United Nations Population Fund

Assessment of available Sexual and Reproductive Health Data in the English- and Dutch-speaking Caribbean: St. Lucia Country Analysis

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List Of Acronyms

BEOC	Basic Essential Obstetric Care
CEOC	Comprehensive Essential Obstetric Care
MoH	Ministry of Health
NAPS	National Aids Program Secretariat
PAHO	Pan American Health Organization
SLAPP	St. Lucia Plan Parenthood Association
SRH	Sexual and Reproductive Health
UNFPA	United Nations Population Fund
WHO	World Health Organization

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BACKGROUND

The meaning and definition of sexual and reproductive health has evolved throughout the years. Today it is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Sexual and reproductive health (SRH) encompasses a wide range of areas including maternal and child health and care, family planning services, fertility services, combating STI's, HIV/AIDS and other gynaecological morbidities and the promotion of healthy sexuality. While there have been great strides in improving SRH issues in many part of the globe, researchers estimate that millions cannot access family planning methods which leads to unintended pregnancy ending in abortions. Millions are still infected by STI and HIV, which may lead to complications for both mother and child. The poor disproportionately bear the consequences of poor reproductive health, especially impoverished women and young people.

Information on sexual behaviours are essential to designing program, polices and interventions so as to improve SRH health in any country.

St. Lucia has a population of approximately 167, 689. The Saint Lucian population is very young with the people under twenty accounting for 40% of the population in 2004. The legacy of past high fertility rates will result in a continuation of population growth for some years to come. Total population is expected to grow from around 160,000 people today to 195,000 in 2016. At present 50 % percent of the female population is of childbearing age. It is estimated the almost 98 % of deliveries occur in hospitalized setting and by trained personnel. In 2006 birth to teenagers accounted for 17.4 % of the total number. The total fertility rate is 1.4 per 1000 live births. Percentage of low birth weight was 11.4% and the average age of mothers was 29 years Saint Lucia's HIV prevalence rate is estimated at 0.12%. This puts it at the low end of the scale

among Caribbean nations. This means that one in every 1,000 persons in Saint Lucia is infected with HIV. However, these figures are estimated to represent only about 26% of the 'true' number of cases.

Organizations such as St. Lucia Planned Parenthood Association, St Lucia Red Cross, NGO's, National Aids Programs, Education Bureau of the Ministry of health, and Ministry of Education also implement programs that address sexual and reproductive health including IEC, BCC, prevention and treatment of STIs, and treatment of opportunistic infections.

INTRODUCTION

Program Goals

To assess available data for Sexual and Reproductive Health (SRH) in the English and Dutch-speaking Caribbean.

Program Objectives

1. To assess the availability of gender-disaggregated data on sexual and reproductive health in St. Lucia
2. To identify gaps and areas for improved data collection of sexual and reproductive health data.

The identification of gap and challenges will facilitate UNFPA in planning and developing programming targets for the period 2007 - 2011

Methodology

The sexual and reproductive health indicators provided by UNFPA were reviewed, analysed and compared with those used in St. Lucia. This evaluation of sexual and reproductive health data was conducted through an assessment of available data as well as interviews with all key SRH organizations. A questionnaire was developed (See Appendix 2) which was used in the interviewing process with focal persons in different organizations responsible for the collection and analysis of SRH data. These interviews gave an insight into the type of data collected, the process through which data was collected as well as the limitations/challenges experienced.

Forms, reports and web site addresses were collected as evidence of data captured. The data was then analysed and recommendations suggested.

Limitation In Data Collection

While raw data is available in St. Lucia, the collection of this data was an arduous task due to the absence of a central data collection department. SRH data gathered by different agencies should all be available in an assigned department in the Ministry of Health. However, although data is available the absence of key personnel makes it impossible to integrate and assess the information from the various organizations. This brings in sharp focus issues of governance since no one institution has taken the responsibility for sexual and reproductive health on the island. Hence there is no accountability and the response from those responsible for data collection is lacking.

INTERVIEW SUMMARIES

Ministry of Health

St Lucia's Ministry of Health is responsible for the provision of health care on the island. There are 3 major hospitals, 2 district hospitals and 32 health centres where most of the sexual and reproductive education and treatments occur (See Appendix 3).

The Epidemiology Unit within the Ministry of Health is responsible for the collect of all SRH data. The Ministry uses a combination of Syndromic surveillance, weekly report from health centres and quarterly HIV report. Data is collected about maternal and child health, STI, HIV, fertility and statistics comes from public hospitals; heath centres STI clinics and NGOs. A fertility report is generated yearly.

The following are the challenges experienced by the ministry in the collection of data:

- Inadequate staffing both at the community and ministerial level to facilitate the collection and analysis of SRH data
- Lack of appropriate training in data analysis for most health personnel.
- Dependence on other departments and organizations for data.
- The move to Syndromic surveillance has affected the collection of STI data. Diseases are not differentiated for recording purposes by their generic names. They are documented as a discharges.
- Like many other countries the research culture is limited.

Statistics Department: Ministry of Finance

The mandate of this Department is the collection, complication and dissemination of national statistical information relevant for policy decision taking in a timely and efficient manner. As it pertains to sexual and reproductive health, the department has the responsibility for mother and child mortality data. This data is generated from internal research and from health facilities.

While there is no formal reports on SRH statistics, data can be found in the core welfare indicators report 2004, 2005 and other social and economic reports. The following are challenges experienced by the department as it pertains to data collection:

- Development of indicators for population projection and analysis
- Lack of adequate training of district registrars in proper recording of births for demographic data.
- Lack of training for staff in population projections.

National Aids Programme and National Aids Programme Secretariat

The National AIDS Programme Secretariat co-ordinates all HIV/AIDS prevention and control work programmes. Staffing comprises persons versed in strategic planning, communication, information technology, monitoring and evaluation and epidemiology. Data is collected through pre-formatted forms used by all health institutions. There is an HIV Registry with all reported cases since 1985. A HAART, STI and attendance register was developed in 2006. Points of service information from clinics are analyzed monthly by staff. A quarterly and annual report is prepared by the NAPS

Even with what seem like an efficient data collect and analysis system the Secretariat faces the following challenges

- Training in data collection and analysis.
- Staffing to increase data collection/ entry.
- Purchasing software, hardware for collection, monitoring and evaluation processes.

- Realize and increase important by other agencies on the importance of data collection as it pertains to planning, implementing and management of programs.

St. Lucia Planned Parenthood Association

The St. Lucia Planned Parenthood Association provides contraceptives and conception information as well as other sexuality related services, counselling and family life education. They are presently running an out-of-school youth programme whose services include vocational and technical training as well as SRH issues.

Presently they generate information only on contraceptives and condom use but a clinical management system has just been installed which should improve the data collection process.

Pan American Health Organization (PAHO)

The Pan American Health Organization (PAHO) is the Regional Office of the World Health Organization (WHO) whose main function is to facilitate technical cooperation with countries and territories in the Americas. Over the pass few years PAHO was instrumental in the process of setting up a surveillance system for prenatal health in St. Lucia. Unfortunately, this project which would have monitored children from pregnancy to 5 years including the quality of care provided by health care professionals was not completed. Research has also been done in the area of teenage pregnancy. From this exercise peer to peer counsellor were trained for all secondary schools on the island.

Ministry of Education and St. Lucia Red Cross

St. Lucia has a very young population and so emphasis must be placed on including them in all national policy and programs. The 2002 National youth policy identified SRH areas that require Government support. **The Ministry of Education** has plans to improve the Health and Family Life Education program HFLE program by increase teacher training in topic delivery and an

increase in HIV/ STI topics. Presently this program can be found in all secondary schools on the island. There are also plans to bring this program to Out of school youth. In addition to its Together We Can program, the **St. Lucia Red Cross** in it's 2008 work plan is working on a Youth Friendly Service policy. The point of this program is to establish a place where youth can assess information and services free from stigma and discrimination. Studies have shown the where services may be available young persons do not assess them. A health and safety program for 8 -12 years olds is also being developed. While all these programs may be successful, collection and analysis of data is important for them to evaluate their progress.

DATA COLLECTION SUMMARY

This section reviews the indicators, their definitions and data collected for the time project.

1. **Total fertility rate defined as** *the number of births a woman would have by the end of her reproductive life if she experienced the currently prevailing age-specific fertility rates from age 15 to 49 years.*

    Table 1 - Total fertility rate for the period 2002 – 2006. Source: Fertility Report 2006

Time period	2002	2003	2004	2005	2006
Fertility rate	2.2	1.9	1.7	1.5	1.4

    The average estimated fertility rate over the last 3 years 1.5 children born per woman for the period under review. 17.4 % of live births were due to teenage pregnancies.

2. **Contraceptive prevalence defined as** *the proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time.*

    Most persons in St. Lucia obtain their contraceptives from SLPPA and private pharmacies. In 2007 SLPPA registered a contraceptive prevalence of 59%. The following table shows the numbers distributed be the Department.

    Table 2 - Contraceptive Methods for 2002-2007. Source SLPPA (2007)

Method	2002	2006	2007
Oral	24, 307	22, 191	29, 172
Injectable	2566	2568	2954
Condom	15668	16919	23, 999

St Lucia Medical Supplies unit distributes a total 232,208 in 2006 and 378,437 in 2007. There is no data for contraceptives distributed from private pharmacies. Until a central data collection policy on contraceptive distribution is developed for the collection of information a true analysis of cannot be done to inform future programs.

3. **Maternal mortality ratio (MMR) – defined as** *the number of maternal deaths per 100,000 live births*.

Between 1989 and 2005, there were 55,313 reported births and 22 reported causes of maternal deaths. Mortality statistics can also be used for program assessment and planning including maternal and child health.

The measurement of the maternal mortality ratio is critical to as it measures obstetric risk. Maternal mortality is widely recognized as a general indicator of the overall health of a population, of the status of women in society and of the functioning of the health system.

Table 3 - Maternal Mortality Ratio for the period 2000 – 2005. Fertility Report 2006

Time period	2000	2001	2002	2003	2004	2005
Maternal Mortality Ratio	103.2	35.9	38.5	120.7	52.2	45.0

4. **Antenatal care coverage – defined as** *the proportion of women attended, at least once during their pregnancy, by skilled health personnel for reasons relating to pregnancy.*

   This data is collected from the district health centres, hospital. Unfortunately the figure does not reveal the true picture as private doctor visits are not compiled thus the proportion of pregnant women who receive antenatal care per year is unknown. Records from health centres and hospitals are compiled on the district and public heath nursing monthly report form. This report is often collated on a monthly basis and submitted to the Epidemiology Department and the Statistical Officer is expected to produce a quarterly and yearly report. In 2006 the district health centres registered 770 for antenatal visits.

5. **Births attended by skilled health personnel – defined as** *the proportion of births attended by skilled health personnel.*

   The Epidemiology unit in the Ministry of Health collects data on all births from the five hospitals and registrar of civil service. Any home deliveries would be recorded in the nearest hospital. The numbers of births attend by skilled personnel (doctors, midwives) remain steady coinciding with the high number of women who attend prenatal clinics.

Table 4 - Number of births attended by skilled health personnel for period 2004-2006.
   Fertility Report 2006

Time period	2004	2005	2006
% Births attended by skilled health personnel	97	98	98

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6. **Availability of basic essential obstetric care – defined as** *the number of facilities with functioning basic essential obstetric care per 500,000 population*.

    As of 2006, there are 3 facilities in St. Lucia that offers the basic essential obstetric care. These are the Victoria hospital, St Jude's Hospital and Tapion Hospital. Services offered include administration of prenatal antibiotics and assisted vaginal delivery.

7. **Availability of comprehensive essential obstetric care (CEOC) defined as** *the number of facilities with functioning comprehensive essential obstetric care per 500,000 population.*

    These facilities are the 2 public and 1 private hospital on the island. These CEOC facilities perform surgeries (caesarean section) and blood transfusions, in addition to the services offered by the units offering basic essential obstetric care.

8. **Perinatal mortality rate (PMR) – defined as** *the number of perinatal deaths per 1000 births.*

    The perinatal period is defined as the period of foetal viability (22 weeks of gestation) up to the end of the sixth (6th) day after birth. These figures include the number of stillbirths, as well as the number of early neonatal deaths. Among the group of causes comprising perinatal causes are Slow foetal growth, foetal malnutrition, short gestation & low birth weight. Information in the table below was supplied by the Epidemiology unit and illustrates the perinatal mortality rate statistics for the years 1999 to 2005. Data for 2006 is not yet available; while the rate remains steady over the last 6 years there was of drop of 4 points in 2004. These numbers are reflections of the accessibility of primary care for pregnant women.

Table 5 - **Perinatal Mortality Rate for period 2000 – 2005. Fertility Report 2006**

Time period	2000	2001	2002	2003	2004	2005
Perinatal Mortality Rate	29.2	29.8	29	29.7	25.5	28.8

9. **Prevalence of low birth weight – defined as** *the percentage of live born babies who weigh less than 2500g.*

This data was sourced from the annual fertility report of the Ministry of Health and is representative of all hospitals. The receipt of timely and comprehensive antenatal care is one of the primary preventive factors against low birth weight babies. Low birth weight is also an important predictor of infant mortality. In St. Lucia very low birth rate babies are usual found in the youngest and oldest cohort of women. In 2006 15.2% of LBR babies were born to 10 -19 year olds.

It is apparent that new strategies aimed at reducing the incidence of low birth weight are needed especially for teenagers. The need to determine whether antenatal care is an important determinant of infant mortality in Saint Lucia also exists.
The Table illustrates a steady prevalence of low birth weight for the period 2002 to 2006.

Table 6 - The percentage of live born babies who weigh less than 2500g for the period 2004-2006

Time period	2002	2003	2004	2005	2006
Prevalence of low birth weight	9.7	10.1	11.7	11.2	11.4

10. **Prevalence of positive syphilis serology in pregnant women– defined as** *the percentage of pregnant women aged 15-24 yrs attending antenatal clinics with a positive serology for syphilis.*

The positive syphilis serology should be captured using the community health services monthly report at the community health centres nationwide and from the STI Clinic. In 2006, 367 women were referred to the STI clinic by the community health centres. Attempts to gather data on prohibitive serology for syphilis was unsuccessful.

11. **Prevalence of anaemia in women – defined as** *the percentage of women of reproductive age screened for haemoglobin levels who have levels below 110g/l (pregnant women) and 120g/l (non-pregnant women).*

While notes may be taken by attending health personnel, there is no formal compilation of data readily available

12. **Percentage of obstetric and gynaecological admissions owing to abortion defined as** *the percentage of admissions for (spontaneous or induced) abortion-related complications to service delivery points providing inpatient obstetric and gynaecological services, among all admissions (except those for planned termination of pregnancy).*

Abortion is an illegal practice in St. Lucia. In 2007 legislation was passed allowing termination of pregnancy under specific conditions. In the interim it is known that back street / illegal abortions do take place, putting women at risk for further of further reproductive complications.

13. **Reported prevalence of women with genital mutilation – defined as** *the percentage of women interviewed in a community survey who report having undergone genital mutilation.*

There are no known cases of genital mutilation in St. Lucia.

14. **Prevalence of infertility in women – defined as** *the percentage of women of reproductive age (15-49 yrs) at risk of becoming pregnant (not pregnant, sexually active, not using contraception and not lactating) who report trying for a pregnancy for two years or more.*

   Discussions with Dr. Lendor (SRH co ordinator) and other health personnel reveal that data is not collected on this Indicator. If any such data is available it would have be obtained from private doctors who rarely systematically collect data.

15. **Reported incidence of urethritis in men** – defined as *the percentage of men aged 15-49 yrs, involved in a community survey, who reported having one or more episodes of urethritis in the previous 12 months.*

   As a measurement of sexual and reproductive morbidity among men, Non Gonococcal urethristis can be found in reported cases. In 2002 there were 21 cases of urethristis reported in men.

16. **Prevalence of HIV infection in pregnant women – defined as** *the percentage of blood samples taken from women aged 15-24 yrs that test positive for HIV during routine sentinel surveillance at selected antenatal clinics.*

   The number of women tested for HIV during pregnancy have fluctuated over the year with the largest number being registered in 2006. It can be assumed that this increase is a direct result of the Mother to child transmission programs operating presently on the island. In 2006 , 2174 babies were born on the island, a documented total of 737 of them were tested for HIV . The difference in the total number pregnant and number tested mean that over half of all pregnant women are not tested.

   The figures in the table below represent women of all ages tested for HIV as it was difficult to get an accurate figure for 15-24 girls.

Table 7 - Prevalence of HIV infection in pregnant women

Time Period	2001	2002	2003	2004	2005	2006
Total Tested Population (Repeat and New Clients)	2,174	8,243	11,056	14,582	4852	4202
Total antenatal women tested	492	517	647	453	594	737
% positive	**2.4**	**1.9%**	**2.2%**	**3.5%**	**3.7%**	**3.6%**

17. **Knowledge of HIV-related preventive practices – defined as** *knowledge of HIV-related preventive practices.*

The 2005 -2006 Behavioural Surveillance Survey assesses HIV- related knowledge and practices. In St. Lucia 988 persons were surveyed. 86 % of boys and 87% of girls had knowledge of HIV related preventative practices. It is interesting to know that only 74 % of respondent rejected some of the myths in about the contraction of the disease (Mosquito bite and meal sharing). 55 % percent of general population interviewed uses the condom at every sexual experience. All data was disaggregated by age and sex, religion , ethnicity , employment and educational status. Only 81 % of boys and 72% of girl express knowledge of condom purchasing in stores. Something to note of interest is the low percentage of knowledge about areas where condoms can be access free. While there are many behavioural and communications program, the content of these programs may need to be revised.

Gaps in Data Collection

At present there is need for an effective system for the management and analysis of data and dissemination of information. In addition data need to readily available to those who require access.

Human resources are very limited and those available are overstretched. The adequate number of health professionals with appropriate skills is needed, with increase accountability in the performance of their duties.

A data collection procedure needs to be development for the collect of data from private doctors. Without this information data used for program development will be lacking.

RECOMMENDATIONS FOR IMPROVED DATA COLLECTION

Improve surveillance and health information systems, as well as the development and implementation of an effective referral system. As a large percentage of person access private care, private and public health care agents need to increase their communication to ensure that SRH data collected is accurate. Relevant SRH country indicators need to be identified, to ensure data on all aspect of this broad topic is captured

Development of human resources is an important factor in this process. Staffing should be adequately distributed and well trained. In additions, there should be a monitoring mechanism to ensure the timely submission of information.

The National Health Strategic Plan needs to be ratified to ensure the proper implementation of programs. At present no department has the specific responsibility for data collection, so while data may be collect no one seems to know who is responsible for the compilation of collected data.

CONCLUSION

St Lucia data collect process is limited by a culture that does not understand its importance. As a result limited budget allocation are appropriated for research. Organizations / departments that incorporate data collection and analysis in their work plans do not have the trained personnel. In the area of SRH it would be beneficial to develop a clear cut list of indicators which would guide program development.

As a response to these deficiencies the UNFPA can help with the development of a training program from relevant organizations in data collection processes, including the importance of its timely submission. In area where hardware and software may not be feasible uniform data collections forms can be just as successful.

NGO's and smaller organizations need assistance in the development of data collection forms, as well as priority area that require data collection that will help inform program development. In the larger Ministries UNFPA can collaborate and help in the modification of existing tools for data collection as well as the integrating international SRH indicators where necessary.

Any changes in the existing data collection procedure will require additional work in the collection process and training of personnel. The Ministry of Health and other organizations that work with SRH must find the best balance between gathering relevant data and adding demands on existing systems.

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APPENDICES

Appendix 1

DESCRIPTION OF INDICATORS					
INDICATOR NAME	INDICATOR DEFINITION	NUMERATOR DEFINED	DENOMINATOR DEFINED	DEFINITIONS OF IMPORTANT TERMS	NOTES
1.Total fertility rate	The number of births a woman would have by the end of her reproductive life if she experienced the currently prevailing age-specific fertility rates from age 15 to 49 yrs.	Sum of the age-specific fertility rate (ASFR) x 5	1000	Age-specific fertility rate (ASFR) = Births in year to women aged X / No. of women aged X at mid-year	ASFR are defined using the number of women in each age group and the number of births to women in that age group. 1. No. of women by age 2. No. of births by age of mother
2.Contraceptive Prevalence	The proportion of women of reproductive age who are using (or whose partner is using) a contraceptive method at a given point in time	No. of women of reproductive age at risk of pregnancy who are using (or whose partner is using) a contraceptive method at a given point in time	No. of women of reproductive age at risk of pregnancy at the same point in time	Contraceptive methods include clinic and supply (modern) methods and non-supply (traditional) methods. Clinic and supply methods = female and male sterilization, intrauterine devices,	Women of reproductive age refers to all women aged 15-49 years

DESCRIPTION OF INDICATORS					
INDICATOR NAME	INDICATOR DEFINITION	NUMERATOR DEFINED	DENOMINATOR DEFINED	DEFINITIONS OF IMPORTANT TERMS	NOTES
				hormonal methods, condoms and vaginal barrier methods. Traditional methods = Rhythm, withdrawal abstinence and lactational amenorrhea	
3. Maternal mortality ratio (MMR)	The number of maternal deaths per 100,000 live births	All maternal deaths occurring in a period (usually a year)	Total number of live births occurring in the same period	1. Maternal death - death of a woman while pregnant or within 42 days of termination of the pregnancy, irrespective of the duration and the site of the pregnancy or its management, but not from accidental or incidental causes; 2. Live births - the complete expulsion or extraction from	MMR also measures obstetric risk- the risk of a woman dying once she is pregnant. Important to identify the numbers, causes and avoidable factors associated with maternal deaths

DESCRIPTION OF INDICATORS					
INDICATOR NAME	INDICATOR DEFINITION	NUMERATOR DEFINED	DENOMINATOR DEFINED	DEFINITIONS OF IMPORTANT TERMS	NOTES
				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,...,each product of such a birth is considered live born.	
4. Antenatal care coverage (ANC)	The proportion of women attended, at least once during their pregnancy, by skilled health personnel for reasons relating to pregnancy	No. of pregnant women attended, at least once during their pregnancy, by skilled personnel for reasons related to pregnancy during a fixed period	Total no. of live births during the same period.	Skilled health attendant - an accredited health professional such as a midwife, doctor or nurse… This definition excludes traditional birth attendants whether trained or not.	ANC coverage is one of four mutually supportive indicators in the minimum list measuring maternal health service coverage. The other 3 indicators are 'births attended by skilled health personnel', 'availability of basic essential

DESCRIPTION OF INDICATORS					
INDICATOR NAME	INDICATOR DEFINITION	NUMERATOR DEFINED	DENOMINATOR DEFINED	DEFINITIONS OF IMPORTANT TERMS	NOTES
					obstetric care' and 'availability of comprehensive essential obstetric care.'
5. Births attended by skilled health personnel	The proportion of births attended by skilled health personnel	Births attended by skilled health personnel during a specified period	Total number of live births occurring in the same period	Live birth - the birth of a foetus after 22 weeks' gestation or weighing 500g or more that shows signs of life -breathing, cord pulsation or with audible heart beat.	
6. Availability of basic essential obstetric care (BEOC)	The no. of facilities with functioning basic essential obstetric care per 500,000 population	No. of facilities with functioning basic care x 500,000	Total population	BEOC facility is one that performed all the following 6 services at least once in the previous 3 months - administration of	

				DESCRIPTION OF INDICATORS	

INDICATOR NAME	INDICATOR DEFINITION	NUMERATOR DEFINED	DENOMINATOR DEFINED	DEFINITIONS OF IMPORTANT TERMS	NOTES
				parenteral antibiotics; oxytocics and anticonvulsants; manual removal of the placenta; removal of retained products; and assisted vaginal delivery. The recommended minimum acceptable level is 4 BEOC facilities per 500,000	
7. Availability of comprehensive essential obstetric care (CEOC)	The no. of facilities with functioning comprehensive essential obstetric care per 500,000 population	No. of facilities with functioning basic care x 500,000	Total population	CEOC facility is one that has performed surgery (caesarean section) and blood transfusion, in addition to all 6 BEOC services, at least once in the previous 3 months. The recommended minimum	

DESCRIPTION OF INDICATORS					
INDICATOR NAME	INDICATOR DEFINITION	NUMERATOR DEFINED	DENOMINATOR DEFINED	DEFINITIONS OF IMPORTANT TERMS	NOTES
				acceptable level is one CEOC facility per 500,000 population	
8. Perinatal mortality rate (PMR)	The no. of perinatal deaths per 1000 births	No. of perinatal deaths (foetal and early neonatal deaths) x 1000	Total no. of births	PMR - the no. of deaths of foetuses weighing at least 500g (or, when birth weight is unavailable, after 22 completed weeks of gestation or with a crown-heel length of 25cm or more), plus the no. of early neonatal deaths, per 1000 total births	Due to the different denominators in each component, this is not necessarily equal to the sum of the foetal death rate and the early neonatal mortality rate.

DESCRIPTION OF INDICATORS					
INDICATOR NAME	INDICATOR DEFINITION	NUMERATOR DEFINED	DENOMINATOR DEFINED	DEFINITIONS OF IMPORTANT TERMS	NOTES
9. Prevalence of low birth weight	The % of live born babies who weigh less than 2500g	No. of live born babies who weigh less than 2500g x 100	Total no. of live births	Birth weight is the first weight of the infant obtained after birth Low birth weight (LBW) is less than 2500g (up to and including 2499g). Very low birth weight is less than 1500g (up to and including 1499g.) Extremely low birth weight is less than 1000g (up to and including 999g.).	The definitions of low, very low and extremely low birth weight do not constitute mutually exclusive categories. Below the set limits they are all-inclusive and therefore overlap (i.e. 'low' includes 'very low' and 'extremely low', while 'very low' includes 'extremely low'.
10. Prevalence of positive syphilis serology in pregnant women	The % of pregnant women aged 15-24 yrs attending antenatal clinics with a positive serology for syphilis	No. of pregnant women aged 15-24 yrs attending antenatal clinics, whose blood has been screened for syphilis, with a positive serology for syphilis during a specified period x 100	Total no. of pregnant women aged 15-24 yrs attending antenatal clinics, whose blood has been screened for syphilis, with a positive serology for syphilis during a specified period		This indicator is useful as a proxy of the burden of sexually transmitted infections (STIs) in the general population and also a marker of progress towards reducing the burden of STI.

DESCRIPTION OF INDICATORS					
INDICATOR NAME	INDICATOR DEFINITION	NUMERATOR DEFINED	DENOMINATOR DEFINED	DEFINITIONS OF IMPORTANT TERMS	NOTES
11. Prevalence of anaemia in women	The % of women of reproductive age screened for haemoglobin levels who have levels below 110g/l (pregnant women) and 120g/l (non-pregnant women).	No. of women of reproductive age screened for haemoglobin levels who have levels below 110g/l (pregnant women) and 120g/l (non-pregnant women) during a specified period x 100	Total no. of women of reproductive age screened for haemoglobin levels during the specified period.		
12. Percentage of obstetric and gynaecological admissions owing to abortion	The % of admissions for (spontaneous or induced)abortion-related complications to service delivery points providing inpatient obstetric and gynaecological services, among all admissions (except those for planned termination of pregnancy).	Admissions for abortion-related complications x 100	All admissions, except those for planned termination of pregnancy.	Abortion-related complications may derive from spontaneous or induced abortion. Induced abortion may be attempted by women themselves (self-induced), by clandestine/ illegal providers. Specific diagnoses following abortion may include hemorrhage,	

DESCRIPTION OF INDICATORS					
INDICATOR NAME	INDICATOR DEFINITION	NUMERATOR DEFINED	DENOMINATOR DEFINED	DEFINITIONS OF IMPORTANT TERMS	NOTES
				local and systemic infection, injury to genital tract and internal organs and toxic or chemical reactions caused by agents used to induce the abortion.	
13. Reported prevalence of women with genital mutilation	The % of women interviewed in a community survey who report having undergone genital mutilation	No. of women interviewed in a community survey who report having undergone genital mutilation x 100	Total no. of women interviewed in the survey	Female genital mutilation (FGM) is the result of all procedures that involve the partial or total removal of external female genitalia or other injury to the female genital organs, whether for cultural or any other non-therapeutic reason.	

			DESCRIPTION OF INDICATORS		
INDICATOR NAME	INDICATOR DEFINITION	NUMERATOR DEFINED	DENOMINATOR DEFINED	DEFINITIONS OF IMPORTANT TERMS	NOTES
14.Prevalence of infertility in women	The % of women of reproductive age (15-49 yrs) at risk of becoming pregnant (not pregnant, sexually active, not using contraception and not lactating) who report trying for a pregnancy for two years or more.	No. of women of reproductive age (15-49 yrs) at risk of becoming pregnant (as defined previously) who report trying unsuccessfully for a pregnancy for two years or more x 100	Total no. of women of reproductive age at risk of becoming pregnant (as defined above).		
15. Reported incidence of urethritis in men	The % of men aged 15-49 yrs, involved in a community survey, who reported having one or more episodes of urethritis in the previous 12 months	No. of men aged 15-49 who reported having one or more episodes of urethritis in the previous 12 months x 100	No. of men aged 15-49 yrs interviewed in the survey	An episode is the occurrence of symptoms either for the first time ever or at least 5 days after the appearance of previous symptoms	The recall period of 12 months refers to the last 12 months and not the previous calendar year

				DESCRIPTION OF INDICATORS	
INDICATOR NAME	INDICATOR DEFINITION	NUMERATOR DEFINED	DENOMINATOR DEFINED	DEFINITIONS OF IMPORTANT TERMS	NOTES
16. Prevalence of HIV infection in pregnant women	The % of blood samples taken from women aged 15-24 yrs that test positive for HIV during routine sentinel surveillance at selected antenatal clinics	No. of HIV positive blood samples taken from pregnant women aged 15-24 yrs at selected antenatal clinics (sentinel surveillance sites) x 100 (In the immediate post-pubertal age group i.e the age group just beginning sexual activity virtually all prevalent infections could be used as proxy for incident/new infections)	Total no. of blood samples taken from pregnant women aged 15-24 yrs from selected antenatal clinics that were tested for HIV	Prevalence of positive syphilis serology in pregnant women is another indicator that might be useful as an early warning indicator for HIV spread, as well as a biological marker for high risk sexual practices.	
17.Knowledge of HIV-related preventive practices	The % of survey respondents who correctly identify all three major ways of preventing sexual transmission of HIV, and who also reject all three major	No. of survey respondents (women and men), who correctly identify all three major ways of preventing sexual transmission of HIV, and who	Total no. of respondents included in the survey	The three major ways of preventing sexual transmission of HIV are: (a) having no penetrative sex; (b) using a condom; and © limiting sexual	This indicator is a composite of two major sets of questions: those on correct knowledge and those concerning incorrect knowledge or misconceptions.

DESCRIPTION OF INDICATORS					
INDICATOR NAME	INDICATOR DEFINITION	NUMERATOR DEFINED	DENOMINATOR DEFINED	DEFINITIONS OF IMPORTANT TERMS	NOTES
	misconceptions about HIV transmission or prevention	also reject all three major misconceptions about HIV transmission or prevention x 100		activity to one faithful, uninfected partner The three major misconceptions about HIV transmission or prevention are: (a) not understanding that a healthy-looking person can carry the AIDS virus; and (b) and (c)two other major misconceptions to be determined in the local cultural context	

Appendix 2 - Questionnaire

1. What specific areas in the broad scope of SRH is the focus of your organization?
2. Describe your organization's data collection procedure
   a. Identify forms used
   b. The frequency of data collection
   c. Is data analyzed by trained personnel?
3. List all places (departments, organizations, facilities) from which data is collected
4. Is data disaggregated by sex, age, religion, ethnicity and income?
5. What tools do you require to improve the collection and analysis of SRH data in your Organization?
   a. Is training provided for persons in the data collection process?
   b. What are the gaps in data collection?
6. What activities / budget allocations have you made for SRH information in your work plans?

Appendix 3 - Structure Of Regional Health Services

**Medical Officer
of Health**

Chief Nursing Officer

12 Priority Health Areas

Policy, Standards

Standards

Monitoring

**Principal Nursing
Officer**

9 Regional Health Teams providing
integrated curative and preventive care

**Level 4 health facilities
(Polyclinics, district hospitals)**

**Level 1, 2 and 3 health facilities
(Health Centres)**