or not there is a law prohibiting arbitrary discrimination on the basis of HIV status) *Yes/No. If yes, please give illustrative examples*

Definitions

Arbitrary discrimination on the basis of HIV and AIDS, in legal terms, is defined as "any measure entailing an arbitrary distinction among persons depending on their confirmed or suspected HIV serostatus or state of health. Arbitrary discrimination may be "the result of an **action** or an **omission**. It may also be **intentional** or **unintentional** (occasionally, it may be the unexpected result of good intentions. (UNAIDS, 2000).

Data Sources

The 2011 UNAIDS publication *Making the Law Work for the Response: A Snapshot of Laws that Support or Block Universal Access to HIV/AIDS Prevention, Treatment, Care and Support*, (http://www.unaids.org/en/media/unaids/contentassets/documents/priorities/20100728_HR_Poster_en.pdf) provides information both on laws against discrimination and discriminatory laws and regulations for UN Member States.

Information about many Asian countries on government policies related to discrimination at the work place on the basis of HIV and AIDS status is available from the International Labour Organization's 2009 report, *HIV/AIDS and the World of Work, Report IV (1), International Labour Conference, 98th session, 2009* (http://www.ilo.org/wcmsp5/groups/public/@ed_norm/@relconf/documents/meetingdocument/wcms_090177.pdf). Also useful is the UNDP publication, *Global Commission on HIV and the Law Report 2012* by Judith Levine (www.hivlawcommission.org/index.php/report).

10. Grievance Redress Mechanisms for Sexual and Reproductive Health Services

In a human rights framework, accountability combines elements of responsiveness, answerability and redress. This indicator assesses government accountability for making SRH services by examining whether there are mechanisms for grievance redress when users have complaints related to the availability, access, affordability, acceptability or quality of SRH services.

INDICATORS

Are there grievance redress mechanisms for SRH services in this country? *Yes/No*

If yes,

- Describe these mechanisms
- At what levels do they function? *Facility level/state or provincial level/national level*
- How accessible are these mechanisms to marginalised sections of the population?
- What is known about the effectiveness of these mechanisms?

Data Sources

Information on the whether there are grievance redress mechanisms in place within the health sector or independent of it, the levels at which they function, and how effective they have been may be difficult to find all at one place. Such information would have to be sought from government orders and departmental orders within and outside the health sector; from documentation available from the private health sector; and from case laws describing the outcome of court cases that sought grievance redress for SRH services.

Definitions

Formal redress procedures in the health sector consist of “official venues in which individuals can present their understanding of their entitlements, receive an attentive hearing, and be given an explanation or compensation.” The purpose of the mechanism is to rectify something that has gone wrong. Compensation is typically sought for a service delivery transaction that has caused harm to a user or a group of users. The harm could be damage to health, financial loss, denial of a service or poor quality of service provided.

Grievance redress procedures may be set up within the health sector at various levels: at the facility level, departmental level at the district, state/province or national levels. They may also be independent non-judicial entities such as the office of an ombudsperson, tribunals or public enquiries. The judicial system, through courts of law, also hears and redresses the failures of health facilities and providers to comply with their statutory and contractual obligations, versus the extent to which courts review the regulations that govern service delivery (Gauri, 2011).

Grievance redress mechanisms may vary across states/provinces within a country. They may also vary between the public and private sector in health. Any assessment of grievance redress mechanisms would have to capture these multiple dimensions.

Sexual and Reproductive Health Indicators

1. Maternal Mortality Ratio

Maternal mortality ratio (MMR) is a reflection of how safe child delivery is for the woman. The fact that MMR can be as low as a certain number indicates that biologically it is possible to lower MMR to such levels. A much higher MMR than this lowest level suggests the lack of investment by the concerned governments in women's health and health care, and/or a poorly functioning health care system.

INDICATORS

$$\frac{\text{Number of perinatal deaths (late foetal and early neonatal deaths) x 1000}}{\text{Total number of births}}$$

Definitions

A 'maternal death' is the death of a woman while pregnant or within 42 days of termination of the pregnancy, irrespective of the duration and the site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Note the term 'after termination of pregnancy' - this indicates that even if the pregnancy does not end in a delivery, but ends in a miscarriage or abortion, the resulting death is a maternal death.

Note also the term 'irrespective of the site of pregnancy.' This means that a death during or following the termination of the pregnancy is a maternal death, even if the site of the pregnancy was not the uterus but the fallopian tube, as happens in ectopic pregnancy.

If a woman dies of malaria or hepatitis during pregnancy, this is to be counted as a maternal death because these conditions are more likely to be fatal in pregnant than in non-pregnant women. Such causes are known as 'indirect' causes of maternal mortality. The denominator ought to be number of pregnancies rather than number of live births. Live births are used as a proxy for pregnancies because data on live births are more easily available through routine data collection.

"Live birth" refers to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g., beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born. (<http://www.who.int/healthinfo/statistics/indmaternalmortality/en/>)

Points to Remember

Maternal deaths are rare events, and it is possible that there will be no maternal deaths in a given year or period of years in a small community. For example, an MMR of 200 would mean that one maternal death would happen in a population of 20,000, assuming a high birth rate of 25 births per 1000 population; an MMR of 100 would mean that one maternal death would happen in a population of 40,000; and so on. While it is useful to track every maternal death no matter how small the community, it would not be wise to compute MMR on this basis as the figure would not be representative.

Another important point when using and interpreting MMR data is to be mindful of the 'confidence intervals' of the MMR value. In tables giving data for MMR, look for a column labelled '95% CI' or '95% confidence interval.' An illustrative table is given below.

For India, the MMR is 212, with a 95% confidence interval of 198-226. This means that if 100 different samples are taken from the population of women delivering and MMR is computed, then in 95 of these the MMR will lie between 198 and 226. So the single value 212 actually stands for a range between 198 and 226.

Another point to note is about need for caution when comparing the MMR of two locations. If the confidence intervals of two places do not overlap, then we can safely assume that there is indeed a difference between the two. However, if the confidence intervals overlap, we cannot say this with certainty.

Table 2. Maternal Mortality Ratio (MMR) for India and Selected States, 2007-09

States	MMR	95% CI
India total	212	(198-226)
Assam	390	(280-500)
Bihar/Jharkhand	261	(210-313)
Madhya Pradesh/Chhattisgarh	269	(213-325)
Orissa	258	(189-327)
Rajasthan	318	(251-384)
Uttar Pradesh/Uttarakhand	359	(308-409)

In the table above, Assam appears to have a much higher MMR (390) than Bihar/Jharkhand (261). However, if you take into account their confidence intervals, then the situation looks like this:

(280 (Assam) 500)

(210 (Bihar/Jharkhand) 313)

We see that there is an overlap between possible MMR values for Assam and for Bihar/Jharkhand, between the ranges 280 and 313. In other words, it is entirely possible that the MMRs of both

these states are not very different. The message is that if two locations have MMRs with overlapping Confidence Intervals, then we cannot assume that there is a real difference in MMR values between these two locations. They could be a real difference or there may not be a difference.

Data Sources

The most widely used source of data for MMR is periodic estimates from WHO/UNFPA/UNICEF and World Bank. These are estimates based on a number of assumptions.

MMR figures are also available from the Demographic and Health Surveys for the countries where these are carried out. These are almost always only national level data because the sample size is not large enough to give figures for provinces or states. Thailand has carried out since 1998 periodic Reproductive Age Mortality Surveys (RAMOS) to compute MMR.

In some countries such as India, special surveys are now being carried out by the government to compute MMR at the state level. In Indonesia, UNFPA supported the Central Bureau of Statistics to estimate the MMR at 34 districts in South Sumatra, West Java, West Kalimantan, and NTT. China has a National Maternal and Child Health Routine Reporting System through which data is regularly gathered on maternal deaths and MMR is calculated at the provincial level

2. Perinatal Mortality Rate

Perinatal mortality rate (PMR) is a good indicator of both the status of maternal health and nutrition, and of the quality of obstetric care. For example, perinatal mortality is higher among women experiencing hypertensive disorders of pregnancy, antepartum haemorrhage, acute infections and chronic illness during pregnancy and failure to deal adequately with obstetric complications such as obstructed labour or inadequate skills for neonatal resuscitation.

INDICATORS

$$\frac{\text{Number of maternal deaths} \times 100,000}{\text{Number of live births}}$$

Definitions

The 'perinatal period' refers to the period between 22 completed weeks (154 days) of pregnancy (the time when birth weight is normally 500 g.) to seven completed days after birth. Perinatal death thus includes both late foetal death and early neonatal death.

Late foetal death—also known as stillbirth—refers to the death of a foetus weighing at least 500 grams or, when birth weight is unavailable, when the length of the foetus (also known as

the crown-heel length) is 25 centimetres or more, or when the pregnancy is of 22 or more completed weeks.

Early neonatal death is death of an infant within the first seven days of birth (WHO, 1980).

Data Sources

This data can be primarily obtained from the Vital Statistics records of a country provided the country has almost complete registration of births and deaths. Comparative data for countries is available from WHO's *Neonatal and Perinatal Mortality: Country, Regional and Global Estimates*. (2006). Geneva, WHO. Retrieved from http://whqlibdoc.who.int/publications/2006/9241563206_eng.pdf.

3. Infant Mortality Rate

One of the major factors contributing to Infant Mortality Rate (IMR) is low-birth weight, which can directly stem from less than optimal maternal health, nutrition and care during delivery. This makes IMR an indicator of maternal health as well. It is for this reason that this indicator is included here.

INDICATORS

$$\frac{\text{Number of infant deaths} \times 1000}{\text{Total number of live births}}$$

Definitions

'Infant death' is death of an infant from birth to 1 year of age. Live birth has been defined earlier.

Data Sources

Data can be obtained from vital registration systems, sample registration systems, national population censuses, and/or household surveys. Vital Registration systems are the preferred method but since they are not well established in some developing countries, household surveys such as the Demographic and Health Surveys may be used as the source of data.

The UN Millennium Development Goals data base provides comparable data on IMR across countries (<http://unstats.un.org/unsd/mdg/Metadata.aspx?IndicatorId=0&SeriesId=562>). When using household survey data for international comparisons, the confidence interval of the data should be considered.

4. Proportion of Births Attended by Skilled Birth Attendants

Across countries and over time, a significant association has been observed between the proportion of births deliveries by skilled birth attendants and maternal mortality ratio. For this reason, this indicator helps understand the extent to which governments have invested in developing the human resources necessary for ensuring safe deliveries and especially for preventing maternal deaths.

INDICATORS

$$\frac{\text{No. of births attended by skilled personnel during the reference period} \times 100}{\text{Total number of live births occurring within the reference period}}$$

Definitions

Skilled birth attendant (sometimes referred to as skilled attendant) is defined as “an accredited 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 new-borns.” This definition excludes traditional birth attendants whether trained or not, from the category of skilled health workers (WHO, ICM, FIGO, 2004: p. 1). ‘Live birth’ has been defined earlier.

Points to Remember

The denominator of all live births is a proxy indicator to represent all women who would require skilled birth attendants. This may result in exclusion of births that were not live (stillbirths) from both the numerator and the denominator.

When considering data collected from household surveys, confidence intervals should also be taken into account. When making comparisons across countries and over time, it is important to note that the definition of skilled birth attendant could be different in different countries and even where definitions do not differ, the level of skill among the personnel could vary widely.

In some countries, all institutional deliveries are counted as deliveries conducted by skilled birth attendants. While the two categories may be identical in most instances, there can be situations where the delivery takes place in an institution but is not attended by a skilled birth attendant.

Data Sources

Comparable data across countries is available from the Millennium Development Goal database of the United Nations (<http://unstats.un.org/unsd/mdg/Metadata.aspx?IndicatorId=0&SeriesId=562>). Demographic and Health Surveys also present information on proportion of births attended by different categories of attendants.

5. Availability of Basic Emergency Obstetric Care and Comprehensive Emergency Obstetric Care

These indicators are most helpful in assessing the needs for health-system strengthening to ensure availability of Emergency Obstetric Care at the national and subnational levels. The recommended minimum acceptable coverage is of four basic essential obstetric care (BEmOC) facilities and one comprehensive essential obstetric care (CEmOC) facility per 500,000 population.

INDICATORS

Availability of basic essential obstetric care (BEmOC):

$$\frac{\text{Number of facilities with functioning basic essential obstetric care} \times 500,000}{\text{Total population}}$$

Availability of comprehensive essential obstetric care (CEmOC):

$$\frac{\text{Number of facilities with functioning comprehensive essential obstetric care} \times 500,000}{\text{Total population}}$$

Definitions

Essential emergency obstetric care is the term used to describe the elements of emergency obstetric care needed for the management of complications during pregnancy, delivery and the post-partum period.

A **basic essential emergency obstetric care (BEmOC) facility** is one that has performed all of the following six services (known as signal functions) at least once in the previous three months:

- administration of parenteral antibiotics;
- administration of parenteral oxytocics;
- administration of parenteral anticonvulsants;
- manual removal of the placenta;
- removal of retained products (e.g., manual vacuum aspiration); and
- assisted vaginal delivery (vacuum extraction or forceps).

The recommended minimum acceptable level of availability is four BEmOC facilities per 500,000 population.

A **comprehensive essential emergency obstetric care (CEmOC) facility** is one that has performed surgery (caesarean section) and blood transfusion, in addition to all six BEmOC services, at least once in the previous three months. The recommended minimum acceptable level is one CEOC facility per 500,000 population (UNICEF, WHO, UNFPA, 1997).

Data Sources

Data on availability of essential and comprehensive emergency obstetric services are not routinely collected or published in many countries. The main source of data for the numerator of these indicators is the routine service statistics from all public and private health facilities. Data for the denominator may be obtained from census data and from population projections based on the census data.

Special studies and surveys carried out may be the main source of information on this indicator for many countries.

6. Coverage of Postpartum / Postnatal Care within 48 Hours of Delivery by a Skilled Health Provider

Postpartum care is crucial because a significant proportion of maternal and new-born deaths occur during delivery or in the postpartum period. Recent WHO guidelines recommend that the first post-partum visit take place within the first week, preferably within the first two to three days. The purpose of this visit is early detection and treatment of complications and preventive care for both mother and baby.

INDICATORS

No. of women attended during the first 48 hours postpartum by skilled personnel x 100

Total no. of live births

No. of infants attended during the first 48 hours postpartum by skilled personnel x 100

Total no. of live births

Definitions

'Skilled personnel' refers to the category of skilled birth attendants and other professional health providers.

The postpartum period begins immediately after the birth of the baby and extends up to six weeks (42 days) after birth.

'Postpartum / postnatal care' includes care for the mother and new-born. Detailed guidelines on what such care includes are given in the WHO Technical Consultation on Postpartum and Postnatal Care (WHO, 2010).

Points to Remember

Since there is no set definition of postpartum / postnatal care that is implemented by all countries, comparison across time and countries can be difficult.

Data Sources

Data on postpartum care are available from the Demographic and Health Surveys. Health service statistics of countries may routinely publish such data. Data for 74 high maternal and child mortality countries, including several Asian countries are available for several time points since 2000 from the 'Countdown to 2015: Maternal, New-born and Child Survival' database: <http://www.countdown2015mnch.org/about-countdown/countdown-data>

7. Antenatal Care Coverage

Measuring the antenatal care women receive is an important indicator of the woman's access to health care services. For antenatal care to achieve its potential for life-saving, four visits are considered to be necessary, during which a range of essential interventions are provided.

If women receive comprehensive antenatal care, then pregnancy-related problems may be detected early and treated accordingly. Antenatal care is also an opportunity to promote the use of skilled attendance at birth and healthy behaviour, such as breastfeeding, early postnatal care, and planning for optimal pregnancy spacing.

INDICATORS

Number of pregnant women attended, at least four times during their pregnancy, by skilled personnel for reasons related to pregnancy during a fixed period x 100

Total no. of live births during the same period

Definitions

'Antenatal care' refers to routine health check-ups and treatment for health problems related to pregnancy received during the pregnancy period. A comprehensive package of antenatal care services includes identification and management of obstetric complications, such as pre-eclampsia, tetanus toxoid immunisation, intermittent preventive treatment for malaria during pregnancy (IPTp) in malaria endemic regions, and identification and management of infections including HIV, syphilis and other sexually transmitted infections (STIs) (The Partnership for Maternal, Newborn and Child Health, 2006).

Points to Remember

Even differences in the way antenatal care is defined across the globe can lead to difficulties in comparisons. Difficulties in analysis can also arise if some data are for all women who visited health facilities for any health care and some data are for women seeking ANC for 'pregnancy-related' services only. It is essential to also remember that this indicator only gives the utilisation of health services and not the quality and adequacy of the services thus utilised.

Data Sources

Routine health service data and household surveys are the most important sources of data for this indicator. However, many countries do not collect information on whether four antenatal visits were received, and information is for 'at least one antenatal visit'. The Millennium Development Goals Data Base has data on antenatal care for at least one visit and for four visits (<http://mdgs.un.org/unsd/mdg/Default.aspx>).

8. Total Fertility Rate (TFR)

Total Fertility Rate is seen as an indirect indicator of good or poor reproductive health, since a high total fertility rate (>5 births) represents a high risk of reproductive ill health.

INDICATORS

TFR (per woman) = Number of children a woman would have at the end of her reproductive life if she experienced the currently prevailing age-specific fertility rates from age 15 to 49 years.

TFR is computed as:

$$\frac{\text{Sum of age-specific fertility rates } (\sum \text{ASFR})}{5}$$

Where ASFR is equal to

$$\frac{\text{Births to women in the age group } (x \text{ to } y)}{\text{All women in the age group } (x \text{ to } y)}$$

Five-year age intervals considered for computation of ASFR are: 15-19, 20-24, 25-29, 30-34, 35-39, 40-44 and 45-49

Some countries take 44 as the upper age limit for reproductive age group. This should be kept in mind while making comparisons between TFR across countries.

Births to girls who are under 15 years of age are added to the 15-19-year age group and those to women over 49 years are added to the 45-49-year age group.

It also helps knowing to what duration prior to the census (12 or 36 months) the data corresponds to.

Data Sources

TFRs are calculated from the ASFRs, data for which can be obtained from vital registration (on births only), population censuses and population-based surveys such as the Demographic and Health Surveys. The UN Department of Economic and Social Affairs, Population Division publishes data for UN Member countries regularly.

The 2012 updates of the World Fertility Data are available at (<http://www.un.org/esa/population/publications/WFD2012/MainFrame.html>). Also useful is the Population Reference Bureau's World Population Data Sheet (http://www.prb.org/pdf13/2013-population-data-sheet_eng.pdf).

Definitions

Age-specific fertility rate is the number of births per 1,000 women of a specific age group.

Points to Remember

While the ASFRs are expressed per 1,000 women, the TFR is expressed per woman.

9. Contraception Prevalence Rate (CPR)

Two indicators are given below. The first of these is contraceptive prevalence rate as usually reported, which serves as a proxy measure to access to reproductive health services, assuming that there is no coercion for acceptance of birth control through government policy.

The second indicator is constructed using data on distribution of contraceptive use by methods. It indicates the extent to which men take responsibility for fertility control by using a method of contraception themselves.

INDICATORS

Number of women of reproductive age at risk of pregnancy who are currently using (or whose partner is using) a contraceptive method at a given point in time x 100

Number of women of reproductive age at risk of pregnancy at the same point in time

Number of women of reproductive age at risk of pregnancy whose partners are currently using a contraceptive method at a given point in time x 100

Number of women of reproductive age at risk of pregnancy at the same point in time

Definitions

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

'Women of reproductive age' refers to all women aged 15-49 years. At risk of pregnancy refers to women who are sexually active, not infertile, not pregnant and not amenorrhoeic.

Points to Remember

In many instances, the denominator used is the number of women who are currently married. However, the correct estimate would be given by all women who are 'at risk of pregnancy'. Similarly, some data sources may include only modern methods of contraception in the numerator. Also, 'current' use and not 'ever use' of contraception is relevant for this indicator. It is important to check the definition of the denominator and numerator before comparing across time or countries.

Data Sources

The Demographic and Health Surveys provide data on contraceptive prevalence rates disaggregated by various characteristics (<http://measuredhs.com/Where-We-Work/Country-List.cfm>).

The United Nations Department of Economic And Social Affairs, Population Division publish data for all UN Member Countries as regularly as wall charts. The most recent data published was for 2013 (<http://www.un.org/en/development/desa/population/publications/pdf/family/worldContraceptivePatternsWallChart2013.pdf>), estimates and projections of family planning indicators 2013 revision is available here: http://www.un.org/en/development/desa/population/theme/family-planning/cp_model.shtml

The Millennium Development Goals Data Base also provides country-level data (<http://mdgs.un.org/unsd/mi/wiki/5-3-Contraceptive-prevalence-rate.ashx>).

10. Unmet Need for Contraception

This indicator serves as a proxy measure for access to reproductive health services. It gives the gap between women's reproductive intentions and actual contraceptive behaviour. This indicator may range from 0 (no unmet need) to 100 (no needs met). Unmet needs of 25% or more are considered very high, and values of 5% or less are regarded as very low.

This indicator is usually disaggregated into two components: a) unmet need for family planning to limit family size, and b) unmet need for family planning for birth spacing.

INDICATORS

Unmet need for family planning is equal to

$$\frac{\text{Women of reproductive age who are married or in a consensual union and who have an unmet need for family planning}}{\text{Women of reproductive age who are married or in a consensual union}} \times 100$$

Definitions

'Women of reproductive age' include all women aged 15 to 49.

'Women with an unmet need for family planning' are women who are fecund and sexually active but are not using any *method of contraception* and report not wanting any more children or wanting to delay the birth of their next child for at least two years. Included are:

- all pregnant women (married or in a consensual union) whose pregnancies were unwanted or mistimed at the time of conception;
- all postpartum amenorrheic women (married or in consensual union) who are not using family planning and whose last birth was unwanted or mistimed;
- all fecund women (married or in consensual union) who are neither pregnant nor postpartum amenorrheic, and who either do not want any more children (want to limit family size), or who wish to postpone the birth of a child for at least two years or do not know when or if they want another child (want to space births), but are not using any contraceptive method.

A woman is considered to be 'fecund' if she does not fall in any of the following categories:

- women who have not had a birth in the past five years, are not currently pregnant, and have never used any kind of contraceptive method.
- women who self-report that they are infecund, menopausal or have had a hysterectomy, never menstruated, have been postpartum amenorrheic for 5 years or longer
- (for women who are not pregnant or in postpartum amenorrhea) if the last menstrual period occurred more than six months prior to the survey.
- 'Postpartum amenorrheic' women who have not had a menstrual period since the birth of their last child and their last child was born in the period 0-23 months prior of the survey.

Methods of contraception considered for the calculation of this indicator are the same as those defined for contraceptive prevalence rate.

Points to Remember

In previous definitions of unmet need for family planning, women were classified as being postpartum amenorrheic if their period had not returned for up to five years after the birth of their last child. This difference in definition has to be kept in mind while comparing estimates across time.

Sometimes, even though the contraceptive prevalence is rising, unmet need for family planning may fail to decline or even show an increase. A decline in the number of children desired leading to an increased demand of family planning services could be a reason for this.

If the society shows an increased desire for 'spacing' between children, the unmet needs could continue to rise in spite of an increasing contraceptive prevalence.

Data Sources

The Demographic and Health Surveys provide data on this indicator disaggregated by various characteristics of women. The Millennium Development Goal database also provides data for UN Member countries at: <http://mdgs.un.org/unsd/mi/wiki/5-3-Contraceptive-prevalence-rate.ashx>

11. Adolescent Birth Rate

Young motherhood also affects the mother and child in many other ways—it can bring down the education status and socioeconomic independence and status of the mother, aside from being a contributor to child and maternal morbidity and mortality. This is therefore an important indicator of adolescent reproductive health, as well as reproductive rights.

INDICATORS

Adolescent birth rate is defined as:

$$\frac{\text{Number of live births to women age 15-19} \times 1000}{\text{Total no. of women age 15-19}}$$

Definitions

'Adolescent women' for the purpose of this indicator refers to women 15 to 19 years of age.

'Live birth' has been defined earlier.

Points to Remember

Adolescent birth rates can vary from less than 2 to as high as 230 per 1,000 adolescent women. Values less than 10 are considered low and values above 50 are considered high. High values indicate an unmet need of contraception in this age group. It is important to remember that adolescent births may happen within marriage or outside marriage.

Data Sources

The Demographic and Health Surveys provides data on this indicator disaggregated by various characteristics of women (<http://measuredhs.com/Where-We-Work/Country-List.cfm>). The Millennium Development Goal data base also provides data for UN Member countries at: <http://mdgs.un.org/unsd/mi/wiki/5-3-Contraceptive-prevalence-rate.ashx>

12. Availability and Range of Adolescent Sexual and Reproductive Health Services

This is a set of indicators of access to health care for adolescents irrespective of marital status.

INDICATORS

- a) Are adolescent SRH services available at the

- Primary Care level	<i>Yes/No</i>
- Secondary Care level	<i>Yes/No</i>
- Tertiary care level	<i>Yes/No</i>
- b) Which of the following services are available at different levels of care?

- Psychosocial counseling	<i>Primary/Secondary/Tertiary</i>
- Contraception	<i>Primary/Secondary/Tertiary</i>
- HIV/STI prevention	<i>Primary/Secondary/Tertiary</i>
- HIV/STI treatment	<i>Primary/Secondary/Tertiary</i>
- Maternal health care	<i>Primary/Secondary/Tertiary</i>
- c) Are services generally available irrespective of marital status? *Yes/No*
- d) Schools in which comprehensive sexuality education is available as a percentage of all schools

Definitions

Adolescent SRH services include “at a minimum...gender sensitive life-skills-based SRH education and a package of social protection services for adolescents and youth, including psychosocial counselling, contraception, HIV-prevention, STI-prevention/ treatment and maternal health services.” (UNFPA, 2008)

Comprehensive sexuality education includes age-appropriate information to children and young adults throughout schooling age, and its content includes at least four components (UNESCO, UNAIDS, UNFPA, UNICEF, WHO, 2009):

- Information about human sexuality, including: growth and development; sexual anatomy and physiology; reproduction; contraception; pregnancy and childbirth; HIV and AIDS; STIs; family life and interpersonal relationships; culture and sexuality; human rights empowerment; non-discrimination, equality and gender roles; sexual behaviour; sexual diversity; sexual abuse; gender-based violence; and harmful practices;
- Values, attitudes and social norms;
- Interpersonal and relationship skills; and
- Responsibility.

Data Sources

Information on availability of SRH services and status of sexuality education for adolescents need to be collected from national sources and from research studies. A 2012 UNESCO publication, *Review of Policies and Strategies to Implement and Scale up Sexuality Education in Asia and the Pacific* (<http://unesdoc.unesco.org/images/0021/002150/215091e.pdf>) provides information for several Asian countries on the status of sexuality education.

13. HIV Prevalence and Burden

This is a set of indicators on the prevalence of HIV among different population subgroups and of the numbers of persons in the population living with HIV or AIDS. These are pointers to the status of sexual health in the population.

INDICATORS

- a) Percentage of young people age 15-24 living with HIV:

$$\frac{\text{Number of young people age 15-24 living with HIV}}{\text{Total number of young people age 15-24}} \times 100$$

- b) Percentage of sex workers living with HIV:

$$\frac{\text{Number of sex workers living with HIV}}{\text{Estimated number of sex workers in the population}} \times 100$$

- c) Percentage of men having sex with men living with HIV:

$$\frac{\text{Number of men having sex with men living with HIV}}{\text{Estimated number of men having sex with men in the population}} \times 100$$

- d) Number of HIV infected female adults

Definitions

A person living with HIV refers to a person whose HIV status has been tested and found to be positive.

Sex workers are women, men and transgendered people who receive money or goods in exchange for sexual services, and who consciously define those activities as income generating even if they do not consider sex work as their occupation (Overs, 2002).

The term 'men who have sex with men' is used to describe those males who have sex with other males, regardless of whether or not they have sex with women or have a personal or social identity associated with that behaviour, such as being 'gay' or 'bisexual' (UNAIDS, 2009).

Data Sources

Comparable cross-country data for all the indicators listed above are available from UNAIDS Global Report published annually by UNAIDS. The latest report is the UNAIDS Report on the Global AIDS Epidemic 2013: (http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf). Country-level estimates may be found at the Asia Pacific AIDS Data hub (www.aidsdatahub.org).

14. Availability of Services for HIV and AIDS

This is a set of indicators on the availability of prevention and treatment for HIV for different subgroups of the population. These are pointers to the availability of sexual health services in the country.

INDICATORS

- Number of pregnant women living with HIV who received antiretroviral therapy for preventing mother-to-child transmission
- Reported number of adults on antiretroviral therapy
- Whether HIV counselling and testing is available with general outpatient care: *Many/Few/None*
- Whether HIV counseling and testing is available as part of sexual and reproductive health services: *Many/Few/None*
- Whether ART is available as part of general outpatient services: *Many/Few/None*

Data Sources

Comparable cross country data for all the indicators listed above are available from UNAIDS Global Report published annually by UNAIDS. The latest report is the UNAIDS Report on the Global AIDS Epidemic 2013 (http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf). Country level estimates may be found at the Asia Pacific AIDS Data hub (www.aidsdatahub.org).

15. Availability of Sexual and Reproductive Health Services at Different Levels of Care

This set of indicators assesses the broad-based availability of a comprehensive set of SRH services.

INDICATORS

- a) Are SRH services available at the
- | | |
|------------------------|--------|
| - Primary care level | Yes/No |
| - Secondary care level | Yes/No |
| - Tertiary care level | Yes/No |
- b) Which of the following services are available at different levels of care?
- | | |
|---|----------------------------|
| - Gynecological services | Primary/Secondary/Tertiary |
| - Maternal health care | Primary/Secondary/Tertiary |
| - Contraception | Primary/Secondary/Tertiary |
| - HIV/STI prevention | Primary/Secondary/Tertiary |
| - HIV/STI treatment | Primary/Secondary/Tertiary |
| - Screening for cervical and breast cancer | Primary/Secondary/Tertiary |
| - Safe abortion services for indications permitted by law | Primary/Secondary/Tertiary |
- c) List the range of services available free at the point of service delivery at the primary health care level
- d) List the range of services included in the Essential Services Package for Government sponsored insurance (if applicable)
- e) Is the Minimum Initial Service Package (MISP) of SRH services implemented in emergency situations (conflicts, wars, disasters and other emergencies)? *Yes/No*
- f) **Proportion of deliveries in public and private health facilities:**
- $$\frac{\text{No. of women whose most recent delivery was in a public (private) health facility}}{\text{Women whose most recent delivery was in a health institution}} \times 100$$
- g) **Proportion of women seeking antenatal care from a public (private) health facility or provider:**
- $$\frac{\text{No. of women who sought ANC for their most recent pregnancy delivery from a public (private) health facility or provider}}{\text{Women who sought ANC for their most recent pregnancy}} \times 100$$
- h) **Proportion of women seeking FP services from a public (private) health facility or provider:**
- $$\frac{\text{No. of women who sought FP services from a public (private) health facility or provider}}{\text{Women who sought FP services}} \times 100$$

Definitions

WHO and the Inter-Agency Working Group for RH in refugee situations have developed a core package of minimum reproductive health (RH) interventions that should be put in place in emergency settings. These include prevention and managing the consequences of sexual violence, reduction of HIV transmission, prevention of excess neonatal and maternal mortality and morbidity, among others. Details of the MISP can be found in a WHO document titled 'Minimum Initial Services Package' (www.who.int/disasters/repo/7345.doc).

Data Sources

There are no centralised data sources for indicators on availability of SRH. Information may have to be gathered from published or unpublished studies or through government sources and reports that may describe the range of services intended to be offered.

The Demographic and Health Surveys provide information on whether maternal health and FP services were sought from a public or private health facility. Data from national surveys and statistics from health services may also provide data on these indicators.

16. Government Expenditure on Health

This is a set two core indicators of health financing and shows the Government's commitment to the betterment of its people's health.

INDICATORS

a) Government spending on health in PPP\$ as a proportion of Total health expenditure in the country in PPP\$:

$$\frac{\text{Government expenditure on health in PPP\$} \times 100}{\text{Total health expenditure in PPP\$}}$$

b) Government spending on health in PPP\$ as a proportion of the Gross Domestic Product in PPP\$:

$$\frac{\text{Government expenditure on health in PPP\$} \times 100}{\text{Gross domestic product in PPP\$}}$$

Definitions

'General government expenditure' includes consolidated direct outlays and indirect outlays, including capital of all levels of government, social security institutions, autonomous bodies, and other extra-budgetary funds.

'Total health expenditure' is the sum of general government expenditure on health and private expenditure on health in a given year (in international dollars).

'GDP' or Gross Domestic Product is the value of goods and services provided in a country by residents and non-residents without regard to their allocation among domestic and foreign claims. This corresponds to the total sum of expenditure (consumption and investment) of the private and government agents of the economy during the reference year.

Values in PPP dollars or 'international dollars' are computed by converting costs in local currency using purchasing power parity (PPP) exchange rates. A PPP exchange rate is the number of units of a country's currency required to buy the same amounts of goods and services in the domestic market as U.S. dollar would buy in the United States. The PPP exchange rates used in national health accounts are those developed by WHO.

Data Sources

The World Health Statistics Annual, published every year, provides data for all WHO Member countries on government spending on health (http://www.who.int/gho/publications/world_health_statistics/2013/en/).

Data can also be obtained from the WHO Global Health Expenditure Database (<http://apps.who.int/nha/database/DataExplorerRegime.aspx>).

17. Out-of-Pocket Expenditure as a Proportion of Total Health Expenditure

This indicator shows the extent of the burden for paying for health services that is borne by households and individuals. A high out-of-pocket expenditure is considered undesirable because it may prevent the use of health services for reasons of affordability.

INDICATORS

Out-of-pocket expenditure as a proportion of Total Health Expenditure:

$$\frac{\text{Out of pocket Expenditure on health} \times 100}{\text{Total expenditure on health}}$$

Definitions

'Total health expenditure' is the sum of general government expenditure on health and private expenditure on health in a given year (in international dollars).

'Out-of-pocket expenditure' is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.

Data Sources

The World Health Statistics Annual, published every year, provides data for all WHO Member countries on out-of-pocket expenditure on health as a proportion of total health expenditure (http://www.who.int/gho/publications/world_health_statistics/2013/en/).

Data can also be obtained from the WHO Global Health Expenditure Database (<http://apps.who.int/nha/database/DataExplorerRegime.aspx>).

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ANNEX I

List of Indicators

Sexual and Reproductive Rights Indicators

1. Difference between median age at marriage and legal minimum at marriage
2. Grounds under which abortion is legal
3. Legislation and policies on sexual orientation
4. Legislation and policies on gender identities
5. Policies on sexual and reproductive health
6. Extent of gender-based violence
7. Legislation related to gender-based violence
8. Policy on adolescent sexual and reproductive health services
9. HIV and AIDS policies
10. Grievance redress mechanisms for sexual and reproductive health services

Sexual and Reproductive Health

1. Maternal Mortality Ratio
2. Perinatal Mortality Ratio
3. Infant Mortality Rate
4. Proportion of births attended by skilled birth attendants
5. Availability of basic emergency obstetric care and comprehensive emergency obstetric care
6. Coverage of post-partum / post natal care within 48 hours of delivery by a skilled health provider
7. Antenatal care coverage
8. Total Fertility Rate
9. Contraception Prevalence Rate
10. Unmet need for contraception
11. Adolescent birth rate
12. Availability and range of adolescent sexual and reproductive health services
13. HIV prevalence and burden
14. Availability of services for HIV and AIDS
15. Availability of sexual and reproductive health services at different levels of care
16. Government expenditure on health
17. Out-of-pocket expenditure as proportion of total health expenditure

ARROW is a regional non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, engagement, advocacy, and mobilisation.

ARROW envisions an equal, just and equitable world, where every woman enjoys her full sexual and reproductive rights. ARROW promotes and defends women's rights and needs, particularly in the areas of health and sexuality, and to reaffirm their agency to claim these rights.

'Strengthening the Networking, Knowledge Management and Advocacy Capacities of an Asian Network for Sexual and Reproductive Health and Rights (SRHR)' is an ARROW-implemented project.

The project brings together five implementing partners and ten associate partners from across Asia to advocate for universal access to SRHR as a key component of national and global policies and agendas; as well as to work on addressing the key challenge of religious fundamentalisms as experienced across the region.

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