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# REPRODUCTIVE HEALTH INDICATORS IN THE EUROPEAN UNION

**FINAL ACTIVITY REPORT**

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## REPROSTAT

### **Reproductive Health Indicators in the European Union EU Community Health Monitoring Programme**

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## 1. Introduction

The European Union (EU) Commission choose Reproductive Health (RH) as a Public Health priority project area for the year 2001, in the frame of the EUPHIN (European Union Public Health Information Network).

REPROSTAT aimed to provide health professionals, policy makers, researchers and health service user groups with RH indicators that they can use to monitor and evaluate RH and associated health care in the EU. This was a two years Project that started in September 2001 and finished in August 2003, and was part of the EU Health Monitoring Programme.

At present many RH indicators used by different EU Member States are inconsistent, preventing useful comparisons between countries. Information about some key indicators is missing in several Member States (MS). By harmonising the definition for each indicator, REPROSTAT hopes to facilitate the comparison of RH services in different MS.

We have shown which indicators are based upon data that already exist in many countries as part of routine health care services and those based on data generated from specific health surveys (see 3.1).

Recognising that RH is important not only for the reproduction of population but also for the well being of EU members, we propose a set of indicators to be used in ongoing monitoring . RH is important for the well being of the people in the EU. It is also important because of concerns about the ageing population of EU and declining fertility rates.

Some MS currently have health information systems that include questions covering several of our proposed indicators, but some definitions and methods of collection differ. These methods need to be harmonised. So, a comprehensive and reliable comparative table containing existing data is not yet feasible.

Limits and biases of indicators depend on the quality of data collected in each MS.

We propose that a specific part of the **EU wide** general health **survey** 2006 be devoted to reproductive and sexual health.

In addition, we believe there is a strong need for a **youth survey** that includes questions about RH, undertaken at regular intervals.

Health indicators can be used to monitor needs for health care, and evaluate the effectiveness and impact of health care programs. Our set of indicators is likely to be used for the:

- 1) development of policies and programs aimed at improving the sexual and RH of EU citizens;
- 2) regular monitoring and evaluation of progress, quality and effectiveness of the RH programs within EU;

- 3) making of comparisons among EU Member States;
- 4) making comparisons between different groups within MS.

In order to avoid making monitoring an unrealistic burden, each indicator should be relevant and useful.

Relevant in the sense that they represent important Public Health problems within RH and useful in the sense that they provide cues for intervention or research. Whenever possible, indicators should be based on readily available information. When such routine information is not available, other data sources, such as specific health surveys should be implemented.

The group also recognised the importance of making sure that our range of indicators covered the sexual health of both sexes. We rapidly realised that this ambition would fail if we relied only on existing indicators and data sources. Several of the new indicators proposed, therefore, require major *development before* they can be *implemented*.

The group recognised the importance of making sure that there was no duplication between different sets of indicators within the HMP. RH indicators could include those related to the screening and occurrence of reproductive cancers, as well as indicators of perinatal health. Discussion was held between the chairs of different EU projects in order to decide where an indicator best set within the overall HMP.

When a **comprehensive picture** of RH is to be measured, indicators from PERISTAT (*perinatal* health) and EUROCHIP (*cancer*) should be also considered. As a result of the communication between project co-ordinators covering adjacent fields, we have excluded from our list indicators related to the perinatal period (from conception to delivery) and reproductive cancers as well.

REPROSTAT included participants from 14 of the 15 European Union Member States (13 participants plus the Project co-ordinator) - see participants list **Annex I** : eight gynaecologists, four epidemiologists and two public health doctors.

This report contains the final **recommended minimum list** of indicators that the 15 actual MS can use to monitor RH. The list of indicators may need to be modified slightly when the number of MS expands in May 2004.

Our list of indicators consist of 13 core indicators, one recommended indicator and four others that need future development (**Tables I and II**, pages 11 and 12).

*Core indicators* are defined as that essential for monitoring RH and related health care.

The *recommended indicator* is considered desirable for a more complete assessment of RH across MS.

Indicators for *future development* represent important aspects of RH and associated health care, but require further work before they can be operationalised in MS.

The list may also develop over time to include new indicators for issues such as erectile dysfunction and sexual health and violence during pregnancy.

## 2. Methodology and meetings

In order to facilitate our project discussion, we had a four members **Steering Committee** (SC): Kitty Bloemenkamp (Holland), Marleen Temmerman (Belgium), Jorn Olsen (Denemark) and Philip Hannaford (United Kingdom). This Steering Committee, always working with the project co-ordinator, co-opted two other participants: Albrecht Jahn (Germany) and Adriano Cattaneo (Italy).

For each indicator we have used a structure similar to that used by WHO (WHO/RHT/HRP/97.25). Thus, for each indicator there is an operational definition, justification for selection, criteria for selection, data sources and (when appropriate) references.

This project was linked with other EU projects for monitoring of the European Union's health, namely ones dealing with cancer and cancer monitoring, as well as perinatal health (Peristat).

For this reason, we have not selected some Reproductive Health indicators, for instance those related to maternal health, routine prenatal care. Thus, we did not include maternal events from conception to delivery, since these were covered, by agreement with the project co-ordinator, by Peristat.

When selecting our indicators we used the WHO **definition of Reproductive Health** (International Conference on Population and Development, Programme of Action, Cairo, 1994, paragraph 7.2):

*“ Reproductive Health is 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 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. It also includes sexual health, the purpose of which is the enhancement of life and personal relationships, and not merely counselling and care related to reproductive and sexually transmitted diseases.”*

We underline the importance of including **sexual health** under this broad concept of reproductive health. This explains the choice of some indicators not directly linked to the reproductive life.

Between September 2001 and March 2002 we worked in order to reach, at the Steering Committee level, a consensus about a RH list of indicators. After this, the list was submitted to discussion and approval by all the other REPROSTAT participants in April and May 2002; between June 2002 and December 2002 we opened the discussion to the external scientific community, asking for criticisms and suggestions.

In doing this, we kept as closed and near as possible of the original tasks-timetable included in the 3. of the approved contract.

### REPROSTAT MEETINGS

	Full team	Extra budget SC	SC	Full team	SC	SC Editorial meeting	Full team
Date	29-30.9.01	30.11.01	21-24.3.02	31.5.02-1.6.02	1.11.02	4-5.4.03	9-10.5.03
Place	Lisbon	Luxembourg	Venice	Sintra	Amsterdam	Copenhagen	Dublin

SC = Steering Committee

#### 2.1 First full team meeting (September 27-29, 2001)

At our **first full team meeting**, in Lisbon, besides introducing to one another and discussing the existing RH data of every MS, it was clearly stated and agreed, with the help and participation of Dr. Henriette Chamouillet, the scope and objective of this Project.

Several participants expressed the wish that, instead of the **meetings schedule** included in the Project budget (three full team meetings and four SC meetings), it would be better if we would have, alternatively, a full team meeting after every SC meeting.

Not having budget for such a schedule, Dr. Henriette Chamouillet suggested a compromise, that we accepted: to invite two other participants to participate at the SC discussions -- Dr. Adriano Cattaneo and Dr. Albrecht Jahn (respectively from Italy and Germany), and having an **extra-budget first SC meeting**, paid by the Commission (November 30, Luxembourg). However, besides travelling and accommodation expenses, no fee would be paid to these two last colleagues.

#### 2.2 First Steering Committee meeting (Luxembourg, Nov. 30, 2001)

During our **first steering committee meeting** we decided

- i) not to feel obliged to use any previous RH indicators list.
- ii) consider only those indicators addressing specific needs of the 15 EU MS.

- iii) build a matrix covering 9 major RH areas: HIV/STD, Maternal health, Family Planning, Violence against women, RH for youth, Infertility, Cancer of reproductive organs, unsafe abortion and sexual dysfunction.  
In each of these areas, several RH indicators were suggested, in a total of thirty three (see **Annex V**).
- iv) provide documents to justify why the selected indicators were chosen.
- v) clearly define each indicator.
- vi) avoid gaps and duplication with other ongoing EU projects (there was no specific STD project; there were two about cancer and one about Perinatology)
- vii) rank/prioritise our first approach of internal RH indicators, marked as Essential = 3; Important = 2; Desirable = 1  
Indicators were marked according with their ethical, useful, valid and action aspects. Final results of this choice are shown in Annex V.
- viii) make the assumption that national and/or European health surveys will be implemented in all member states
- ix) consider the costs of introducing new and/or refining existing RH indicators

According to these decisions, and using a matrix covering the nine mentioned major RH areas, we asked all REPROSTAT participants, between December 2001 and January 15 th 2002, to rank/prioritise all these eventual RH indicators. All REPROSTAT participants were free to have informal consultation and discussion with local experts

### **2.3 Second Steering Committee meeting** (March 21-24, 2002)

We decided that our main goal would consist on reaching an internal consensus among all REPROSTAT participants (and not only among SC elements) about a provisory RH list not later than May 2002, i.e., at the time of the scheduled Second Full Team meeting.

### **2.4 Second full team meeting** (May 31-June 1, 2002)

At our **second full team meeting** we decided to:

- i) agree on our RH indicators internal list
- ii) emphasise the importance of **sexual wellbeing** (and related indicators that would reflect it), taking into account the mentioned reproductive health definition;



- iii) extend the concept of female reproductive life to include the **post-menopausal** period, so as to embrace associated treatments, such as hormone therapy and urinary incontinence;
- iv) open the discussion to the scientific community and national authorities.

An initial set of proposed indicators had been discussed among the fourteen project participants (plus WHO representative) between September 2001 and June 2002. This was an *internal* agreement: at this second SC meeting we reached an internal consensus about our RH list.

After that, we would open the discussion to the scientific community and national reproductive and statistical authorities, through formal invitation letters and e-mail invitations. In order to make this approach more fruitful and comprehensive we decided to open a specific REPROSTAT site after June 2002, where our goals, methodology and internal RH list could be consulted.

Between July and December 2002, an open invitation to an *external* discussion and review of the proposed list was issued to over 200 experts in reproductive and sexual health within the 15 MS. A specific web *site* – <http://reprostat.com> - was created and this resulted in a number of suggestions and criticisms (sent to [suggestions@reprostat.com](mailto:suggestions@reprostat.com)), which have been incorporated into the final set of indicators.

This web site, although not contemplated in the approved budget, was considered and discussed since the very beginning of the project, namely at the first full team meeting and at the first SC meeting, with Dr. Henriette Chamouillet agreement.

### **2.5 Third Steering Committee meeting** (November 1st, 2002)

At the Amsterdam meeting we discussed and decided which criticism and suggestions should be incorporated in our previous RH list.

### **2.6 Third full team meeting** (May 9-10, 2003)

At the last full team meeting we agreed upon the final written document and some final changes about several RH indicators were discussed and approved in Dublin.

### **2.7 Extra-meetings**

Besides these meetings, there were two other authorised extra meetings:

- i) one in Luxembourg (November 20-21<sup>th</sup>, 2002) with Dr. Henriette Chamouillet and Dr. Dirk Backendorf, in order to evaluate the REPROSTAT projection situation;
- ii) one in Helsinki, with Dr. Arpo Aroma and Prof. Elina Hemminki (December 14-16, 2002) in order to discuss and evaluate the possibility of collecting several of our indicators through an European Health Survey and a specific Youth Health Survey.

## **2.8 WHO co-operation**

The group readily acknowledges the excellent work that the World Health Organisation (WHO) has already done in the development of RH indicators. We had an open dialogue and co-operation with WHO /Euro from the start of REPROSTAT. The WHO RH list of 17 indicators was examined and used, when appropriate, to develop our set of indicators. It was recognised, however, that EU Member States have specific needs, and that new issues are emerging in RH, requiring the development of a new set of indicators for EU.

From the very beginning, in order to facilitate interagency dialogue and co-operation on the issue of RH indicators, we decided to articulate our work with WHO experts. A WHO element was always invited to participate at our meetings. Dr. Assia Brandrup-Lukanow and Dr. Jose Kasonde, both from WHO Regional Office for Europe, participated, respectively, at the first Steering Committee (Luxembourg, November 30, 2001), at the second Full Team Meeting (Sintra, May 31, 2002) and at the third and last Full Team Meeting (Dublin, May 2003).

## REPRODUCTIVE HEALTH INDICATORS IN THE EUROPEAN UNION

REPROSTAT list of indicators

**Table I**  
**(areas)**

Areas	Core	Recommended	Future development
<b>STI / Sexual Behaviour</b>	1-HIV(tested pregnant women) 2-Chlamydia prevalence 3-Condom use (last high-risk intercourse)		
<b>Youth</b>	4- Median age at 1 <sup>st</sup> intercourse 5- Contraceptive use at 1st intercourse 6- Teenage birth rate		
<b>Contraception</b>	7- Contraceptive Prevalence		
<b>Fertility &amp; Reproduction</b>	8 – Mean age at 1st childbirth 9 – Total fertility rate 10- % trying to get pregnant 11- % deliveries after ART		
<b>Abortion</b>	12 – Induced abortions		
<b>Emerging areas</b>	13- % of women with hysterectomy	14-Urinary incontinence	15-Hormonal therapy at menopause 16 – Erectile dysfunction 17 - Sexual health and wellbeing 18 – Violence during pregnancy

Note: Perinatal and reproductive cancer areas are covered by other projects.

## REPRODUCTIVE HEALTH INDICATORS IN THE EUROPEAN UNION

REPROSTAT list of indicators

**Table II  
(categories)**

Category	Core	Recommended	Future development
<b>Individual health</b>	1-HIV (tested pregnant women) 2-Chlamydia prevalence 6-Teenage birth rates	14-Urinary incontinence	16 – Erectile dysfunction 17 - Sexual health and wellbeing
<b>Risk factors</b>	3-Condom use (last high risk intercourse)		
<b>Population characteristics and/or Risk factors</b>	4- Median age at 1 <sup>st</sup> intercourse 5- Contraceptive use at 1st intercourse 7- Contraceptive Prevalence  8 – Maternal age at 1st childbirth 9 – Total fertility rate 10- % trying to get pregnant 11-% deliveries after ART 12-Induced abortions		18 – Violence during pregnancy
<b>Health care services</b>	13-% of women with hysterectomy		14-Hormonal therapy at menopause

Note: Perinatal and reproductive cancer areas are covered by other projects.

### 3. Reproductive health indicators

#### 3.1 Sources of data

Data will come from three different sources:

- a) administrative data
- b) youth surveys
- c) general health surveys

We expect the following indicators to stem from:

- a) Indicators 1,6, 8,9,11,12,13
- b) Indicators 2,3,4,5 (15-19 years old)
- c) Indicators 7,10,12,13,14,15,16,17,18

Although we have tried in all participating countries to search for data sources and the latest values for our selected indicators, this task was not fruitful in most Member States.

Several reasons of which we were not fully aware when starting our project – different age groups within the similar indicator, different definitions and methods of collection, non existing data, unreliable or only regional data – explain why this was a partially missed goal. And, however, at the end of the project, we still had some unspent budget for data collection.

This issue has to be overcome in a future project

When surveys are to be considered, all surveys should include a representative sample of individuals from the country or region studied.

If the surveys are region specific, we suggest that the regions be comparable in size and urbanisation. We do not expect the reproductive health indicators be collected every time that the surveys are done, if there is a short interval between surveys. Some reproductive health indicators could be collected at, say, 5 year intervals.

The indicators have to be developed when the conditions for such a design is agreed upon.

An option could be to offer a self administered and anonymous questionnaire at the end of the survey to be filled out in privacy and to be returned by mail in sealed envelopes to the survey centre.

Indicators 16, 17, 18 will require a special design that could be incorporated into the Health Survey. This is why they are not detailed in this report.

#### 3.2 Indicators description

In the following pages we will consider each indicator separately, according to the following item:

- Operational definition
- Justification for selection
- Criteria for selection
- Data sources
- References

Indicator 1: **1 a Acceptance of HIV testing among pregnant women**  
**1 b HIV seroprevalence among HIV tested pregnant women (all ages)**

### **Operational definition**

Percentage of pregnant women attending antenatal care who accept to be screened for HIV (1a), and the percentage of these who were found HIV seropositive (1b).

### **Justification for selection**

HIV seroprevalence in pregnant women is a useful indicator to measure prevalence rates in the heterosexual population and trends over time in different Member States. Limitations are the likely operational complexity of measuring the indicator in some countries, and the inherent biases involved in sampling only pregnant women.

### **Criteria for selection**

- Useful – it is impossible to have a perfect HIV indicator. HIV seroprevalence in pregnant women is perhaps the best obtainable proxy of HIV trends in the general population.  
The indicator is, however, subject to bias because of exclusion of men and non-pregnant women.  
A further limitation is the general low risk of HIV in pregnant women in most of actual Member States, and the risk of selection bias among those who refuse to be tested.
- Robust - relatively large sample sizes (minimum of 3000 individuals) are needed to ensure adequate precision of the estimates.
- Ethical - data collection should be through individual serological screening. Offering medical adequate care is essential when the test is positive.
- Representative - a sentinel surveillance of unselected pregnant women who attend the health sector . Depends on the representativeness of the sample used for the global community.
- Understandable - if applied properly according to definitions and methodology.

### **Data sources**

From laboratories performing routine tests in pregnant women, or national HIV/AIDS data collection systems based on the same primary source.

The data are available in antenatal care in some countries. In most Member States blood is obtained from pregnant women for at least one or several occasions.

### **References**

Adapted from WHO/RHT/HRP/97.26 (Monitoring Reproductive Health)

## Indicator 2 : Chlamydia prevalence

### **Operational definition**

Prevalence of chlamydia positive persons (male and females) within a youth survey selected for testing between 15 to 19 years old tested by a NAAT (nucleic acid amplification technique) in urine.

### **Justification for selection**

Chlamydia infection is the most common sexually transmitted bacterial disease in USA and in most Member States. Chlamydia infection can be associated with long-term complications, such as PID, ectopic pregnancy and infertility.

A high-quality randomised trial demonstrated that screening and treating at-risk women could reduce PID incidence by more than 50%.

### **Criteria for selection**

- Useful – represents an important Public Health problem where treatment is available.
- Robust – a minimum of 1,000 individuals is needed in order to ensure adequate statistical precision if the expected prevalence is between 4 and 10%.
- Ethical – if easy access to effective treatment and follow up is available.
- Representative – if the testing is accepted by most of the invited.
- Understandable – easy to understand.

### **Data sources**

Through urinary LCR assays

Varies by country. We propose to use the recommended youth survey to collect the information.

### **References:**

Atkins D. First new screening recommendations from the third US Preventive Services Task Force BMJ USA 2001;1:187-190

Brito de Sá A et al. Genital infection by Chlamydia trachomatis in Lisbon: prevalence and risk markers. Family Practice 2002; 19 (4): 362-364

Scholes D et al. Prevention of PID by screening for cervical chlamydia infection. N Engl J Med 1996;334:1362-1366

### Indicator 3: **Reported condom use at last higher risk sex (15-19 years old)**

#### **Operational definition**

The percent of respondents who reported high-risk sex, defined as having had penetrative sex with a non-marital, non-cohabiting partner in the last 12 months, of all respondents reporting sexual activity in the last 12 months.

Numerator: The number of respondents who reported having had penetrative sex with a non-marital, non-cohabiting partner in the last 12 months using a condom.

Denominator: Total number of respondents who report having had penetrative high-risk sex in the last 12 months.

#### **Justification for selection**

This indicator has been used in several surveys and it has been selected by UNAIDS as core indicator. It is included in the millennium indicators.

#### **Criteria for selection**

- Useful – good measure of risk behaviour.
  - Appropriate for needs assessment and evaluation of interventions related to the reduction of high-risk behaviour.
  - Can be stratified for age and sex.
- Robust – the indicator relies on self-reported practice and suffers from reporting bias problems like all survey derived indicators on sexual behaviour. However, there is no alternative to self-reported data.
- Ethical – like all indicators derived from population surveys, confidentiality must be guaranteed. The related questions may be perceived as inappropriate in specific communities.
- Representative - depends on the representativeness of the sample.
- Understandable – easy to understand.

#### **Data sources**

From youth health surveys.

Youth surveys are available in some Member States, but specific questions should be written.

#### **References:**

[http://millenniumindicators.un.org/unsd/mi/mi\\_series\\_results.asp?rowID=709](http://millenniumindicators.un.org/unsd/mi/mi_series_results.asp?rowID=709)  
<http://www.cpc.unc.edu/measure/publications/bulletins/bulletin2/article3.pdf>



#### Indicator 4: **Median age at first intercourse**

##### **Operational definition**

Sex specific proportions of youth with experience of penetrative sex rates by age (15 to 19 years).

##### **Justification for selection**

The indicator is straightforward and captures trends in sexual activity among young people and related vulnerability of unwanted side effects such as STDs.

##### **Criteria for selection**

- Useful - good measure of timing and trends of the start of sexual activity.  
Appropriate for needs assessment and identification of target groups for sex education.
- Robust - the indicator relies on self-reported practise and suffers from reporting bias (and lack of recall) problems like all surveys on sexual behaviour. However there is no alternative to self reported data.
- Ethical - like all indicators derived from population surveys, confidentiality must be guaranteed. The related questions may be perceived as inappropriate in specific communities.
- Representative - good if based upon properly sampled survey.
- Understandable - easy to understand.

##### **Data sources**

From youth health surveys

Specific questions need to be developed for the Youth Survey

##### **References:**

[http://www.measuredhs.com/hivdata/ind\\_detl.cfm?ind\\_id=56&prog\\_area\\_id=9](http://www.measuredhs.com/hivdata/ind_detl.cfm?ind_id=56&prog_area_id=9)  
<http://www.cehip.org/apheo/indicators/pages/indicators/ind06a01.html>

Indicator 5: **Proportion of contraceptive use at first intercourse**

### **Operational definition**

The number of respondents reporting contraceptive use \* at the first penetrative sex, among those who had penetrative sex in the age group of 15 to 19 years.

### **Justification for selection**

To estimate the proportion of those not using contraception at first penetrative sex and risking unwanted pregnancies in this age group.

### **Criteria for selection**

- Useful – for planning sex education. Can be stratified by method.
- Robust – depends on sample size and the proportion having had sexual debut in the sample.
- Ethical – confidentiality must be guaranteed.
- Representative – depends on the representativeness of the sample.
- Understandable – needs a clear definition of contraceptive methods;  
easy if the participation rates are high in the surveys.

### **Data sources**

Youth health surveys

Specific questions need to be developed for the questionnaire

### **References**

[http://www.measuredhs.com/hivdata/ind\\_detl.cfm?ind\\_id=56&prog\\_area\\_id=9](http://www.measuredhs.com/hivdata/ind_detl.cfm?ind_id=56&prog_area_id=9)  
<http://www.cehip.org/apheo/indicators/pages/indicators/ind06a01.html>

\* Contraceptive methods include female and male sterilisation, injectable, oral, subdermal and transdermal hormones, intrauterine devices and systems, diaphragms, spermicides and condoms, natural family planning, lactational amenorrhoea and coitus interruptus

## Indicator 6 : Age-specific birth rates in teenagers

### **Operational definition**

The number of births in women aged less than 20 years (at delivery) per 1000 women of the same age by one-year interval.

### **Justification for selection**

Teenage pregnancy can be associated with adverse health and social outcomes.

A low teenage pregnancy rate is desirable.

Interventions to reduce teenage pregnancy rates are in progress.

Data are already available in most countries and can be easily analysed.

### **Criteria for selection**

- Useful – to set priorities for health of teenagers
  - to develop and modify policies and strategies
  - most useful if stated in one-year age intervals
  - usefulness would be improved if the rates are stratified for different subgroups of the population.
- Robust – birth data from routine statistics are fairly complete and accurate in the EU
  - all countries should use the same definition, i.e. age at delivery, not age at conception
- Ethical - no figures should be produced which may identify individuals
- Representative – as miscarriages and induced abortions are not included, and vary between countries, delivery rates may not be a reliable and consistent indicator of pregnancy rates.
- Understandable – Easy to understand for policy makers and experts in public health

### **Data sources**

Routine birth registers

Population census

### **References**

Council of Europe collects and publishes birth rates among women aged 15-19 years in Europe  
[http://www.coe.int/t/e/social\\_cohesion/population/demographic\\_year\\_book/](http://www.coe.int/t/e/social_cohesion/population/demographic_year_book/)

## Indicator 7 : Contraceptive Prevalence

### **Operational definition**

Percentage of women of reproductive age (15-49) who are using (or whose partner is using) a contraceptive method\* at a particular point in time.

### **Justification for selection**

Complementary to the Total Fertility Rate (indicator 9).

Effective utilisation is mediated by many factors—cognitive (knowledge), economic, accessibility, reimbursement politics, quality of services.

### **Criteria for selection**

- Useful – as an intermediate measure of contraception use;  
more useful if information by method is available about choice, appropriateness and compliance; with use of the methods the indicator should be given for the population at large and subgroups.
- Robust – can be made more specific by confining to women at risk of pregnancy.
- Ethical – if privacy is respected.
- Representative – depends on the representativeness of the sample.
- Understandable – needs a clear definition of contraceptive methods.

### **Data sources**

Population-based health surveys using standard questions.

### **References**

Adapted from WHO/RHT/HRP 97.26, Annex 5 (Monitoring Reproductive Health)

\* Contraceptive methods include female and male sterilisation, injectable, oral, subdermal and transdermal hormones, intrauterine devices and systems, diaphragms, spermicides and condoms, natural family planning, lactational amenorrhea and coitus interruptus

## Indicator 8: **Maternal age at first childbirth**

### **Operational definition**

Age of women at the birth of their first child, expressed as mean and median age.

### **Justification for selection**

Increasing age at first childbirth, as seen in most European countries, is associated with adverse reproductive health outcomes.

Since fecundity is a function of age, the starting age of childbearing will indicate not only change in expected fertility rates but also expected need for fertility treatment.

### **Criteria for selection**

- Useful – for planning of reproductive health services and social policies.  
Since the distribution of maternal age at first childbirth is skewed, two measures (mean and median) are needed and should be specified when reported.
- Robust – data from routine statistics are fairly complete and accurate in the EU
- Ethical – no problems are foreseen if privacy is respected
- Representative- not applicable
- Understandable – Easy to understand.  
The use of maternal age distribution by five-year age groups (less than 20, 20-24, 25-29, 30-34, 35-39, 40-44, 45 or more) is even more informative.

### **Data sources**

The data will be available in all countries with valid and updated populations statistics

Vital statistics

Routine birth registers

Council of Europe – The demographic situation in Europe

### **References**

Annual publication by Council of Europe. Recent demographic developments in Europe. Strasbourg, Council of Europe Publishing.

[http://www.coe.int/t/e/social\\_cohesion/population/demographic\\_year-book/](http://www.coe.int/t/e/social_cohesion/population/demographic_year-book/)

## Indicator 9: **Total Fertility Rate**

### **Operational definition**

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

### **Justification for selection**

Needed for planning reproductive health services and social policy development.  
Complementary indicator of contraceptive prevalence.

### **Criteria for selection**

- Useful – requires the calculation of age specific fertility rates (ASFR)-the number of livebirths occurring to women within a specific age range per thousand women in that age range. ASFR can be calculated for specific subgroups of the population.
- Robust – the measure reflects social and cultural changes in society in addition to the biological capacity of the population to reproduce.
- Ethical – no special problems.
- Representative – valid only as hypothetical measure of expected total number of births per women since it assumes constant ASFRs over time.
- Understandable – it uses the term fertility as understood by demographers  
It is a measure of livebirths not of conceptions  
ambiguity remains over inclusion of livebirths only.

### **Data sources**

Routine statistics  
Population census

### **References**

WHO RHT/HRP 97.26, Annex 5  
Council of Europe  
WHO – Health for All database  
OECD Health Data  
The data will be available in all Member States with valid and updated statistics

Indicator 10: **Proportion of women trying to get pregnant for one year or more**

**Operational definition**

Percentage of women of reproductive age (15–49) who have tried to get pregnant for one year or more among those trying to conceive at the time of the survey.

**Justification for selection**

There are concerns that subfertility is increasing in some European countries, perhaps as long-term sequelae of sexually transmitted infections (STIs), decreased sperm quality, older age at starting to get pregnant and other factors affecting conception rates.

Subfertility has important emotional, social, health and economical consequences.

Many European countries use a one-year waiting time before initiating treatment.

**Criteria for selection**

- Useful - is a measure of reproductive health related to a couple's biological capacity to reproduce. Usefulness will be improved if age and parity specific figures can be provided
- Robust - provides a point prevalence measure of the "failure to conceive" in 15–49 year old women, but requires a large sample size.

The measure will be influenced by the prevalence of effective contraception, help seeking behavior and provision of reproductive health care services in the population. If there are differences in these influences between countries or over time interpretation of data may be difficult.

- Ethical – provided privacy is protected and consent is obtained.
- Representative- depends on representativeness of sample used.
- Understandable- provided that the limitations of the measure indicated above are recognised.

**Data sources**

Health surveys using standardised and validated questions (which have to be developed).

**References**

European Society for Human Reproduction and Embryology (ESHRE) collection of Europe-wide statistics (published in *Human Reproduction*)

Indicator 11: **Proportion of deliveries associated with assisted reproductive technology (ART)**

**Operational definition**

The number of women delivering live or stillborn babies after ART divided by the total number of women delivering live or stillborn babies.

At present ART includes IVF (in vitro fertilization, including ICSI, MESA and TESE), GIFT (gamete intrafallopian transfer), ZIFT (zygote intrafallopian transfer) and frozen embryo transfer after these treatments. The indicator does not include treatments in which only sperms are handled (i.e., artificial insemination or intrauterine insemination) or procedures in which a woman takes drugs only to stimulate egg production without the intention of having eggs retrieved.

**Justification for selection**

- An increasing number of women are receiving ART. This may reflect an increasing acceptability, accessibility and availability of ART, as well as possible increase in infertility.
- More multiple births are reported after ART treatment which will lead to more preterm births, and as a consequence more perinatal and maternal morbidity and mortality.

**Criteria for selection**

- Useful - reflects changes in fecundity and treatment options and availability; usefulness will be improved if also disaggregated by: a) type of ART b) indication for ART c) age group of woman.
- Robust - the indicator requires adequate and complete registration of deliveries associated with ART. ART includes all fertility treatments in which both egg and sperm are handled.
- Ethical – provided privacy is protected and consent is obtained
- Representative - the indicator will be representative as long as all ART treatments and all life and still births are recorded in the registers.
- Understandable -when clear definitions are used, the indicator will be understandable. The indicator does not give information about the total frequency of pregnancies associated with ART or their outcome. This is not an indicator of the success rate of ART.

**Data sources**

From birth registers, or linkage of birth and ART registers

This indicator will require changes in birth registration policies in some Member States

**References**

European Society for Human Reproduction and Embryology (ESHRE) collection of Europe-wide statistics (published in *Human Reproduction*)



## Indicator 12 : **Frequency of induced abortions**

### **Operational definition**

12a) Induced abortion rate (induced abortions per 1000 women aged 15-49 years).

12b) Induced abortion ratio to live births( induced abortions per 1000 livebirths).

### **Justification for selection**

Induced abortions are social and public health problem, and they also reflect maternal mortality and morbidity rate.

Provide information about the use of effective contraceptive methods.

Complementary to Contraception Prevalence (indicator 7).

### **Criteria for selection**

- Useful – Usefulness would be improved if the rates are stratified by age.  
When interpreting the available data it is essential to know the legal status of induced abortion in each Member State.
- Robust – Routine data are not always available in some Member States. Moreover, it is likely to be underestimated in countries where registration is not legally required. Selfreported information is also usually inaccurate.
- Ethical – provided privacy is protected.
- Representative – likely to be underreported in some Member States.
- Understandable – easy to understand

### **Data sources**

Routine statistics in Member States where data collection is of good quality

Population-based surveys will complete them

### **References**

[http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?view\\_id=1&doc\\_id=234](http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?view_id=1&doc_id=234)

For 12 b) World Health Organisation, Regional office for Europe. Health for All – database,

<http://hfadb.who.dk/hfa/>

Indicator 13: **Proportion of women with hysterectomy**

### **Operational definition**

Proportion of women with hysterectomy at the age of 50 years.

### **Justification for selection**

High hysterectomy rates are a matter of concern in some European countries. Indications vary widely, are not always evidence based and may suggest overmedicalisation of reproductive health.

### **Criteria for selection**

- Useful – usefulness will be improved if data on indications are available.  
information will be more useful if given by age group, even above the age of 50 years.
- Robust - depends on the completeness of registration of surgical interventions (if indicator is derived from hospital data) or accuracy of recall (survey).
- Ethical - provided privacy is protected
- Representative - may be affected by completeness of registers
- Understandable – easy to understand

### **Data sources**

Population based survey

Data on hospital treatments and/or interventions can be used to gather comparable data

### **References**

[http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?view\\_id=18doc\\_id=234](http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?view_id=18doc_id=234)

Indicator 14: **Proportion of women with urinary incontinence**

**Operational definition**

Proportion of women in a community survey reporting themselves to have urinary incontinence in at least one episode per month in the three previous months (40-49 years), by five-year age groups.

**Justification for selection**

Symptoms of urinary incontinence are common and frequently not disclosed to health care services. Incontinence can have a severe impact on quality of life, although there is poor correlation between severity of symptoms and quality of life. Short-term symptoms are more likely to reflect temporary problems such as urinary infections, whereas long-term problems are likely to reflect anatomical problems. An increasing variety of interventions are available for treating the symptom. Information about prevalence of the symptom is not readily available from routine sources and would need to be collected in a specific health survey.

**Criteria for selection**

- Useful- Indicator of possible need for health services  
Usefulness is improved if age- and parity-specific prevalence rates are available  
Usefulness is improved if information about duration of symptoms and quality of life is also available
- Robust - The questions used need to have proven validity, reliability and responsiveness when used in the different member states
- Ethical - provided privacy is protected and based on consent
- Representative - Depends on the representativeness of the women answering the relevant questions
- Understandable - Valid, reliable and responsive self-completed questionnaires about urinary symptoms have been devised.

**Data sources**

From community survey.

Self-completed questionnaire is the recommended method of data collection. The number of questions needs to be small.

Data are not yet available from all Member States.

**References:**

Donovan JL, Badia X, Corcos J, Gotoh M, Kelleher C, Naughton M, Shaw C, Lukas B. Symptom and quality of life assessment. In: Incontinence: 2nd International Consultation on Incontinence, Anonymous  
Plymouth:Health Publication Ltd, 2002, p. 267-316

Indicator 15: **Proportion of women using peri and post-menopausal hormone medication**

**Operational definition**

Proportion of women aged 45-59 years using peri and post-menopausal hormone medication (also called HRT) at the point in time of the survey, also by five-year age groups.

Hormone replacement therapy includes oestrogens (with or without progestogens) and selective oestrogen receptor modulators

**Justification for selection**

The use of hormone replacement therapy shows huge variations between regions and countries reflecting 1) the perceived health benefits by women and by caregivers, 2) economic factors in relation to health and health-seeking behaviour, and 3) guidelines from policymakers and professional societies. Measuring differences between Member States and trends in time may provide evidence of overmedicalisation.

**Criteria for selection**

- Useful - improved if age-specific prevalence and duration of use is available
- Robust - valid only if specific standardised questionnaires are used
- Ethical - provided privacy is protected
- Representative - Depends on the representativeness of the women answering the relevant questions in the survey. National measures may hide wide differentials
- Understandable – interpretation may be affected by changes in duration of HRT use over time

**Data sources**

Community health surveys

**References**

Gynacol. Geburtshilfliche Rundsch, 2002

Italian Study Group on Incontinence – *Arch Ital Urol Androl.*, 2001 Sep, 73 (3): 160-167.

## 4. Main reasons for inclusion and exclusion of indicators

Besides the considerations done in the previous pages under the item *justification for selection*, we believe it is interesting to know some other reasons why certain indicators were included or not included.

### 4.1 Those **included**

## CORE INDICATORS

### 4.1.1 HIV seroprevalence in pregnant women

It was decided to restrict HIV seroprevalence to pregnant women because this issue is more directly relevant to RH. First pregnancy was also considered since it might make comparability easier if nulliparous women were more or less of the same age group. However, in some MS, it would be difficult to identify the denominator (number of first pregnancies).

In addition, there are differences in MS in the mean age at first pregnancy.

The group is aware that HIV testing during pregnancy is routinely done in several, but not all, MS. Guidelines on how to undertake appropriate testing have to be disseminated in those MS where routine testing of HIV status during pregnancy currently does not occur.

### 4.1.2 Chlamydia prevalence

The prevalence of genital Chlamydia infection, regarded as the most important and prevalent STI in most MS, was chosen as an indicator of reproductive and sexual health. This indicator is more specific than prevalence of urethral discharge (included in WHO list).

Urinary assays allow screening of both sexes, although questions related with cost / effectiveness have to be clarified.

### 4.1.3 Reported condom use during last high risk intercourse

Recognising differences in intercourse frequency (intra and inter individual differences), it was accepted that condom use during last intercourse across the whole male population was a useful RH indicator.

This indicator is more relevant than *knowledge about how to prevent STI*, previously considered as a possible RH indicator to include.

When collected through an EU survey, the question should be restricted to use at last intercourse, although it is recognised that behaviour during last intercourse is not the same as safe behaviour.

If data were not available through a survey, data might be collected from sales figures, although the group recognised that sales figures do not necessarily reflect usage.

#### **4.1.4 Median age at first intercourse**

Ideally, obtained through a special anonymous youth survey, due to sensitive nature of asking these informations in a general EU survey.

Denominator should be restricted to young age group (less than 20), sexually active and not wishing to get pregnant. Questions could be: *how old you were when you first had sexual intercourse ? What contraceptive did you use ?*

#### **4.1.5 Contraceptive use at first intercourse**

*Idem*

#### **4.1.6 Teenage birth rate**

This indicator is preferred to *teenage pregnancy rate*, since some pregnancies end in a spontaneous or induced (probably frequent in this age group) abortion.

This indicator is based upon the number of deliveries per 1000 women age 12 to 19 years of age at the time of delivery.

#### **4.1.7 Contraceptive Prevalence Rate (CPR)**

Percentage of women of reproductive age \* who are using (or whose partner is using) a contraceptive method at a particular point in time.

\* Women of reproductive age here refers to all women aged 15-49, who are at risk of pregnancy, i.e. sexually active women who are not infecund, pregnant or amenorrhoeic.

Two main issues dominated the discussion of this unquestionable RH indicator: last versus regular contraceptive method and the need to have age specific prevalence rates.

It was recognised that there is no other way to get the data, than through a survey. The importance of a *clear phrasing* of questions in such survey was emphasised.

Questions formulations could be: *which was the contraceptive method you used when you last had sexual intercourse ? Is it also regular method ? If no, which is your regular method ?*

#### **4.1.8 Mean age at first childbirth**

This indicator might be partially covered by Peristat *Maternal age distribution*. Due to its importance to RH (pregnancy and delivery risk factors, increasing subfertility with increasing maternal age, association with and breast cancer rates, etc) and the ongoing trend to postpone first pregnancy in many EU MS, it was decided to keep this indicator in our dataset.

#### **4.1.9 Total fertility rate**

The average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given age specific fertility rate (ASFR).

#### **4.1.10 % of women trying to get pregnant**

The group discussed whether to use a 12 or 24 month threshold for waiting time (24 months is the WHO definition of infertility).

Taking into consideration the aforementioned trends of starting to have children later in a woman's reproductive life, most of couples with delays in conception in EU do not want to wait 24 months before being treated.

#### **4.1.11 Deliveries associated with ART**

The treatments will include FIV, ICSI and Embryo Transfer (ET).

The group is aware of the heterogeneity of the different treatments, differences in number of cycles treated per couple, inclusion and exclusion criteria (vg: age), medical and surgical treatments.

#### **4.1.12 Induced abortions**

Instead of the previous *termination of pregnancy* indicator, we agreed to exclude spontaneous abortions.

The group is aware of the existence of different ways of registering induced abortions in different MS and that this indicator could only be collected where induced abortion is legal. Indeed, in MS where the huge majority of induced abortions are illegal, no valid data can be provided, even through a survey. Some people consider that obtaining reasonable and internationally comparable data about this indicator is a new project in itself.

It was also decided to include all induced abortions, regardless of cause and gestational age. However, these should be collected according to different age groups.

We agreed to include induced abortions per 1000 women aged 15-49 years old and per 1000 livebirths.

#### **4.1.13 Hysterectomy rate**

This indicator will be collected by surveys or by hospital data, stratified by age group.

In case of a survey questions could be: *Have you ever had your uterus removed? If yes, which year?*

These questions permit the production of prevalence and incidence rates.

The group is aware that there will be no distinction between total and partial hysterectomy, even though the later is decreasing dramatically.

### **RECOMMENDED**

#### **4.1.14 Urinary incontinence**

Can be partially considered as an outcome of bad obstetric care (during childbirth) and has a severe impact on quality of life, namely sexual life. It is an example of a sexual health indicator considered once the reproductive cycle is over.

### **FUTURE DEVELOPMENT**

#### **4.1.15 Menopausal hormone medication**

It was decided to extend the female age group of RH indicators to 45-59 years old women and to include point prevalence of Hormone Therapy use as a RH indicator.

#### **4.1.16 Ectile dysfunction**

As mentioned before this indicator requires a special design. Some ideas considered included the possibility of exploring issues such as impotence and/or drugs sales.



#### **4.1.17 Sexual violence / wellbeing**

As mentioned before this indicator requires a special design. Some ideas considered included the possibility of exploring issues such as number of sexologists/100000 inhabitants, self-evaluated sexual wellbeing (e.g. “how do you consider your personal health status regarding sexuality? If you had problems would you know were to go ?”) and sexual satisfaction.

#### **4.1.18 Violence during pregnancy**

This indicator requires future development.

### **4.2 Those excluded**

#### **4.2.1 Mode of delivery**

This indicator is more comprehensive than the previously suggested *percentage of caesarean sections*. Once it is included in the Peristat list, we decided to exclude it from our datasets.

#### **4.2.2 New cases of AIDS / HIV positive**

Finish colleagues proposed deleting *new cases (incidence) of AIDS* , as it would not be a good measure of RH because it depends on treatment, drug abuse, drug policy, costs, etc.

The possibility of changing it to *new cases of HIV* , as a partial indicator of sexual behaviour was also considered but rejected because of the to lack of validity as RH indicator.

#### **4.2.3 AIDS mortality**

An AIDS indicator has already been included. Furthermore, other factors (e.g. waiting list, resources, drug policy, effectiveness) influence case fatalities which might make data difficult to interpret.

#### **4.2.4 HIV Antenatal and Syphilis ANC**

All RH indicators directly related to antenatal care (also, for instance, time of first consultation) are covered by another EU ongoing specific project dealing with Perinatology (Peristat).

#### **4.2.5 % Blood transfusions**

Culturally driven and local hospital policy influenced.

#### **4.2.6 Average day of maternity stay**

Depends too much on cultural differences in countries, location and type of delivery.

#### **4.2.7 Access to FP services**

Very difficult to measure, with great potential for erroneous interpretation of results, that would mean very little about quality and adequateness of the chosen / counselled method.

Has also to do with women decisions and health services organisation.

#### **4.2.8 Prescribing and reimbursement policies**

Very political/culturally driven; questionable if any actions will result from data.

Emergency contraception can be available as over the counter (OTC) but expensive (can be 20 £ in UK, 10 € in Portugal): perceived access in case of need includes financial barriers

#### **4.2.9 Sexual abuse, Rape, Female Genital Mutilation**

Problems of definition.

Ability to collect robust data is questionable.

Ascertainment problems (at least based in neutrally collected data). Possible in special survey.

Low prevalence of FGM in EU; change in prevalence reflects migration patterns.

#### **4.2.10 Sex Education Policy**

Problems of definition and interpretation too vague.

Presence or official absence does not tell how much good or bad it is.

#### **4.2.11 Access to Family Planning centres for youth**

Other indicators cover this issue. Some countries do not have special centres.

Is it correct to assume that the youth needs special health services ?

## ANNEX I

### PARTICIPANTS LIST

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## ANNEX II

### REPRODUCTIVE HEALTH INDICATORS IN EUROPEAN UNION

#### PROGRAMME

Lisbon, September 27 and 29, 2001

First Full Team meeting

Alfa Hotel

#### September 27

Afternoon and evening: Arrival of participants

21 h : Get together dinner

#### September 28

14 Welcome. Agenda

14.30 Participants self-presentation – All the team

15.15 Introduction: rationale, scope and main objectives of the Project -- MOS and HC (EU)

16.00 Criteria for participants selection – MOS

16.15 Coffee break

16.45 Reproductive health: definition

Reproductive health indicators: examples of a critic overview – MOS

17.30 Discussion

18.00 End of session

#### September 29

9.15 Scientific community participation in the Project. Site development – JN

10.00 Comments and suggestions

10.30 Coffee break

10.45 National Reproductive Health Indicators: what do we have ?

Are these indicators scientifically robust, valid, reliable and sensitive ? - All the group  
(10-15 minutes by participant)

13.00 Lunch

14.45 National Reproductive Health Indicators: what do we have ?

Are these indicators scientifically robust, valid, reliable and sensitive ? - All the group  
(10-15 minutes by participant)

15.30 Coffe break

16.00 Starting and running of the Project. Next tasks chronology - MOS and all the group

16.30 Next meetings schedule - MOS

AOB

17.30 End of session

20.00 h Dinner

MOS – Miguel Oliveira da Silva

HC – Henriette Chamouillet (EU)

JN – Joaquim Neves

## ANNEX III

### **REPRODUCTIVE HEALTH INDICATORS PROJECT** **FIRST STEERING COMMITTEE MEETING PROGRAMME**

Luxembourg, November 29<sup>th</sup> and 30<sup>th</sup>, 2001

Venue: Jean Monnet building, Room M 9

#### **November 29<sup>th</sup> (Thursday)**

21.00 Optional dinner

#### **November 30<sup>th</sup> (Friday)**

8.30 h : Tasks chronology and schedule : from December/01 to July/03.

9.00 h : Reproductive Health definition

Concept extension in the frame of the on-going Perinatal Health Project (Peristat)

9.45 h : Health indicators : ECHI and WHO documents

10.15 h : Coffee break

10.45 h: Critical review of each of the 17 WHO RH indicators definitions

12.30 h Lunch

13.30 h Critical review of each of the 17 WHO RH indicators definitions

14.30 h Morbidity and quality of care RH indicators in EU: what we have, what we need

15.30 h Coffee break

15.45 Site development. Liaison with all Member States.

Next tasks

AOB

16.45h End of the meeting

## ANNEX IV

### FIRST STEERING COMMITTEE MEETING DECISIONS

(Luxembourg, November 30<sup>th</sup>, 2001)

1. Not to use any previous (eg: WHO) RH indicators list as a mandatory starting point.
2. Consider only the specific needs of the 15 EU member states (MS).
3. Build a matrix covering nine (9) major RH areas (**see ANNEX**)  
In each of these areas, several RH indicators are suggested
3. Provide documents (from scientific literature, WHO, FIGO, ACOG, etc) to justify why these indicators were chosen
4. Each indicator has to be clearly defined.
5. Avoid gaps and overlapping with of other ongoing EU Projects, namely: STD, Perinatology, Cancer, Nutrition, Health Survey
6. Rank/prioritise our RH list as

Essential	= 3
Important	= 2
Desirable	= 1
7. Consider the costs of introducing new and/or improve/refining existing RH indicators.
8. Informal consultation and discussion with local experts, in order to help each of the SC members in several of these tasks.
9. Formal letters to scientific societies can be send after the March/2002 SC meeting.
10. Dead line: 15<sup>th</sup> Janaury 2002

**ANNEX V**  
**INDICATORS MATRIX**

(Steering Committee average marks of possible indicators)

1 DESIRABLE, 2 IMPORTANT, 3 ESSENTIAL

**1. HIV / STIs SEXUAL AND REPRODUCTIVE HEALTH (SRH) INDICATORS**

	AIDS incidence	AIDS mortality	Men urethritis
<b>Ethical</b>			
<b>Useful</b>			
<b>Valid</b>			
<b>Actions</b>			
<b>Ranking (1-2-3)</b>	1.75	2	1.25

**2. MATERNAL MORBIDITY SRH INDICATORS**

	% ANC <12 weeks	% Caesarean sections	% blood transfusions	Average day of maternity stay
<b>Ethical</b>				
<b>Useful</b>				
<b>Valid</b>				
<b>Actions</b>				
<b>Ranking (1-2-3)</b>	1.5	3	1.5	1

	HIV prevalence in ANC users	Syphilis prevalence in ANC users	Hysterectomies per age (%)
<b>Ethical</b>			
<b>Useful</b>			
<b>Valid</b>			
<b>Actions</b>			
<b>Ranking (1-2-3)</b>	1.75	1.25	2.75

ANC = Antenatal care



### 3. FAMILY PLANNING SRH INDICATORS

	Contraceptive Prevalence rates	Access situation	Prescribing and reimbursement policies	Emergency Contraception status
Ethical				
Useful				
Valid				
Actions				
Ranking (1- 2-3)	3	1.5	1.25	1.66

### 4. VIOLENCE

	Rape incidence	FGM prevalence and policies	Sexual abuse	Domestic violence
Ethical				
Useful				
Valid				
Actions				
Ranking (1-2-3)	1.75	1.25	1.75	1.5

FGM= Female Genital Mutilation

### 5. YOUTH SEXUAL AND REPRODUCTIVE HEALTH INDICATORS

	Sexual education policy	FP centres	Age of first intercourse	Age of first contraception
Ethical				
Useful				
Valid				
Actions				
Ranking (1-2-3)	1.5	1.5	1.25	1.75

FP = Family Planning

## 6. INFERTILITY / SUBFERTILITY

	% childless women at the 50 y	Age at first childbirth	Waiting time to first pregnancy	Livebirth after infertility
<b>Ethical</b>				
<b>Useful</b>				
<b>Valid</b>				
<b>Actions</b>				
<b>Ranking (1 – 2-3)</b>	3	2.5	2.75	2

## 7. REPRODUCTIVE ORGANS CANCER

	Cervical cancer	Testis cancer	Cancer Mortality in women < 40 y
<b>Ethical</b>			
<b>Useful</b>			
<b>Valid</b>			
<b>Actions</b>			
<b>Ranking (1-2-3)</b>	2.33	2.33	2.33

## 8. UNSAFE ABORTION

<b>Ethical</b>	
<b>Useful</b>	
<b>Valid</b>	
<b>Actions</b>	
<b>Ranking (1-2-3)</b>	1.66

## 9. SEXUAL DYSFUNCTION

	<b>Sexual satisfaction</b>	<b>Frequency</b>	<b>Contraceptive Satisfaction</b>
<b>Ethical</b>			
<b>Useful</b>			
<b>Valid</b>			
<b>Actions</b>			
<b>Ranking (1-2-3)</b>	<b>1.33</b>	<b>1.33</b>	<b>1.33</b>

## ANNEX VI

### Health monitoring programme/ Reproductive Health Indicators in the EU

March 21-24, 2002,

2nd Steering Committee Meeting

Venice, WHO

Agenda

#### **Thursday, 21**

8.30 pm: Get together dinner (Meeting at the Hotel)

#### **Friday, 22**

9.30 am : Adoption of the agenda

9.45 am: Review of outline sequence and goals of REPROSTAT

10.0 am: Review of Luxembourg meeting decisions (November 01)

10.30 am: Presentation of some importantat EU Co-ordinators meeting (Feb4-5,2002) informations concerning REPROSTAT scope and RH areas

11.00 am: Break

11.20 am: SC members' comments and ranking ("marks") of RH indicators

11.50 am: SC members' comments and ranking ("marks") of RH indicators – Individual presentation of each member & discussion

1 pm Lunch

2.30 pm: SC members' comments and ranking ("marks") of RH indicators – Individual presentation of each member & discussion

4.30 pm: Finantial informations about REPROSTAT

5.50 pm: End of session

#### **Saturday, 23**

9.00 am – Final SC adoption of the RH areas and indicators to be submitted to the full team meeting in May 31 (Santiago).

10.30 am : Scientific community broad participation in the discussion: site, formal contacts, invitation letters, etc

12.30 End of the meeting

## ANNEX VII

### REPRODUCTIVE HEALTH INDICATORS IN THE EUROPEAN UNION (REPROSTAT)

**2nd Full Team Meeting**  
**Sintra, May 30-June 2, 2002**  
**Venue: Hotel Tivoli Sintra**

**Instituto de Medicina Preventiva da Faculdade de Medicina de Lisboa**  
**European Commission – Health and Consumer Protection Directorate-General ,**  
**Directorate G-Public Health, Luxembourg**

#### **PROGRAMME**

##### **May 30 (Thursday)**

Arrival of participants

Dinner free

##### **May 31 (Friday) –**

9.00-12.00 Informal discussions between the participants and the Project co-ordinator (Lord Byron room) about last Steering Committee meetings and decisions.

12.00 Lunch free

13.30 Welcome and agenda approval.

Administrative and previous payment questions.

14.00 General overview of REPROSTAT scope and objectives – where we are, where we have to go. Timings. Contractual objectives.

14.10 EU Public Health ongoing Projects: avoiding gaps and overlapping.

14.20 Reproductive Health (RH) definition: WHO definition, criticisms and suggestions.

14.50 Last Steering Committee decisions. Later suggestions. REPROSTAT revised structure.

15.15 RH indicators list analyses. Definition: numerator and denominator

HIV seroprevalence

New cases of AIDS

SDI prevention knowledge

16.15 Coffee break

16.45 RH indicators list analyses (continued)

% of caesarean sections

% of hysterectomies

Contraception prevalence rate

18.00 End of session

20.00 Dinner (Hotel Seteais)

## June 1 (Saturday)

9.15 Résumé of last day decisions

9.30 RH indicators list analyses (continued)

Termination of pregnancy

Contraception at first intercourse

Teenage pregnancy rate

10.45 Coffee break

11.10 RH indicators list analyses (continued)

Total fertility rate

Couples trying to get pregnant

Age at first childbirth

12.15 Desirable indicators and health survey

13.00 Lunch

14.15 Desirable indicators and health survey

14.50 Next tasks

*Web site* participation

Data sources (health statistics, reports, studies) and latest values of selected and desirable RH indicators.

Member States expert's participation and suggestions: list and addresses.

15.15 Any other business

15.30 Future schedule and next meetings places.

16.00 End of session

19.30 Dinner (Praia Grande, Sintra)

## ANNEX VIII

### Second Full Team meeting minutes

#### REPROSTAT MEETING

Sintra, Portugal

May 30-June 2

Report of the afternoon session of 31/5/02

Chair: K Bloemenkamp

Rapporteur: M Temmerman

#### 1. Introduction

Participants were welcomed by the project coordinator, Dr M Oliveira da Silva. Present were: K Bloemenkamp, A Montes, E Makrakis, A Catteano, E Hemminki, J Kasonde, and M Temmerman. Apologies from: P Hannaford, A Jahn, M Short, M Bouvier-Colle, K Bremme, L Auerbach

#### 2. Administrative issues

The co-ordinator apologised for the earlier delays in refunding expenses for the previous meetings, and explained the new procedure. All participants are requested to fill a form, return it to Miguel asap, and a cheque will be sent to them within a few weeks after submitting the documents.

#### 3. General overview

- Short presentation of Reprostat contractual objectives by Miguel
- To finalise the RHI list asap
- To organise for an external debate of the indicators in the different member states in June-September 2002
- to compile the final report by September 2003
- Discussion on other related EU ongoing projects
- Peristat
- Two projects on cancer
- Apparently there is no working group on STDs/STIs/RTIs. Maybe this group should put more emphasis on STDs?

- Conclusion: clear definitions are needed from the other networks, overlap and confusion have to be avoided
- Action: our co-ordinator will liaise with the other co-ordinators and transfer the questions of our group.

#### 4. Definitions

ICPD 1994, WHO definition on Reproductive Health. The group agreed unanimously that the above referred definition is useful, and no changes are needed in order to develop RH indicators

#### 5. Review of reproductive health indicators

The list of indicators proposed by the steering committee was reviewed by the group. The discussion is summarised in the table below.

It was emphasized at several occasions that not all variables mentioned below will easily be accessible as not all countries register these data. However, the fact that data will be available from some countries could motivate other European countries to ameliorate the data collection systems

Indicator	Modification	Motivation	Source	Data needed	Question to be asked
1.HIV seroprevalence	HIV seroprevalence in pregnant women	related to reproductive health	national/regional registers	age parity	No of HIV+/births
2.New cases of AIDS/HIV	Freeze				
3. STI prevention knowledge	Condom use	in practice more relevant	surveys (condom sales)	standardised age rates	Condom use last intercourse?
4. C section rate	Mode of delivery		national statistics		N of CS/assisted deliveries/births
5. Hysterectomy rate	Hysterectomy rate		surveys hospital data	age year of surgery	N of women without uterus per age group
6. CPR	CPR		surveys	age parity	last intercourse regular method

It was recognised that demographers and other experts have a long lasting expertise in data collection in this area, and should be consulted for the phrasing of some specific questions, e.g.



CPR Before ending this session, all participants were asked to list other variables that were not on the list and were considered as crucial for Reprostat. The following variables were proposed:

Elina: negative sides of sex life (violence, abuse...), menopause

Marleen: chlamydia prevalence, induction of labour, violence, hormonal replacement therapy in menopause

Kitty: chlamydia, violence, impotence

The session ended at 6 pm

EH-survey= European Health Survey

Indicator	Modified indicator	Source	Information needed	Notes
<b>7. Termination of pregnancy</b>	Number of induced abortions per births "- per population	Registers and statistics	By age groups	
<b>8. Contraception at 1<sup>st</sup> intercourse</b>	Age at first intercourse Age at first contraceptive use	EH-survey; special youth survey		May be sensitive; question formulation later
<b>9. Teenage pregnancy rate</b>	Rate of births < 18 years per 12-17.9 year old population	Indicator 12		
<b>10. Total fertility rate</b>	No change	Routine statistics		
<b>11. % couples trying child &gt;12 months</b>	Waited longer than 12 (6, 24) months to get pregnant or received treatment per women trying to get pregnant	EH-survey	"In the last 5 years have you tried to become pregnant" "How long did it take to become pregnant __months" "Did you receive treatment"	Exact formulation of the question later
<b>12. Age at 1<sup>st</sup> childbirth</b>	Mean age at 1 <sup>st</sup> childbirth	Routine statistics/ registers		Peristat: Maternal age distribution
<b>13. Miscarriage in the past</b>	Deleted			
<b>14. Births after IVF</b>	Births after IVF as % of all births	Routine statistics/ registers		IVF includes ICSI, ET and like
<b>New</b>	Prevalence of current HRT use among 50-59 year old	HT-survey		SG will do the exact question formulation
<b>New?</b>	Urinary incontinence	HT-survey		SG will think about this
<b>New?</b>	Sexual violence/ forced unwanted sex in the past x years by partner/ some one else			SG will think in more detail

From **Peristat**: the following indicators will be cross-referred:

Maternal mortality by cause

Birth weight distribution

Mode of delivery (see indicator 4)

Smoking during pregnancy

Mode of onset of labour (% induced labours)

#### **Cancer group:**

The group will encourage the cancer group to retain "coverage of screening of cervical cancer" as an indicator.

The following questions will be suggested to the **general EH- survey**:

BMI

Smoking

5.2.2. **Chlamydia.** It was decided that steering committee will find out what is available. If useful, an indicator will be adopted

#### **Discussion**

1. In the report a table showing the suggested questions and indicators built from them could be given (one question may provide several indicators and one indicator may need several questions)
2. Adriano will find out what is the European youth survey and can it be utilised for data gathering on young people.
3. Prostitution is an important reproductive issue (relevance to STIs, trafficking etc). The group could not think of any ready data collection method.
4. Sexual well being was considered an important issue, but the group concluded that one or two indicators cannot measure it. If there is a separate survey or longer list of questions on sexual health, this group is ready to help with it.
5. The group members wish to get a copy of the WHO paper on sexual health.
6. Also other potential indicators were discussed:  
premature menopause, violence during pregnancy, tubal problems (??), male reproductive health. No suitable indicator was found, or the topic was considered to be a matter of research rather than routine monitoring.

ANNEX IX

**REPRODUCTIVE HEALTH INDICATORS IN THE EUROPEAN UNION**

(Reprostat)

Health Monitoring Programme  
European Commission  
**3rd STEERING COMMITTEE MEETING**  
Venue: Sheraton Airport Hotel, Amsterdam, November 1, 2002  
Room: Saturn II (2nd floor)  
**AGENDA**

9.30 – Reprostat objectives and timings (review)

9.40 – Linkage with other HMP Projects

9.50 - RH indicators internal List – suggestions and criticisms received.

10.20- Each RH indicator final review

11.00- Coffee break

11.30 – Each RH indicator final review

13.00 - Lunch

14.00 – Each RH indicator final review

16.00 – Coffee break

16.15 – Final report redaction: how to do it ?  
Methodology and tasks

17.15 - AOB

17.30 End of session

## ANNEX X

### REPROSTAT- Third SC meeting in Amsterdam, 1 November 2002

#### Minutes

Rapporteur: Mika Gissler

#### Opening:

Our objectives are to list reproductive health indicators for the European Commission. The Final Report is written in English, in French and in German (translation covered in our budget), perhaps also in other EU languages. National dissemination strategy has to be decided after the final EU report is ready. The project has co-operated with other Health Monitoring Programme -projects, especially with PERISTAT (Perinatal Health), Cancer monitoring -project and European Health Interview Survey -project. It was decided that 6-7 questions regarding reproductive health should be included in the European Health Interview Survey. It is still unknown, when the survey will be started.

#### General criticisms received:

- It has been suggested that the term sexual health should be used instead of reproductive health. It was decided that the old term reproductive health will be used.
- Some comments stated that it is important to monitor all indicators at educational level. After discussion it was decided that indicators received from the European Health Interview Survey will be monitored by educational level. Other efforts are beyond routine health monitoring and the requested information can be collected in EU research projects.
- Some comments stated that only the existing 15 EU member states are included in the project.
- Some comments stated that it is important to monitor reproductive health among migrants. A general statement will be included in the report on this subject.
- Discussion on male reproductive health indicators. The limitations of data collection by interview should be kept in mind (for example it may be difficult to get reliable information on impotence).

#### Final list of indicators

- It was decided that all indicators will be divided into core indicators, recommended indicators and indicators for further development (as was done in the PERISTAT project). The indicators were further divided into indicators of individual health, population characteristics and risk factors, and health care services.

- It is important that after each indicator is chosen the definition and its rationale is written in order to avoid the same criticisms. Also the feasibility and current availability of each indicator in each EU member state should be evaluated. There are some funds to collect information on the

Indicator (rapporteur) - indicator status:

1 HIV seroprevalence among pregnant women (Marlene and Kitty)

- core indicator under individual health

2 Chlamydia prevalence among population aged 18-25 years in a specific survey (Miguel and Adriano)

- core indicator under individual health

3 Condom use during last intercourse among population aged 18-25 years in a specific survey (Mary and Albrecht)

- recommended indicator under population characteristics and risk factors

4 Age at first intercourse or proportion of respondents reporting intercourse among population participating in the EU youth survey/WHO survey on health and health behaviour among school-aged children (Mary and Albrecht)

- core indicator under population characteristics and risk factors

5 Contraceptive used at first intercourse among population participating in the EU youth survey/WHO survey on health and health behaviour among school-aged children (Mary and Albrecht)

- core indicator under population characteristics and risk factors

6 Age-specific birth rates among teenagers, i.e. girls less than 20 years, age at delivery (Miguel and Adriano)

- core indicator under individual health

7 Contraceptive prevalence rate among women aged 15-49 years in the EU Health Interview Survey (WHO definition)

- core indicator under population characteristics and risk factors

8 Mean age at first childbirth, collected by Council of Europe, age at delivery (Miguel)

- core indicator under population characteristics and risk factors

9 Total fertility rate, collected by Council of Europe (Jørn and Katarina)

- core indicator under population characteristics and risk factors

10 Women reporting problems to get pregnant in 12 months in the EU Health Interview Survey (Jørn and Kitty)

- core indicator under population characteristics and risk factors

11 The proportion of births after assisted reproductive technology, partly collected by ESHRE and partly covered as a recommended indicator by PERISTAT (Jørn and Kitty)

- indicator for future development under population characteristics and risk factors

- 12 Induced abortions per 1000 women aged 15-49 (Jørn and Miguel)  
 - core indicator under population characteristics and risk factors
- 14 Proportion of women reporting hysterectomy in the EU Health Interview Survey by age groups (Albrecht and Katarina)  
 - code indicator under health care services
- 15 Proportion of women reporting hormone replacement therapy in the EU Health Interview Survey by age groups (Marlene and Phil)  
 - indicator for future development under health care services
- 16 Proportion of women reporting urinary incontinence in the EU Health Interview Survey by age groups (Phil and Mary)  
 - recommended indicator in individual health
- 17 Proportion of men reporting impotence in the specific survey by age groups (Miguel)  
 - indicator for further development in individual health
- 18 Self-evaluated sexual health in the EU Health Interview Survey (Phil and Jørn)  
 - indicator for further development in individual health
- 19 Sexual violence during pregnancy  
 - indicator for further development, perhaps recommendation for research
- 20 An indicator for male urinary symptoms should be developed  
 - indicator for further development, perhaps recommendation for research

Removed, since covered as a PERISTAT core indicator:

- 13 Mode of delivery (Miguel)  
 - core indicator under health care services

Individual health	1, 2, 6, 16,17, 18, 19
Population characteristics and risk factors	4, 5, 7, 8, 9, 10, 12,3,11
Health care services	14,15

Time table:

- First version of complete indicator list available in 15 December 2002.
- Second version of complete indicator list and introduction written by Elina Hemminki (with the help of Mika Gissler) completed in 15 January 2003.
- Data on core and recommended indicators will be collected in January-April 2003 (1000 Euro per participating country).

- Final report should be finalised before April 2003.
- Final meeting in Dublin 9-10 May 2003.
- End of project August 2003.

Future collaboration in the new Public Health Programme or in research (6<sup>th</sup> framework):

- The priorities thematic areas of sixth framework are quite far from public health and health care systems. Under genomics and biotechnology for health includes combating rare diseases (congenital anomalies, stillbirths). It should be investigated what is included in human development. There are also support for clinical trials. It is unknown if the co-operation with the candidate countries for the accession to the EU is taken into account in decision making.
- The contracts will be larger than before, some 12-15 million Euro per contract.
- The best data source for more information is CORDIS (<http://www.cordis.lu/focus/>).
- Call of tenders will be opened in 17 December 2002 and it will be closed March 2003.
- After discussion following ideas for further work was listed up: teenage pregnancies, family planning, common European Sex Survey, case-control study on explained stillbirths together with PERISTAT-group. The project leader will follow-up the proceedings in EU. All participants can consider research co-operation related to current study interest listed below.
- Albrecht Jahn promised to forward the document on co-operation between EU and ACP-countries (Asian, Caribbean and Pacific countries).

Current study interests and international collaboration:

- Finland: For the statistical division at STAKES, the use of register data in reproductive health questions is the only. For the research division, also other data sources can be used. The main interests have been IVF, place of birth, hormone replacement therapy, breast implants, long-term follow-up studies, pregnancy-associated and maternal mortality, inequalities in perinatal health etc. Co-operation with the Nordic countries, the Baltic states (especially Estonia), France, USA, UK and China.
- Denmark: A large pregnancy cohort data has now been completed. Side effects of drugs have been studied in an EU study (together with the Netherlands, Italy, Sweden, Hungary). Co-operation with Guinea-Bissau (vaccination) and China (prevention of preterm births by fatty acids).
- Netherlands: Main interests are pre-eclampsia, preterm birth and contraceptive. Co-operation with Finland and Sweden.
- Spain: Main study interests are related to nutrition and cancer.
- Sweden: Main study interests are induced abortions, pre-eclampsia. Co-operation with Finland, the Netherlands and the UK.
- Germany: Main study interests are antenatal care, role and safety of ultrasound, cohort of children with intrauterine growth retardation. Co-operation with Sweden and several developing countries.



- Portugal: Main study interests are teenage pregnancies, contraception, menopause and environmental health.
- Italy: Main study interests are assessment for quality of care for childbirth and newborn and breast-feeding. Co-operation with Albania, Moldova, Central Asian Republic-countries and countries in Latin America and Africa.
- UK: Main study interests are related to pharmaco-epidemiological studies, e.g. drug safety related to contraceptive. Good register linkage possibilities in Scotland. Co-operation with Ireland.
- Ireland: Main study interests are multiple teenage pregnancies and public health impact of certain diseases (including cardiovascular diseases and diabetes).
- Belgium: Main study interests are preterm birth, working with twin register data, domestic violence, HIV/AIDS/STD, cervical cancer and reproductive health among refugees. Co-operation with African countries, China and Latin America.

## ANNEX XI

### **REPROSTAT Third full team meeting**

**Dublin, 9-10 May 2003**

#### Opening

Miguel Oliveira da Silva opened the last REPROSTAT meeting and thanked all participants for their contribution in the project, and especially Dr Mary Short to organising this meeting. Dr Marie-Hélène Bouvier-Colle, Professor Phil Hannaford and Dr Marleen Temmerman as well as the new EU representative had sent their apologies for not attending this meeting.

Dr Adriano Cattaneo was chosen as the chairman and Dr Mika Gissler as the rapporteur.

#### General overview of REPROSTAT

Last meeting was in Amsterdam 1 November 2002. After that all participants have commented the list of indicators. An editorial meeting was held in Copenhagen to modify the list of indicators. The presentation and framework of indicators has been standardised with other, but not all EU Health Monitoring Programme projects (e.g. PERISTAT and Child Health). It was concluded that it is important that the indicator lists from different projects are pooled together so that in both national and international monitoring of reproductive health will be more complete than the indicator list produced by this project. This will also be mentioned in the covering letter sent for the European Commission. The final suggestions of all Health Monitoring Programme projects will be merged together by the civil servants at the European Commission. Their time table is currently unknown.

Dr Jose Kasonde, WHO asked about the different categorising in the list of indicators for PERISTAT and REPROSTAT projects. It was agreed that the categories are not - and they have not to be - consistent.

#### REPROSTAT final report

After lively discussion, following changes were made in the final report:

##### Introduction

- The number of indicators (13 core indicators, 1 recommended indicator and 4 indicators for future development) and references (2) will be corrected.

- The fifth paragraph in page 1 will be changed to "This reproductive health has relevance to events in early life..."
- The sentence "Member states are free to add.." will be removed.
- The following sentence will be added to the end of third paragraph in page 2: When a comprehensive picture of reproduction health is to be measured, indicators from PERISTAT (perinatal health) and EUROCHIP (cancer) should be considered.
- Regarding the two last indicators (sexual health and sexual violence), it will be mentioned that these areas have been identified as important aspects of reproductive health. No definite proposal for indicators will be given, but a request for future research and development. This will also be mentioned in the covering letter sent to the European Commission.
- The list of experts who have been participated in the work will be distributed among the participants.
- A list of indicators with their availability in each member state will be added as an Annex, after all participants have collected the information and sent to the project leader.

#### Tables 1 and 2

- Indicators 16-18 will be kept in the table, even though their description will be removed.
- Indicator 18 will be changed to sexual health and wellbeing.
- Future development will be changed to "Recommended indicators with further development needed" according to the decision made by PERISTAT.
- In table 2, Indicator 5 will be corrected to "% of contraceptive use at first intercourse".

#### Sources of data

Sources of data should be checked after the list of indicator has be completed.

#### Final list of indicators

1. a Acceptance of HIV testing among pregnant women  
b HIV seroprevalence among HIV tested pregnant women
2. Chlamydia prevalence
3. Reported condom use at last higher risk sex
4. Median age at first intercourse
5. Proportion of contraceptive use at first intercourse
6. Age-specific birth rates in teenagers
7. Contraceptive prevalence
8. Mean age at first childbirth

9. Total fertility rate
10. Proportion of women at trying to get pregnant for one year or more
11. Proportion of pregnancies after assisted reproductive technology
12. Frequency of induced abortions
13. Proportion of women with hysterectomy
14. Proportion of women using peri- and post-menopausal hormone medication
15. Proportion of women with urinary incontinence
16. Erectile dysfunction
17. Self-reported sexual health and wellbeing
18. Sexual violence

#### Changes in the indicator list

1. Abbreviations ANC and MS will be written out. The sentence "Estimates of prevalence..." will be removed.
2. The age limits will be changed to 15-19 years instead of 15-24 years. The abbreviation NAAT will be written out and specified to be a urinary test. The sentence "Although the cost of testing..." will be removed. The text under point Understandable "... if the testing is accepted by most of the invited" will be moved under point Representative.
3. The age limits will be changed to 15-19 years instead of 15-24 years. The denominator will be changed to "Total number of respondents who report having had penetrative high risk sex in the last 12 months". Technical criteria will be changed to Criteria for selection.
4. The age limits will be changed to 15-19 years instead of 15-24 years. The operational definition will be changed to "Sex-specific proportions of youth with experience of penetrative sex rates by age".
5. The age limits will be changed to 15-19 years instead of 15-24 years. In the part of justification for selection, the reference to STDs will be removed. Contraceptives mentioned in indicator 7 will be referenced.
6. The operational definition will be augmented by "by one year interval".
7. The point Useful will be augmented by "useful, if information by method... ." In the point of Representative text "Depends on the representativeness of the sample" will be added.
8. The point Understandable will be augmented by "The use of maternal age distribution by five-year age groups (less than 20, 20-24, 25-29, 30-34, 35-39, 40-44, 45 or more) is even more informative". The correct reference for Council of Europe will be added: Annual publication by Council of Europe. Recent demographic developments in Europe. Strasbourg, Council of Europe Publishing. Also available in internet at the homepage of Council of Europe: [http://www.coe.int/t/e/social\\_cohesion/population/demographic\\_year\\_book/](http://www.coe.int/t/e/social_cohesion/population/demographic_year_book/)
9. No changes.

10. Percentage will be changed to proportion in the title. Technical criteria will be changed to Criteria for selection.
  11. Percentage will be changed to proportion in the title. Technical criteria will be changed to Criteria for selection. In reference, the abbreviation ESHRE will be written out, and a correct reference to the annual European-wide IVF statistics published in Human Reproduction will be added.
  12. The title will be change to "Frequency of induced abortions". Indicator 12a will be called induced abortion rate and 12b induced abortion ratio to live births. Under point Justification for selection, text "Induced abortions are social and public health problem, and they also reflect maternal mortality and morbidity rate". Under point Robust, the text "due to illegal situation" will be removed. The last sentence will be modified to "Self-reported information is also usually inaccurate". Technical criteria will be changed to Criteria for selection. In data sources, routine statistics will be mentioned first followed by text "The population-based surveys to complete them". The reference to illegal abortion will be removed also in data sources. WHO Health for all -database will be mentioned as a reference for indicator 12b: World Health Organization, Regional Office for Europe. Health for All -database. Available at <http://hfadb.who.dk/hfa/>.
  13. Hysterectomy will be measured by proportion of women with hysterectomy at the age of 50 years. Under point Useful, the text "Information will be more useful, if given by age group, even above the age of 50 years" will be added. The primary data source will be population-based surveys, but also data on hospital treatments and/or interventions can be used to gather comparable data. The text "simple to define and interpret" on point Understandable will be removed.
  14. The title will be changed to proportion of women using peri- and post-menopausal hormone medication. Operational definition will be changed to "Proportion of women aged 45-59 years using peri- and post-menopausal hormone medication (also called HRT) at the point of time of the survey, also by five-year age groups". Technical criteria will be changed to "criteria for selection".
  15. In the title and in the operation definition, the percentage will be changed to proportion. Age limits will be set at 40-49 years. The indicator will be recommended to be given in five-year age groups. Technical criteria will be changed to Criteria for selection.
- 16-18: No details will be given for the indicators requiring further development.

Each of member were asked to provide following information latest 31 May 2003:

- Data availability for the 15 first indicators: available, available with different definition, not available.
- Name, title, address etc. (format given by Miguel Oliveira da Silva)

Future collaboration after REPROSTAT project

The dead line for the application for the new EU Public Health Programme is 16 May 2003. Sexual and reproductive health has been chosen as one of the main themes. The idea is to continue the work with the existing list of indicators and to enlarge the data collection to the forthcoming new EU member states. Another idea is to concentrate in the survey methods and to pilot new questionnaires in some members states. The following three main objectives were suggested by Jose Kasonde, WHO: 1) Further development of indicators, 2) Mechanisms for implementing the currently chosen indicators and 3) Implication of the EU enlargement in 2004 onwards. Miguel Oliveira da Silva asked all the participants to return back with further suggestions as soon as possible.

### Closing

Miguel Oliveira da Silva thanked all the participants for a successful meeting.



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