Metadata

WHO Results Framework: Outcome Indicators

Fourteenth General Programme of Work (GPW14)

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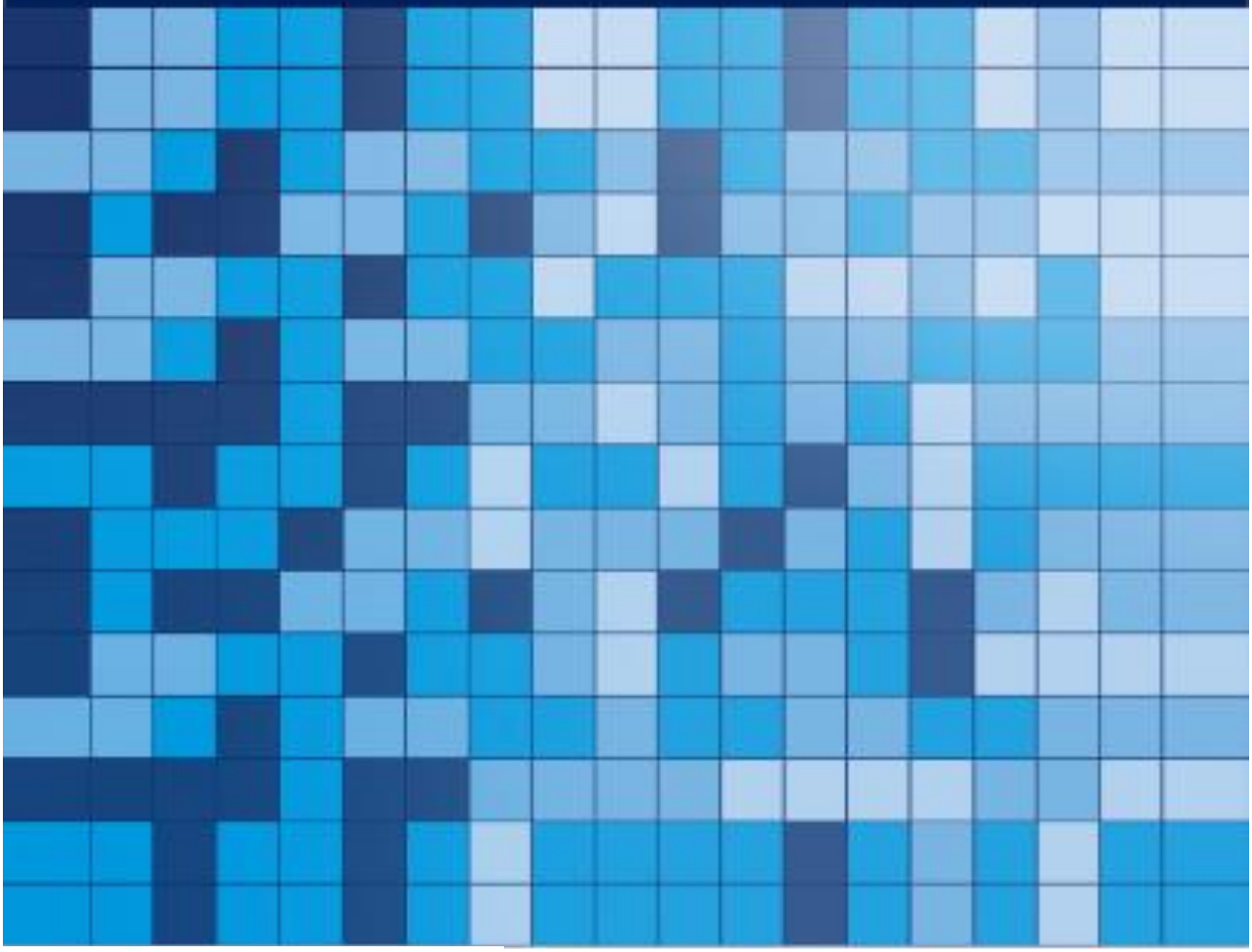

World Health Organization

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1. GPW 14 JOINT OUTCOMES AND INDICATORS

The "joint outcomes" of the GPW 14 are Member States-led and establish the specific results to be achieved during the four-year period from 2025 to 2028 through the collective work of countries, partners, key constituencies and the Secretariat. The proposed indicators for the joint outcomes include:

(i) those that are globally relevant, have high data coverage among Member States, and can reflect the joint efforts of Member States, the Secretariat and partners; and

(ii) selected indicators that reflect important global health topics, but have limited data availability, and will be areas of intensified focus for data strengthening during the course of GPW 14 (indicated with an asterisk "*").

Joint outcomes	**Draft joint outcome indicators for GPW 14**
GPW 14 goal: PROMOTE HEALTH (Target: 6 billion people will enjoy healthier lives) Progress is measured by the healthier populations billion index[1]	
Strategic objective 1 Respond to climate change, an escalating health threat in the 21st century	
1.1. More **climate-resilient health systems** are addressing health risks and impacts	Index of national climate change and health capacity *(New)*
1.2. **Lower-carbon health systems and societies** are contributing to health and well-being	Health care sector greenhouse gas emissions *(New)*
Strategic objective 2 Address health determinants and the root causes of ill health in key policies across sectors	
2.1. Health inequities reduced by acting on social, economic, environmental and other **determinants of health**	SDG[2] indicator 10.7.2. Does the government provide non-national (including refugees and migrants) equal access to (i) essential and/or (ii) emergency health care *(New)*
	Proportion of refugees and migrants that have equal access to (i) essential and/or (ii) emergency health care *(New)**
	SDG indicator 11.1.1. Proportion of urban population living in slums, informal settlements or inadequate housing *(New)**
	SDG indicator 1.3.1. Proportion of population covered by at least one social protection benefit (%) *(New and cross-referenced with related indicator under outcome 5.1)*

Joint outcomes	Draft joint outcome indicators for GPW 14
2.2. **Priority risk factors** for noncommunicable and communicable diseases, violence and injury, and poor nutrition, reduced through multisectoral approaches	SDG indicator 2.2.1. Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age *(GPW 13)*
	SDG indicator 2.2.2. Prevalence of overweight (weight for height more than +2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age *(GPW 13)*
	SDG indicator 2.2.2. Prevalence of wasting (weight for height less than -2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age *(GPW 13)*
	SDG indicator 2.2.3. Prevalence of anaemia in women aged 15 to 49 years, by pregnancy status (%) *(GPW 13)*
	Resolution WHA69.9. Exclusive breastfeeding under six months *(New)*
	SDG indicator 3.9.1. Mortality rate attributed to household and ambient air pollution *(GPW 13)*
	SDG indicator 3.9.2. Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All [WASH] services) *(GPW 13)*
	Resolution WHA73.5. Proportion of people who have suffered a foodborne diarrheal episode of non-typhoidal salmonellosis *(New)*
	SDG indicator 3.9.3 Mortality rate attributed to unintentional poisoning *(GPW 13)*
	SDG indicator 6.1.1. Proportion of population using safely managed drinking water services *(GPW 13)*
	SDG indicator 6.2.1. Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water *(GPW 13)*
	SDG indicator 7.1.2. Proportion of population with primary reliance on clean fuels and technology *(GPW 13)*
	SDG indicator 11.6.2. Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted) *(GPW 13)*
	Resolution WHA66.10. Prevalence of obesity among children and adolescents (aged 5–19 years) (%) *(GPW 13)*

Joint outcomes	Draft joint outcome indicators for GPW 14
	Resolution WHA66.10. Prevalence of obesity among adults aged ≥18 years *(GPW 13)*
	SDG indicator 3.6.1. Death rate due to road traffic injuries *(GPW 13)*
	Decision WHA75(11). Proportion of population aged 15+ with healthy dietary pattern *(New)*[1]
	SDG indicator 16.2.1. Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month *(GPW 13)*
	Resolution WHA71.6. Prevalence of insufficient physical activity *(New)*
	SDG indicator 3.a.1. Age-standardized prevalence of current tobacco use among persons aged 15 years and older *(GPW 13)*
	Resolution WHA66.10. Prevalence of raised blood pressure in adults aged ≥18 years *(GPW 13)*
	SDG indicator 3.5.2. Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol *(GPW 13)*
2.3. Populations empowered to control their health through **health promotion programmes** and community involvement in decision-making	Proportion of a country's population living in a healthy municipality, city or region (%) *(New)*
	Proportion of countries with national-level mechanisms or platforms for societal dialogue for health (%) *(New)*

Joint outcomes	Draft joint outcome indicators for GPW 14
GPW 14 goal: PROVIDE HEALTH (Target: 5 billion people will benefit from universal health care without financial hardship) Progress is measured by the universal health coverage billion index[1]	
Strategic objective 3 Advance the primary health care approach and essential health system capacities for universal health coverage	
3.1. The **primary health care** approach renewed and strengthened to accelerate universal health coverage	SDG indicator 3.8.1. Coverage of essential health services (GPW 13) *(cross-referenced with related indicator under outcome 4.1)*
	Resolution WHA72.2. Primary health care-oriented governance and policy composite *(New)*
	Resolution WHA72.2. Institutional capacity for essential public health functions (meeting criteria) *(New)*
	Resolution WHA72.2. Health facility density and distribution (by type and level of care) *(New)*
	Resolution WHA72.2. Integrated services and models of care composite indicator *(New)*
	Resolution WHA72.2. Service utilization rate (primary care visits, emergency care visits, hospital admissions) *(New)*
	Resolution WHA72.2. % of population reporting perceived barriers to care (geographical, sociocultural, financial) *(New)**
	Resolution WHA72.2. Service availability and readiness index (% facilities with service availability, capacities and readiness (WASH, infection prevention and control, availability of medicines, vaccines, diagnostics, priority medical devices, priority assistive products) to deliver universal health care package) *(New)**
	Gender equality advanced in and through health[2] *(New)*
	Resolution WHA72.2. People-centredness of primary care (patient experiences, perceptions, trust) *(New)**

Joint outcomes	Draft joint outcome indicators for GPW 14
3.2. Health and care **workforce, health financing** and access to **quality-assured health products** substantially improved	SDG indicator 3.c.1. Health worker density and distribution (by occupation, subnational, facility ownership, facility type, age group, sex) *(GPW 13)*
	Resolution WHA64.9. Government domestic spending on health (1) as a share of general government expenditure, and (2) per capita *(New)*
	Access to Health Product Index *(New)*[1]
	Resolution WHA67.20. Improved regulatory systems for targeted health products (medicines, vaccines, medical devices including diagnostics) *(New)*
	Resolution WHA64.9. Government domestic spending on primary health care as a share of total primary health care expenditure *(New)*
3.3 Health **information systems** strengthened, and **digital transformation** implemented	Existence of national digital health strategy, costed implementation plan, legal frameworks to support safe, secure and responsible use of digital technologies for health *(New)*
	SCORE index *(New)*
	Resolution WHA71.1. % of health facilities using point-of-service digital tools that can exchange data through use of national registry and directory services (by type) *(New)**
Strategic objective 4 Improve health service coverage and financial protection to address inequity and gender inequalities	
4.1 Equity in access to quality services improved for **noncommunicable diseases, mental health conditions** and **communicable diseases**, while addressing **antimicrobial resistance**	SDG indicator 3.3.1/Resolution WHA75.20. Prevalence of active syphilis in individuals 15 to 49 years of age (%) *(New)*
	SDG indicator 3.3.1/Resolution WHA75.20. Number of new HIV infections per 1000 uninfected population, by sex, age and key populations *(GPW 13)*
	SDG indicator 3.3.2 Tuberculosis incidence per 100 000 population *(GPW 13)*
	SDG indicator 3.3.3. Malaria incidence per 1000 population *(GPW 13)*
	Vector-borne disease incidence *(New)*
	SDG indicator 3.3.4/resolution WHA75.20. Hepatitis B incidence per 100 000 population *(GPW 13)*

Joint outcomes	Draft joint outcome indicators for GPW 14
	Resolution WHA75.20. Hepatitis C incidence per 100 000 population *(New)*
	SDG indicator 3.3.5. Number of people requiring interventions against neglected tropical diseases *(GPW 13)*
	SDG indicator 3.4.1. Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease *(GPW 13)*
	Decision WHA75(11). Prevalence of controlled diabetes in adults aged 30–79 years *(New)*
	SDG indicator 3.4.2. Suicide mortality rate *(GPW 13)*
	SDG indicator 3.5.1. Coverage of treatment interventions (pharmacological, psychosocial, and rehabilitation and aftercare services) for substance use disorders *(GPW 13)*
	Document WHA72/2019/REC/1. Service coverage for people with mental health and neurological conditions *(New)*
	SDG indicator 3.d.2. Percentage of bloodstream infections due to selected antimicrobial-resistant organisms *(GPW 13)*
	Decision WHA74(12). Effective refractive error coverage (eREC) *(New)*
	Resolution WHA66.10. Prevalence of controlled hypertension, among adults aged 30–79 years *(New)*
	Resolution WHA68.7. Patterns of antibiotic consumption at national level *(GPW 13)*
	SDG indicator 3.8.1. Coverage of essential health services *(GPW 13) (cross-referenced with related indicator under outcome 3.1)*
	Resolution WHA74.5. Proportion of population entitled to essential oral health interventions as part of the health benefit packages of the largest government health financing schemes *(New)*
	Resolution WHA73.2. Cervical cancer screening coverage in women aged 30–49 years, at least once in lifetime *(New)*
4.2. Equity in access to **sexual, reproductive, maternal, newborn, child, adolescent, and older person health and nutrition services and immunization coverage** improved	Resolution WHA67.10. Postnatal care coverage *(New)*
	SDG indicator 3.1.1. Maternal mortality ratio *(GPW 13)*
	SDG indicator 3.1.2. Proportion of births attended by skilled health personnel *(GPW 13)*

Joint outcomes	Draft joint outcome indicators for GPW 14
	SDG indicator 5.6.1. Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care *(GPW 13)*
	SDG indicator 5.2.1. Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age *(GPW 13)*
	Resolution WHA67.15. Proportion of health facilities that provide comprehensive post-rape care as per WHO guidelines *(New)*
	SDG indicator 3.2.1. Under-5 mortality rate *(GPW 13)*
	SDG indicator 3.2.2. Neonatal mortality rate *(GPW 13)*
	Resolution WHA67.10. Stillbirth rate (per 1000 total births) *(New)*
	Obstetric and gynaecological admissions owing to abortion *(New)*
	SDG indicator 3.7.1. Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods *(GPW 13)*
	SDG indicator 3.7.2. Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group *(New)*
	SDG indicator 3.b.1. Proportion of the target population covered by all vaccines included in their national programme *(GPW 13)*
	SDG indicator 4.2.1. Proportion of children aged 24–59 months who are developmentally on track in health, learning and psychosocial well-being, by sex *(GPW 13)*
	SDG indicator 5.6.2. Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education *(New)*
	Treatment of acutely malnourished children *(New)*

Joint outcomes	Draft joint outcome indicators for GPW 14
	Decision WHA73(12) Percentage of older people receiving long-term care at a residential care facility and home. *(New)**
	SDG indicator 5.3.2. Proportion of girls and women aged 15–49 who have undergone female genital mutilation *(New)**
4.3. **Financial protection** improved by reducing financial barriers and out-of-pocket health expenditures, especially for the most vulnerable	Incidence of catastrophic out-of-pocket health spending (SDG indicator 3.8.2 and regional definitions where available) *(New)*
	Incidence of impoverishing out-of-pocket health spending (related to SDG indicator 1.1.1 and regional definitions where available) *(New)*
	Resolution WHA64.9. Out-of-pocket payment as a share of current health expenditure *(New)*
GPW 14 goal: PROTECT HEALTH (Target: 7 billion people will be better protected from health emergencies by 2028) Progress is measured by the health emergencies protection billion index[1]	
Strategic objective 5 Prevent, mitigate and prepare for risks to health from all hazards	
5.1. **Risks of health emergencies** from all hazards reduced and impact mitigated	Vaccine coverage of at-risk groups for high-threat epidemic/pandemic pathogens: yellow fever,[2] cholera,[3] meningitis, polio and measles *(New)*
	Social protection *(New and cross-referenced with related indicator under outcome 2.1)*
	Number of cases of poliomyelitis caused by wild poliovirus *(GPW 13)*
	Probability of spillover of zoonotic diseases *(New)*
	Coverage of WASH in communities and health care facilities *(New)**
	Trust in government *(New)**

Joint outcomes	Draft joint outcome indicators for GPW 14
5.2. **Preparedness, readiness and resilience** for health emergencies enhanced	National health emergency preparedness *(New)*
	SDG indicator 3.d.1. International Health Regulations (2005) capacity and health emergency preparedness *(GPW 13)*
Strategic objective 6 Rapidly detect and sustain an effective response to all health emergencies	
6.1. **Detection of and response** to acute public health threats is rapid and effective	Timeliness of detection, notification and response of International Health Regulations (2005) notifiable events (7–1–7 as new target in draft GPW 14) *(GPW 13)*
6.2. **Access to essential health services during emergencies** is sustained and equitable	Composite indicator comprising three tracer indicators for essential health services among population in settings with humanitarian response plan *(New)*
	Proportion of vulnerable people in fragile settings provided with essential health services (%) *(GPW 13)*

2. PROMOTE HEALTH

Table 1. Overview of 29 outcome indicators[1]

SDG / WHA	Outcome Indicators
	Index of national climate change and health capacity (adaptation/resilience indicator)
	Healthcare Sector Greenhouse Gas Emissions (mitigation indicator)
SDG 10.7.2	Does the government provide non-national equal access to i) essential and/or ii) emergency healthcare?
	Proportion of refugees and migrants that have equal access to i) essential and/or ii) emergency healthcare
SDG 11.1.1.	Proportion of urban population living in slums, informal settlements or inadequate housing
SDG 1.3.1	Proportion of population covered by at least one social protection benefit (%)
SDG 2.2.1	Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age
SDG 2.2.2	Prevalence of overweight (weight for height more than +2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age
SDG 2.2.2	Prevalence of wasting (weight for height more than -2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age
SDG 2.2.3	Prevalence of anaemia in women aged 15 to 49 years, by pregnancy status (percentage)
WHA 69.9	Exclusive Breastfeeding under Six Months
SDG 3.9.1	Mortality rate attributed to household and ambient air pollution
SDG 3.9.2	Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All [WASH] services)
WHA73.5	Proportion of people who have suffered a foodborne diarrhoeal episode of non-typhoidal salmonellosis
SDG 3.9.3	Mortality rate attributed to unintentional poisoning
SDG 6.1.1	Proportion of population using safely managed drinking water services (%)
SDG 6.2.1	Proportion of population using (a) safely managed sanitation services and (b) a hand- washing facility with soap and water
SDG 7.1.2	Proportion of population with primary reliance on clean fuels and technology
SDG 11.6.2	Annual mean levels of fine particulate matter (e.g., PM2.5 and PM10) in cities (population weighted)
WHA 66.10	Prevalence of obesity (%) (among children and adolescents (aged 5–19 years), and among adults ≥ 18 years)
SDG 3.6.1	Death rate due to road traffic injuries
WHA75 (11)	Proportion of population aged 15+ with healthy dietary pattern
SDG 16.2.1	Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month
WHA71 (6)	Prevalence of insufficient physical activity
WHA71 (6)	*Prevalence of insufficiently physically active adults*
WHA71 (6)	*Prevalence of insufficiently physically active adolescents*
SDG 3.a.1	Age-standardized prevalence of current tobacco use among persons aged 15 years and older
WHA 66.10	Prevalence of raised blood pressure in adults aged ≥18 years
SDG 3.5.2	Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol
	Proportion of a country's population living in a Healthy Municipality, City or Region (%)
	Proportion of countries with national-level mechanisms or platforms for societal dialogue for health (%)

[1] This includes all 30 indicators from Promote Health. Metadata for the two indicators on prevalence of obesity have been consolidated.

2.1. Index of national climate change and health capacity

Indicator	Index of national climate change and health capacity (adaptation/resilience indicator)
Rationale	WHO promotes climate-resilient health systems as the comprehensive approach to protecting health from climate risks that is most directly under the control of MS Ministries of Health, and has published an Operational Framework and accompanying technical guidance. Example indicators are proposed for the domains in the operational framework, and monitored through a bi-annual WHO global survey on country progress in climate change and health, with data collected from 95 countries in the last round. Preliminary work has been done to combine these into a single index, and WHO is leading a global technical collaboration specifically on indicator and index development for climate resilient and low carbon health systems.
Mandate (WHA resolution, SDG)	WHA resolution 61.19 on "Climate Change and Health". Expected WHA77 resolution on Climate change and Health. UNFCCC COP28 Global Adaptation target for health: "*Attaining resilience against climate change related health impacts, **promoting climate-resilient health services**, and significantly reducing climate-related morbidity and mortality, particularly in the most vulnerable communities;"*
Definition	Composite indicator at national level from combined scores across the resilience indicators for the 10 domains of the WHO Operational framework for building climate resilient and low carbon health systems. See page https://iris.who.int/bitstream/handle/10665/373837/9789240081888-eng.pdf?sequence=1
Numerator	Number of indicators to be combined to form index TBD.
Denominator	TBD
Preferred data sources	Biennial WHO health and climate change global survey report https://www.who.int/publications/i/item/9789240038509
Other data sources	
Disaggregation	National level, by indicator/resilience domain
Frequency of data collection	Bi-annual through WHO country survey
Limitations	Indicator scores are currently self-reported, without independent assessment, although this could be added. Weighting of scores to create a single index is subjective.
Data type	Self-reported indicator scores
Related links	https://www.who.int/publications/i/item/9789240038509 https://iris.who.int/bitstream/handle/10665/373837/9789240081888-eng.pdf?sequence=1

2.2. Healthcare Sector Greenhouse Gas Emissions

Indicator	Healthcare Sector Greenhouse Gas Emissions (mitigation indicator)
Rationale	The healthcare sector, including supply chain, is now responsible for approximately 5% of global greenhouse gas emissions. Controlling these emissions is heavily influenced by Ministries of Health. Estimated emissions are available for all (tbc) MS, based on models using the WHO Global Health Expenditure Database.
Mandate (WHA resolution, SDG)	WHA resolution 61.19 on "Climate Change and Health". Expected WHA77 resolution on Climate change and Health. This constitutes the health specific component of SDG 13.2.2: "Total greenhouse gas emissions per year"
Definition	Per capita emissions of greenhouse gases (GHG) emissions resulting from provision of healthcare
Numerator	KG of greenhouse gas emissions from healthcare provision
Denominator	National population
Preferred data sources	https://www.lancetcountdown.org/data-platform/mitigation-actions-and-health-co-benefits/3-4-healthcare-sector-emissions
Other data sources	Or Lenzen et al. The environmental footprint of health care: a global assessment. Lancet Planet Health. 2020; 4(7):E271-E279. (data available for 65 countries)
Disaggregation	National level
Frequency of data collection	Models can be re-run depending on frequency of update of WHO Global Health Expenditure Database.
Limitations	Modelled estimates based on WHO Global Health Expenditure Database, rather than directly measured by countries. Politically contentious if presented in isolation without health sector adaptation assessment, particularly for LMICs.
Data type	Modelled quantitative estimates of Greenhouse gas emissions
Related links	https://www.lancetcountdown.org/data-platform/mitigation-actions-and-health-co-benefits/3-4-healthcare-sector-emissions https://iris.who.int/bitstream/handle/10665/373837/9789240081888-eng.pdf?sequence=1

2.3. SDG 10.7.2 Does the government provide non-national (including refugees and migrants) equal access to i) essential and/or ii) emergency healthcare?

Indicator	Does the government provide non-national equal access to i) essential and/or ii) emergency healthcare
Rationale	Monitoring health inequities in access to essential and emergency healthcare for refugees and migrants, to leave no one behind, and to make targeted interventions on ensuring access to healthcare both essential and emergency for refugee and migrant populations

Mandate (WHA resolution, SDG)	SDG 10.7.2 (domain 1a) – Tier I indicator
Definition	The indicator to assess if national government has explicit policies legislating access to both essential as well as emergency healthcare to refugees and migrants within its borders
Numerator	Binary indicator disaggregated for refugees and migrants and for essential and emergency healthcare
Denominator	Not applicable
Preferred data sources	Country reported data through questionnaires sent to all MSs
Other data sources	Confirmation of evidence and validation of the data through national household surveys, routine health information systems and other administrative sources, as well as regional questionnaires for various indicators related to health of refugees and migrants. The implementation of the government policies providing equal access to refugees and migrants as nations can be found through data on health and health related indicators disaggregated for income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts – as stipulated by SDG target 17.18 – currently this is done generally and systematically only for gender, age and geographic location of urban-rural Please see the attached document 'Mapping GPW14 priorities, strategic objectives and outcomes to the GPW13 programmatic indicators (to be updated for GPW14) and outputs using the delivery milestones'
Disaggregation	Refugees and migrants and for essential and emergency healthcare
Frequency of data collection	Every 2 years
Limitations	Government reporting bias, and limitation of data for validation and confirmation of data reported by the governments
Data type	Binary data
Related links	https://unstats.un.org/sdgs/metadata/files/Metadata-10-07-02.pdf

2.4. Proportion of refugees and migrants that have equal access to i) essential and/or ii) emergency healthcare

Indicator	Proportion of refugees and migrants that have equal access to i) essential and ii) emergency healthcare services
Rationale	To measure if there is an equitable access to essential and emergency healthcare for over I billion refugees and migrants around the world. The measure of this indicator intends to reduce inequality among various population groups.
Mandate (WHA resolution, SDG)	WHA76.14 (resolution: https://apps.who.int/gb/ebwha/pdf_files/WHA76-REC1/A76_REC1_Interactive_en.pdf#page=1)

Definition	This indicator intends to measure if the refugees and migrants have access to essential healthcare (minimum package of services) as well as those needed in emergency situations, including in acute health emergency situations. The information collected also include a measure of equity between these population groups and the host populations to be able to build a story of any inequity in access in order to address the gaps towards the universal health coverage.
Numerator	Number of refugees and migrants within the national boundaries that have the desired access
Denominator	All refugees and migrants within the national boundaries
Preferred data sources	Health and Migration survey conducted among the WHO Member States – first round of survey to be conducted in 2024 to have the baseline for 2025.
Other data sources	Other data sources from UN and International Orgs such as DHS, MICS, or ILO Labour Force Surveys, national surveys. Other data sources from WHO technical programmes
Disaggregation	Disaggregation for refugees and migrants, and also for age and sex
Frequency of data collection	Health and Migration surveys every two years, and the compilation, analysis and integration of various data sources at the time of preparation of the monitoring report.
Limitations	Representativity of the population intended to be surveyed, especially the hard to reach population groups
Data type	Quantitative data from various data sources mentioned above.
Related links	Link to SDG10.7.2: https://unstats.un.org/sdgs/metadata/files/Metadata-10-07-02.pdf Link to primary healthcare monitoring: https://iris.who.int/bitstream/handle/10665/352205/9789240044210-eng.pdf?sequence=1

2.5. SDG 11.1.1. Proportion of urban population living in slums, informal settlements or inadequate housing

Indicator	Proportion of urban population living in slums, informal settlements or inadequate housing
Rationale	Most of the criteria for defining slums, informal settlements and inadequate housing overlap. Table 2. The three criteria of informal settlements are essentially captured in the definition of slums, which sustains the combination of both (slums/informal settlements). Both aspects of slums and informal settlements are therefore combined into one component of the indicator, providing some continuity with what was captured under MDG 7. At a later stage, a composite index will be developed that will incorporate all measures (combining slum/informal settlements and inadequate housing) and provide one estimate. The second component of the indicator is on inadequate housing. From the seven criteria of adequate housing, the three that are not covered by slums / informal settlements are affordability, accessibility and cultural adequacy. However, affordability is the most relevant and easier to measure. In this regard, housing affordability is not only a key housing adequacy criterion, but is a suitable means of measuring inadequate housing in a more encompassing manner, as it remains a global challenge across different countries and income levels, with strong negative impact on urban inequality. The underlying principle is that household financial costs associated with housing should not threaten or compromise the attainment and satisfaction of other basic needs such as, food, education, access to health care, transport, etc. Based on the existing method and

	data of UN-Habitat's Urban Indicators Program (1996-2006), unaffordability is currently measured as the net monthly expenditure on housing cost that exceeds 30% of the total monthly income of the household. Table 1 details the proposed definition of Slum/Informal Settlements and Inadequate Housing as well as the respective measurements. Definition and measurement criteria for slums, informal settlements and inadequate housing. **Table 1 – Definition and measurement criteria for slums, informal settlements and inadequate housing**

	Slums / Informal Settlements	**DEFINITION**: As adopted in the MDG, slum households are households whose members suffer one or more of the following 'household deprivations':
		1) Lack of access to improved water source,
		2) Lack of access to improved sanitation facilities,
		3) Lack of sufficient living area,
		4) Lack of housing durability and,
		5) Lack of security of tenure.
			MEASUREMENT[2]:
			Security of Tenure:
			• Proportion of households with formal title deeds to both land and residence.
			• Proportion of households with formal title deeds to either one of land or residence.
			• Proportion of households with agreements or any document as a proof of a tenure arrangement.
			Access to improved water sources:
			• Proportion of households whose members have access to improved drinking water sources (i.e. piped in water into dwelling, plot or yard; public tap/stand pipe service; protected spring; rain water collection; bottled water if secondary source is also improved; bore hole/tube well; and protected dug well).
			Access to improved sanitation facilities:
			• Proportion of households whose members have access to improved sanitation facilities (i.e. pour-flush toilets or latrines connected to a sewer, septic tank or pit; ventilated improved pit latrine; pit latrine with a slab or platform that covers the pit entirely; composting toilets/latrines).
			Structural quality of Housing and location:
			• Proportion of households residing on or near a hazardous site. The following locations should be considered:
			  • housing in geologically hazardous zones (landslide/earthquake and flood areas);
			  • housing on or under garbage mountains;
			  • housing around high-industrial pollution areas; o housing around other unprotected high-risk zones (e.g. railroads, airports, energy transmission lines).
			• **Structural quality of the housing and permanency of the structure:** Proportion of households living in temporary and/or dilapidated	

[2] Measurements based on those in the (2003) UN-Habitat Challenge of Slums

			structures. The following factors should be considered when placing a housing unit in these categories: ○ quality of construction (e.g. materials used for wall, floor and roof); ○ compliance with local building codes, standards and bylaws. • Sufficient living area: ○ Proportion of households in which not more than three people share the same habitable room.
	Inadequate housing	**DEFINITION:** Proposed to complement the slums/informal settlements measuring affordability of housing at the global level. A housing is considered inadequate if it is not affordable to the household, i.e. the net monthly expenditure on its cost exceeds 30% of the total monthly income of the household.	**MEASUREMENT:** Inadequate housing: • Proportion of households with net monthly expenditure on housing exceeding 30% of the total monthly income of the household2[3].
Mandate (WHA resolution, SDG)	The United Nations Human Settlements Programme (UN-Habitat) is the specialized agency for sustainable urbanization and human settlements in the United Nations. The mandate derives from the priorities established in relevant General Assembly resolutions and decisions, including General Assembly resolution 3327 (XXIX), by which the General Assembly established the United Nations Habitat and Human Settlements Foundation, and resolution 32/162 by which the Assembly established the United Nations Center for Human Settlements (Habitat). In 2001, by its Resolution 56/206, the General Assembly transformed the Habitat into the secretariat of the United Nations Human Settlements Programme (UN-Habitat), with a mandate to coordinate human settlements activities within the United Nations System. As such, UN-Habitat has been designated the overall coordinator of SDG 11 and specifically as a custodian agency for 9 of the 14 indicators under SDG 11 including indicator 11.1.1. UN-Habitat also supports the monitoring and reporting of 4 urban specific indicators in other goals.		
Definition	As per the 2030 Agenda, it is necessary to identify and quantify the proportion of the population that live in slums, informal settlements and those living in inadequate housing in order to inform the development of the appropriate policies and programmes for ensuring access for all to adequate housing and the upgrading of slums.		

[3] To note, housing affordability can also be measured using house price-to-income ratio (HPIR) and the house rent-to-income ratio (HRIR). Housing is considered affordable when the house-price-to-annual household income ratio (HPIR) is 3.0 or less and the rent-to-monthly household income ratio (RIR) is 25% or less.

	Slum An expert group meeting was convened in 2002 by UN-Habitat, the United Nations Statistics Division and the Cities Alliance to agree on an operational definition for slums to be used for measuring the indicator of MDG 7 Target 7.D. The agreed definition classified a 'slum household' as one in which the inhabitants suffer one or more of the following 'household deprivations': 1. Lack of access to improved water source, 2. Lack of access to improved sanitation facilities, 3. Lack of sufficient living area, 4. Lack of housing durability and, 5. Lack of security of tenure. By extension, the term 'slum dweller' refers to a person living in a household that lacks any of the above attributes.[4] These five components –all derived from the adequate housing's definition have been used ever since for reporting and tracking of the MDGs, as the primary or secondary data measured to determine the number of slum dwellers living in developing countries. They were also the basis to establish the successful achievement of MDG Target 7.D. For each component, the experts agreed with the following sub-definitions:4[5] **1) Access to improved water** – A household is considered to have access to improved drinking water if the household members use a facility that is protected from outside contamination, in particular from faecal matters' contamination. Improved drinking water sources include: piped water into dwelling, plot or yard; public tap/stand pipe serving no more than 5 households; protected spring; rainwater collection; bottled water (if secondary source is also improved); bore hole/tube well; and, protected dug well. **2) Access to improved sanitation** – A household is considered to have access to improved sanitation if household members have access to a facility with an excreta disposal system that hygienically separates human waste from human contact. Improved facilities include: flush/pour-flush toilets or latrines connected to a sewer, septic tank or pit; ventilated improved pit latrine; pit latrine with a slab or platform, which covers the pit entirely; and, composting toilets/latrines. **3) Sufficient living area /overcrowding**– A dwelling unit provides sufficient living area for the household members if not more than three people share the same habitable room.[6] Additional indicators of overcrowding have been proposed: area-level indicators such as average in-house living area per person or the number of households per area. Additionally, housing-unit level indicators such as the number of persons per bed or the number of children under five per room may also be viable. However, the number of persons per room has been shown to correlate with adverse health risks and is more commonly collected through household survey.[7]

[4] UN-Habitat (2003), Slums of the World: The face of urban poverty in the new millennium; <mirror.unhabitat.org/pmss/getElectronicVersion.aspx?nr=1124&alt=1>

[5] United Nations (2007), Indicators of Sustainable Development: Guidelines and Methodologies. Third Edition, United Nations, New York; < https://sustainabledevelopment.un.org/index.php?page=view&type=400&nr=107&>; UN-Habitat (2003), Slums of the World: The face of urban poverty in the new millennium.

[6] The original EGM's advice considered a range of less than three to four people per habitable room. When this indicator got operationalized during the MDG 7 Target 7.D's tracking, overcrowding was fixed at a maximum of three people per habitable room ('minimum of four square meters,' <http://mdgs.un.org/unsd/mdg/Metadata.aspx>).

[7] UN-Habitat (1998), Crowding and Health in Low Income Settlements of Guinea Bissau, SIEP Occasional Series No.1.

	UN-Habitat believes that the definition as it stands does not reflect the practical experience of overcrowding and as noted below, is proposing an alternative. **4) Structural quality/durability of dwellings** – A house is considered as 'durable' if it is built on a non-hazardous location and has a permanent and adequate structure able to protect its inhabitants from the extremes of climatic conditions such as rain, heat, cold, and humidity. The following criteria are used to determine the structural quality/durability of dwellings: permanency of structure (permanent building material for the walls, roof and floor; compliance with building codes; the dwelling is not in a dilapidated state; the dwelling is not in need of major repair); and location of house (hazardous location; the dwelling is not located on or near toxic waste; the dwelling is not located in a flood plain; the dwelling is not located on a steep slope; the dwelling is not located in a dangerous right of way: rail, highway, airport, power lines). **5) Security of tenure** – Secure tenure is the right of all individuals and groups to effective protection by the State against forced evictions. Security of tenure is understood as a set of relationships with respect to housing and land, established through statutory or customary law or informal or hybrid arrangements, that enables one to live in one's home with security, peace and dignity (A/HRC/25/54). Regardless of the type of tenure, all persons with security of tenure have a legal status against arbitrary unlawful eviction, harassment and other threats. People have secure tenure when: there is evidence of documentation that can be used as proof of secure tenure status; and, there is either de facto or perceived protection from forced evictions. Important progress has been made to integrate the measurement of this component into the computation of the people living in slums. **2.2 Informal Settlements** Informal settlements are usually seen as synonymous of slums, with a particular focus on the formal status of land, structure and services. They are defined by three main criteria, according to Habitat III Issue Paper #22[8], which are already covered in the definition of slums. These are: 1. Inhabitants have no security of tenure vis-à-vis the land or dwellings they inhabit, with modalities ranging from squatting to informal rental housing, 2. The neighborhoods usually lack, or are cut off from, formal basic services and city infrastructure, and 3. The housing may not comply with current planning and building regulations, is often situated in geographically and environmentally hazardous areas, and may lack a municipal permit. Informal settlements can be occupied by all income levels of urban residents, affluent and poor. **2.3 Inadequate Housing** c. Inadequate Housing – Article 25 of the Universal Declaration of Human Rights includes housing as one of the components of the right to adequate standards of living for all.[9] The United Nations Committee on Economic, Social and Cultural Rights' general comments No.4 (1991) on the right to adequate housing and No.7 (1997) on forced evictions have underlined that the right to adequate housing should be seen as the right to live somewhere in security, peace and dignity. For housing to be adequate, it must provide more than four walls and a roof, and at a minimum, meet the following criteria:

[8] United Nations (2015), Conference on Housing and Sustainable Urban Development – Habitat III, Issue Paper No. 22 on Informal Settlements; UN-Habitat (2015), Slum Almanac 2015-2016.

[9] Article 25 (1) "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

<table>
<tr><td></td><td>
1. Legal security of tenure, which guarantees legal protection against forced evictions, harassment and other threats;
2. Availability of services, materials, facilities and infrastructure, including safe drinking water, adequate sanitation, energy for cooking, heating, lighting, food storage or refuse disposal;
3. Affordability, as housing is not adequate if its cost threatens or compromises the occupants' enjoyment of other human rights;
4. Habitability, as housing is not adequate if it does not guarantee physical safety or provide adequate space, as well as protection against the cold, damp, heat, rain, wind, other threats to health and structural hazards;
5. Accessibility, as housing is not adequate if the specific needs of disadvantaged and marginalized groups are not taken into account (such as the poor, people facing discrimination; persons with disabilities, victims of natural disasters);
6. Location, as housing is not adequate if it is cut off from employment opportunities, health-care services, schools, childcare centres and other social facilities, or if located in dangerous or polluted sites or in immediate proximity to pollution sources; and
7. Cultural adequacy, as housing is not adequate if it does not respect and take into account the expression of cultural identity and ways of life.

Table 1. Criteria defining slums, informal settlements and inadequate housing
<table>
<tr><th></th><th>Slums</th><th>Informal Settlements</th><th>Inadequate Housing</th></tr>
<tr><td>access to water</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>access to sanitation</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>sufficient living area, overcrowding</td><td>X</td><td></td><td>X</td></tr>
<tr><td>structural quality, durability and location</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>security of tenure</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>affordability</td><td></td><td></td><td>X</td></tr>
<tr><td>accessibility</td><td></td><td></td><td>X</td></tr>
<tr><td>cultural adequacy</td><td></td><td></td><td>X</td></tr>
</table>
</td></tr>
<tr><td>Numerator</td><td>The indicator considers two components to be computed as follows:
a) Percentage of people living in Slum/Informal Settlements households (SISH):
Numerator= $Number\ of\ people\ living\ in\ SISH$
b) Percentage of people living in Inadequate housing households (IHH):
Numerator= $Number\ of\ people\ living\ in\ IHH$</td></tr>
<tr><td>Denominator</td><td>For the two components the denominator will be;
Denominator= $Urban/City\ population$</td></tr>
<tr><td>Preferred data sources</td><td>The computation of this indicator is mainly based on analysis of existing data sources including population and housing censuses and household surveys that contain information on all five components of slum: improved water, improved sanitation, durable housing, sufficient living area and secure tenure. Nationally representative household surveys, which typically collect information on water, sanitation and housing conditions, include Urban Inequities Surveys (UIS), Multiple Indicator Cluster Surveys (MICS), Demographic Health Surveys (DHS), World Health Surveys (WHS), Living Standards and Measurement Surveys (LSMS), Core Welfare Indicator Questionnaires (CWIQ), and other relevant surveys. National-level household surveys are generally conducted every 3-5 years in most developing countries, while censuses are generally conducted every 10 years.</td></tr>
</table>

Other data sources	Data for the inadequate housing component can be computed through income and household surveys that capture housing expenditures.
Disaggregation	**Potential Disaggregation:** • Disaggregation by location (intra-urban) • Disaggregation by income group • Disaggregation by sex, race, ethnicity, religion, migration status (head of household) • Disaggregation by age (household members) • Disaggregation by disability status (household members) **Quantifiable Derivatives:** • Proportion of households with durable housing • Proportion of households with improved water • Proportion of households with improved sanitation • Proportion of households with sufficient living space • Proportion of households with security of tenure • Proportion of households with one (1) housing deprivation • Proportion of households with multiple (2 or more) housing deprivations • Proportion of households with approved municipal permit • Proportion of households with (in) adequate housing (affordability)
Frequency of data collection	While continuous follow-up is done with countries and compilation of data sources occur on an annual basis, changes in trends within individual countries are likely to happen in spans of about 3-5 years, so a three-year window will be applied for comprehensive review of all data, with updates made based on availability of new data.
Limitations	As with all indicators, there are some potential challenges and limitations. Some of these are outlined below. • Difficulties to agree universally on some definitions and characteristics when referring to deteriorated housing conditions, often due to political or economic considerations. • Lack of appropriate tools at national and city levels to measure all components required by Indicator 11.1.1, sometimes resulting in the underestimation of deteriorated housing units. • The complicated relation between security of tenure with land and property makes it a difficult, but vital, aspect to include in the different surveys, and thus, to measure and monitor. • Indicator 11.1.1 does not capture homelessness. • Many countries still have limited capacities for data collection, management and analysis, their update and monitoring. These are key to ensure national and global data consistency.
Data type	The unit of measurements for all these indicators will be %. Currently, the data for this indicator is already being reported in nearly all developing countries on what refers to slums and informal settlements, and in some countries for what refers to expenditure on housing (for inadequate housing).

Related links	**Bibliographic References:** • United Nations (2007). Indicators of Sustainable Development: Guidelines and Methodologies. Third Edition, United Nations, New York • A/HRC/25/54 (2013), Report of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context • UN-Habitat (2002) Urban Indicators Guidelines. Nairobi • UN-Habitat, Global Urban Indicators Database 2012 a. Nairobi • UN-Habitat (2002), Expert Group Meeting on Urban Indicators, Nairobi, Kenya, November 2002 • UN-Habitat (2003a), Slums of the World: The face of urban poverty in the new millennium • UN-Habitat (2003b), Improving the Lives of 100 Million Slum Dwellers – Guide to Monitoring Target 11 • UN-Habitat (1998), Crowding and Health in Low Income Settlements of Guinea Bissau, SIEP Occasional Series No.1 • Global report on Human settlement on Slums (2002) • Turkstra, J. and Raithelhuber, M. (2004). Urban slum Monitoring. ESRI User Conference paper 1667 • Urban Indicators Programme, World Bank and UN-Habitat, Guidelines • Habitat for Humanity, Global Housing Indicators • Habitat for Humanity, Housing Indicators for the Sustainable Development Goals, 2015 • McKinsey Global Institute (2014), A Blueprint for Addressing the Global Affordable Housing Challenge • United Nations (2015), Conference on Housing and Sustainable Urban Development – Habitat III, Issue Paper No. 22 on Informal Settlements • UN-Habitat, UN-AIDS (2015a) Ending the Urban Aids Epidemic. Nairobi • UN-Habitat (2015b). Slum Almanac 2015-2016 • UN-Habitat (2016). World Cities Report 2016 **URL References:** 1) http://www.un.org/esa/sustdev/natlinfo/indicators/methodology_sheets.pdf 2) http://unhabitat.org/urban-indicators-guidelines/ 3) http://mdgs.un.org/unsd/mdg/Metadata.aspx?IndicatorId=0&SeriesId=710, 4) http://unhabitat.org/urban-initiatives/initiatives-programmes/participatory-slum-upgrading/ 5) http://unhabitat.org/slum-almanac-2015-2016/ 6) http://wcr.unhabitat.org/

2.6. Proportion of population covered by at least one social protection benefit (%)

Indicator	Proportion of population covered by at least one social protection benefit (%)
Rationale	Access to at least a basic level of social protection throughout the life cycle is a human right. Social protection systems include contributory and non-contributory schemes for children, pregnant women with newborns, people in active age, older persons, for victims of work injuries and persons with disabilities. The principle of universality of social protection evidences the importance of social protection systems in guaranteeing decent living conditions to the whole population, throughout their

	lives. The proportion of the population covered by social protection systems/floors provides an indication of the extent to which universality is accomplished, and thus, how secure are the population's living conditions. Having the resources necessary to achieve a decent quality of life is a main social determinant of health and a major aim of social protection systems. Of all resources important for health and wellbeing, those that are economic occupy a special position, as they can easily be transformed into other types. Income in general, and poverty in particular, are linked with a range of health outcomes over the life course through material, psychological, and social factors. Policies that reduce risks of poverty or, more generally, contribute to better family incomes are therefore likely to contribute to better health and wellbeing. A key aim of welfare (and other) policy should be the development and maintenance of minimum standards needed for healthy living. Social protection policies are critically important in protecting populations from the health effects of poverty and financial insecurity and have the potential to mitigate health inequities. The amount of social spending, a crude indicator of the generosity of social protection programmes, is important for health by reducing poverty risks and increasing individuals' and families' resources. Spending on welfare has the potential to reduce health inequity by having greater effects on groups of lower socioeconomic position. Measurements of effective coverage should reflect how in reality legal provisions are implemented. It refers to the percentage of people actually receiving benefits of contributory and non-contributory social protection programmes, plus the number of persons actively contributing to social insurance schemes.
Mandate (WHA resolution, SDG)	SDG 1: End poverty in all its forms everywhere SDG Target 1.3: Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable SDG Indicator 1.3.1: Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable
Definition	Definition: The indicator reflects the proportion of persons effectively covered by a social protection system, including social protection floors. It also reflects the main components of social protection: child and maternity benefits, support for persons without a job, persons with disabilities, victims of work injuries and older persons. Effective coverage of social protection is measured by the number of people who are either actively contributing to a social insurance scheme or receiving benefits (contributory or non-contributory). Concepts: Social protection systems include contributory and non-contributory schemes for children, pregnant women with newborns, people in active age, older persons, for victims of work injuries and persons with disabilities. Social protection floors provide at least a basic level in all main contingencies along the life cycle, as defined in the Social Protection Floors Recommendation 2012 (no. 202) referred to in SDG 1.3. When assessing coverage and gaps in coverage, distinctions need to be made between coverage by (1) contributory social insurance, (2) universal schemes covering all residents (or

	all residents in a given category), and (3) means-tested schemes potentially covering all those who pass the required test of income and/or assets.
Numerator	Method of computation: Calculations include separate indicators in order to distinguish effective coverage for children, unemployed persons, older persons and persons with disabilities, mothers with newborns, workers protected in case of work injury, and the poor and the vulnerable. For each case, coverage is expressed as a share of the respective population. Indicators are obtained as follows: 1. Proportion of population covered by at least one social protection cash benefit: ratio of the population receiving cash benefits under at least one of the contingencies/social protection functions (contributory or non-contributory benefit) or actively contributing to at least one social security scheme to the total population. 2. Proportion of children covered by social protection benefits: ratio of children/households receiving child or family cash benefits to the total number of children/households with children. 3. Proportion of women giving birth covered by maternity benefits: ratio of women receiving cash maternity benefits to women giving birth in the same year (estimated based on age-specific fertility rates published in the UN's World Population Prospects or on the number of live births corrected for the share of twin and triplet births). 4. Proportion of persons with disabilities receiving benefits: ratio of persons receiving disability cash benefits to persons with severe disabilities. The latter is calculated as the product of prevalence of disability ratios (published for each country group by the World Health Organization) and each country's population. 5. Proportion of unemployed receiving benefits: ratio of recipients of unemployment cash benefits to the number of unemployed persons. 6. Proportion of workers covered in case of employment injury: ratio of workers protected by injury insurance to total employment or the labour force. 7. Proportion of older persons receiving a pension: ratio of persons above statutory retirement age receiving an old-age pension to persons above statutory retirement age (including contributory and non-contributory). 8. Proportion of vulnerable persons receiving benefits: ratio of social assistance recipients to the total number of vulnerable persons. The latter are calculated by subtracting from total population all people of working age who are contributing to a social insurance scheme or receiving contributory benefits, and all persons above retirement age receiving contributory benefits. 9. Proportion of poor population receiving social assistance cash benefit: ratio of social assistance recipients to the population living below the national poverty line.
Denominator	*See above for method of computation
Preferred data sources	Data sources: The main data source is the Social Security Inquiry (SSI) (online questionnaire https://qpss.ilo.org/), the ILO's periodic collection of administrative data from national ministries of labour, social security, welfare, finance, and others. Since 1950, the ILO's Social Security Inquiry has been the main global source of administrative data on social protection. Secondary data sources include existing global databases of social protection statistics, including those of the World Bank, UNICEF, UNWOMEN, HELPAGE, OECD and the International Social Security Association.

	This forms the World Social Protection Database (WSPDB). It provides a unique source of information and serves as the basis for the ILO flagship World Social Protection Report, which periodically presents development trends of social protection systems, including floors, providing data for a wide range of countries (214 countries and territories). Data collection method: Data is collected using the SSI questionnaires, which are filled in direct collaboration with government agencies - Ministries of labour, ministries of finance, social protection institutions and others. The collected data collected is revised by the Social Protection Department in order to identify internal inconsistencies between data and indicators, and detect major differences regarding indicators calculated in previous years. When significant discrepancies are detected, the questionnaires are sent back to the countries, including detailed comments, for further revision and adjustments. In many cases direct contact with national counterparts are required, as SSI application lies on a strong coordination with our governmental counterparts. Data providers: National data is provided by national Ministries of Labour, Welfare, Finance, National Statistical Institutions and others, as well as by social security and social protection institutions. Data compilers: International Labour Organization (ILO) Data availability: The Social Security Inquiry/World Social Protection Database includes data on 214 countries and territories. As of March 2017, ILO is processing the Social Security Inquiry data for approximately 70 countries per year. An updated pre-filled version of the questionnaire is sent to the countries in April-May.
Other data sources	
Disaggregation	Whenever data are available, the indicator is disaggregated by sex and age groups.
Frequency of data collection	Data collection calendar: Continuous (214 countries and territories in three years) Data release calendar: Continuous (after new data for the country are processed) on https://wspdb.social-protection.org Time series: From 2015 (for some series from 2000)
Limitations	
Data type	Administrative data from national ministries of labour, social security, welfare, finance, and others
Related links	Metadata: https://unstats.un.org/sdgs/dataportal/SDMXMetadataPage?1.3.1-SI_COV_BENFTS

	ILOSTAT: https://ilostat.ilo.org/data/ World Social Protection Data Dashboards: https://wspdb.social-protection.org Social Security Inquiry (questionnaire): https://qpss.ilo.org/ Social Security Inquiry. Manual 2018: http://www.social-protection.org/gimi/gess/RessourcePDF.action?ressource.ressourceId=53711 ILO Social Protection Floors Recommendation (n°202), 2012 http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID, P12100_LANG_CODE:3065524 World Social Protection Report 2020-22 https://wspr.social-protection.org

2.7. SDG 2.2.1 Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age

Indicator	Prevalence of stunting in children under 5 years of age
Rationale	Child growth is an internationally accepted outcome reflecting child nutritional status. Child stunting refers to a child who is too short for his or her age and is the result of chronic or recurrent malnutrition. Stunting is a contributing risk factor to child mortality and is also a marker of inequalities in human development. Stunted children fail to reach their physical and cognitive potential. Child stunting is one of the World Health Assembly nutrition target indicators.
Mandate (WHA resolution, SDG)	WHA Resolution 65.6 – Comprehensive Implementation Plan for Maternal, Infant and Young Child Nutrition, establishing this indicator as a global nutrition target SDG 2.2.1
Definition	Prevalence of stunting (height-for-age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age
Numerator	Number of children with height-for-age z-scores less than -2 standard deviations (SDs) from the median height-for-age based on the WHO 2006 Child Growth Reference
Denominator	Number of children below the age of 5 in the sample with a valid height-for-age
Preferred data sources	Nationally representative household surveys such as the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), National Nutrition Surveys (NNS).
Other data sources	Surveillance Systems

Disaggregation	
Frequency of data collection	WHO, UNICEF and the World Bank update the model-based estimates every other year.
Limitations	Survey estimates have uncertainty due to both sampling error and non-sampling error (e.g., measurement technical error, recording error etc.,). The JME modelled estimates for stunting take into account estimates of sampling error around survey estimates. While non-sampling error cannot be accounted for or reviewed in full, when available, a data quality review of weight, height and age data from household surveys supports compilation of a time series that is comparable across countries and over time. The JME working group carefully utilizes all available national data sources, and documents all the steps taken to infer about country trends based on the national data sources. The estimation method is based on and closely aligned to country data. The approach smooths and fits a trend line across the national data points. The basis of the estimates are nationally representative household surveys. However, as surveys are conducted infrequently (e.g., less frequently than every 3 years) in some countries, models produce a complete time series with estimates available in the same years for all countries. This allows for comparable assessment of progress; for example, all countries can be assessed using the same baseline year. For any individual country, an increase in the availability of primary data points can result in more robust and accurate modelled estimates.
Data type	Health Estimate (Prevalence)
Related links	WHO Nutrition Data Portal https://platform.who.int/nutrition/nutrition-portals/ WHO Child Growth Database https://platform.who.int/nutrition/malnutrition-database UNICEF-WHO-World Bank Joint Child Malnutrition Estimates https://www.who.int/teams/nutrition-and-food-safety/monitoring-nutritional-status-and-food-safety-and-events/joint-child-malnutrition-estimates

2.8. SDG 2.2.2 Prevalence of overweight (weight for height more than +2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age

Indicator	Prevalence of overweight in children under 5 years of age
Rationale	Child growth is an internationally accepted outcome area reflecting child nutritional status. Child overweight refers to a child who is too heavy for his or her height. This form of malnutrition results from expending too few calories for the amount of food consumed and increases the risk of noncommunicable diseases later in life. Child overweight is one of the World Health Assembly nutrition target indicators.
Mandate (WHA resolution, SDG)	WHA Resolution 65.6 – Comprehensive Implementation Plan for Maternal, Infant and Young Child Nutrition, establishing this indicator as a global nutrition target SDG 2.2.2
Definition	Prevalence of overweight (weight for height >+2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age.

Numerator	Number of children with weight-for-height z-scores greater than +2 standard deviations (SDs) from the median weight-for-height based on the WHO 2006 Child Growth Reference
Denominator	Number of children below the age of 5 in the sample with a valid weight-for-height
Preferred data sources	Nationally representative household surveys such as the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), National Nutrition Surveys (NNS).
Other data sources	Surveillance Systems
Disaggregation	
Frequency of data collection	WHO, UNICEF and the World Bank update the model-based estimates every other year.
Limitations	The JME working group carefully utilizes all available national data sources, and documents all the steps taken to infer about country trends based on the national data sources. The estimation method is based on and closely aligned to country data. The approach smooths and fits a trend line across the national data points. The basis of the estimates are nationally representative household surveys. However, as surveys are conducted infrequently (e.g., less frequently than every 3 years) in some countries, models produce a complete time series with estimates available in the same years for all countries. This allows for comparable assessment of progress; for example, all countries can be assessed using the same baseline year. For any individual country, an increase in the availability of primary data points can result in more robust and accurate modelled estimates.
Data type	Health Estimate (Prevalence)
Related links	WHO Nutrition Data Portal https://platform.who.int/nutrition/nutrition-portals/ WHO Child Growth Database https://platform.who.int/nutrition/malnutrition-database UNICEF-WHO-World Bank Joint Child Malnutrition Estimates https://www.who.int/teams/nutrition-and-food-safety/monitoring-nutritional-status-and-food-safety-and-events/joint-child-malnutrition-estimates

2.9. SDG 2.2.2 Prevalence of wasting (weight for height more than -2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age

Indicator	Prevalence of wasting in children under 5 years of age
Rationale	Child growth is an internationally accepted outcome reflecting child nutritional status and well-being. Child wasting refers to a child who is too thin for his or her height and is the result of recent rapid weight loss or the failure to gain weight. A child who is moderately or severely wasted has an increased risk of death, but treatment is possible. Child wasting is one of the World Health Assembly nutrition target indicators.
Mandate (WHA resolution, SDG)	WHA Resolution 65.6 – Comprehensive Implementation Plan for Maternal, Infant and Young Child Nutrition, establishing this indicator as a global nutrition target SDG 2.2.2

Definition	Prevalence of wasting (weight for height <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age
Numerator	Number of children with weight-for-height z-scores less than -2 standard deviations (SDs) from the median weight-for-height based on the WHO 2006 Child Growth Reference
Denominator	Number of children below the age of 5 in the sample with a valid weight-for-height
Preferred data sources	Nationally representative household surveys such as the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), National Nutrition Surveys (NNS).
Other data sources	Surveillance Systems
Disaggregation	Sex of the child, place of residence, age of the child, household wealth, mother's education, subnational region
Frequency of data collection	WHO, UNICEF and the World Bank update the database every 6 months. Member States conduct nationally representative household surveys every 3-5 years
Limitations	Survey estimates have uncertainty due to both sampling error and non-sampling error (e.g., measurement technical error, recording error etc.,). While non-sampling error cannot be accounted for or reviewed in full, when available, a data quality review of weight, height and age data from household surveys supports compilation of a time series that is comparable across countries and over time. None of the two sources of errors have been fully taken into account for deriving estimates neither at country nor at regional or worldwide levels. Surveys are carried out in a specific period of the year, usually over a few months. However, this indicator can be affected by seasonality, factors related to food availability (e.g., pre-harvest periods), disease (e.g., rainy season and diarrhoea, malaria, etc.), and natural disasters and conflicts.
Data type	Primary Data (Prevalence)
Related links	WHO Nutrition Data Portal https://platform.who.int/nutrition/nutrition-portals/ WHO Child Growth Database https://platform.who.int/nutrition/malnutrition-database UNICEF-WHO-World Bank Joint Child Malnutrition Estimates https://www.who.int/teams/nutrition-and-food-safety/monitoring-nutritional-status-and-food-safety-and-events/joint-child-malnutrition-estimates

2.10. SDG 2.2.3 Prevalence of anaemia in women aged 15 to 49 years, by pregnancy status (percentage)

Indicator	Prevalence of anaemia in women aged 15 to 49 years
Rationale	Anaemia is highly prevalent globally, disproportionately affecting children, adolescent girls, and women of reproductive age. It negatively affects cognitive and motor development and work capacity, and among pregnant women iron deficiency anaemia is associated with adverse reproductive outcomes, including preterm delivery, low-birth-weight infants, and decreased iron stores for the baby, which may lead to impaired development. Iron deficiency is considered the most common cause of anaemia, but there are other nutritional and non-nutritional causes. Blood haemoglobin concentrations are affected by many factors, including altitude (metres above sea level), smoking, trimester of pregnancy, age and sex. Anaemia can

	be assessed by measuring blood haemoglobin, and when used in combination with other indicators of iron status, blood haemoglobin provides information about the severity of iron deficiency anaemia. The anaemia prevalence for the population is used to classify the public health significance of the problem.
Mandate (WHA resolution, SDG)	WHA Resolution 65.6 – Comprehensive Implementation Plan for Maternal, Infant and Young Child Nutrition, establishing this indicator as a global nutrition target WHO Accelerating anaemia reduction: a comprehensive framework for action SDG Target 2.2.3
Definition	Percentage of women aged 15−49 years with a haemoglobin concentration less than 120 g/L for non-pregnant women and lactating women, and less than 110 g/L for pregnant women, adjusted for altitude and smoking.
Numerator	Number of women aged 15−49 years with a haemoglobin concentration less than 120 g/L for non-pregnant women and lactating women, and less than 110 g/L for pregnant women, adjusted for altitude and smoking.
Denominator	Total number of women aged 15-49 sampled
Preferred data sources	The preferable source of data is population-based surveys such as demographic and health surveys, national micronutrient surveys, malaria indicator surveys.
Other data sources	Data from surveillance systems may be used under some conditions, but recorded diagnoses are typically underestimated
Disaggregation	Pregnancy status (i.e. pregnant and non-pregnant)
Frequency of data collection	Data on anaemia are continuously being collected from survey reports and manuscripts and entered into the WHO Micronutrients Database.
Limitations	Despite the extensive data search, data for blood haemoglobin concentrations are still limited, compared to other nutritional indicators such as child anthropometry. This is especially true in the high-income countries. As a result, the estimates may not capture the full variation across countries and regions, tending to converge towards global means when data are sparse. Estimates may differ from those reported by countries.
Data type	Health Estimate (Percentage)
Related links	WHO Nutrition Data Portal https://platform.who.int/nutrition/nutrition-portals/ WHO Micronutrients Database https://platform.who.int/nutrition/micronutrients-database WHO Vitamin and Mineral Nutrition Information System (VMNIS) https://www.who.int/teams/nutrition-and-food-safety/databases/vitamin-and-mineral-nutrition-information-system

2.11. WHA 69.9 Exclusive Breastfeeding under six months

Indicator	Exclusive Breastfeeding under six months
Rationale	WHO Global Strategy for Infant and Young Child Feeding recommends that infants be exclusively breastfed until they turn six months of age. Exclusive breastfeeding is the safest and healthiest option for children everywhere, guaranteeing infants a food source that is uniquely adapted to their needs while also being safe, clean, healthy and accessible. Evidence suggests that infants in low- and middle-income countries who received mixed feeding (foods and liquids in addition to breast milk) before six months were nearly three times more likely

	to die than those who were exclusively breastfed. Exclusive breastfeeding protects against diarrhoea, lower respiratory infections, acute otitis media and childhood overweight and obesity
Mandate (WHA resolution, SDG)	WHA 54.2 - Sets global recommendation of "6 months" exclusive breastfeeding, with safe and appropriate complementary foods and continued breastfeeding for up to two years or beyond. WHA 65.6 – The Comprehensive Implementation Plan on Maternal and Child Nutrition, establishing this indicator as a global nutrition target WHA 69.7 - Guidance on ending the inappropriate promotion of foods for infants and young children WHA 69.9 - Ending inappropriate promotion of foods for infants and young children
Definition	Percentage of infants 0–5 months of age who were fed exclusively with breast milk during the previous day.
Numerator	Infants 0–5 months of age who were fed only breast milk during the previous day
Denominator	Infants 0–5 months of age.
Preferred data sources	Nationally representative household surveys such as the Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS), National Nutrition Surveys (NNS)
Other data sources	Specific population surveys
Disaggregation	Sex of child, place of residence, household wealth, mother's education, subnational
Frequency of data collection	Nationally representative household surveys are usually conducted every 3-5 years
Limitations	
Data type	Primary Data (Prevalence)
Related links	WHO Global Health Observatory - https://www.who.int/data/gho/data/indicators/indicator-details/GHO/infants-exclusively-breastfed-for-the-first-six-months-of-life-(-) UNICEF Global Databases https://data.unicef.org/topic/nutrition/infant-and-young-child-feeding/ WHO Health Equity Assessment Toolkit https://www.who.int/data/inequality-monitor/assessment_toolkit

2.12. SDG 3.9.1 Mortality rate attributed to household and ambient air pollution

Indicator	Mortality rate attributed to household and ambient air pollution
Rationale	
Mandate (WHA resolution, SDG)	Burden of disease attributed to air pollution is calculated by first combining information on the increased (or relative) risk of a disease resulting from exposure, with information on how widespread the exposure is in the population (in this case, the annual mean concentration of particulate matter to which the population is exposed). This allows calculation of the

	'population attributable fraction' (PAF), which is the fraction of disease seen in a given population that can be attributed to the exposure, in this case the annual mean concentration of particulate matter. Applying this fraction to the total burden of disease (e.g. cardiopulmonary disease expressed as deaths or DALYs), gives the total number of deaths or DALYs that results from ambient air pollution. Population Attributed Fraction (PAF) = $\frac{\sum_{i=1}^{n} P_i \times RR_i - \sum_{i=1}^{n} P_i' \times RR_i}{\sum_{i=1}^{n} P_i \times RR_i}$ P_i = proportion of population at exposure level *i*, current exposure P_i' = proportion of population at exposure level *i*, counterfactual or ideal level of exposure RR = the relative risk at exposure level *i* *n* = the level of exposure levels Mortality rate attributed to household and ambient air pollution = $\frac{Total\ number\ of\ deaths\ attributed\ to\ household\ and\ ambient\ air\ pollution}{Total\ population} \times 100{,}000$
Definition	Evidence from epidemiological studies have shown that exposure to ambient air pollution is linked, among others, to the important diseases taken into account in this estimate: acute respiratory infections in young children (estimated under 5 years of age); cerebrovascular diseases in adults (estimated above 25 years); ischemic heart diseases in adults (estimated above 25 years); chronic obstructive pulmonary disease in adults (estimated above 25 years); and lung cancer in adults (estimated above 25 years).
Numerator	Total number of deaths attributed to household and ambient air pollution
Denominator	Total population
Preferred data sources	Civil registration with complete coverage and medical certification of cause of death; Special studies
Other data sources	Sample Registration Systems and Verbal Autopsy
Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).
Frequency of data collection	Annual or every 5 years
Limitations	- incomplete or unusable death registration data - measurement errors
Data type	Rate
Related links	WHO: http://apps.who.int/gho/data/node.wrapper.imr?x-id=2259; http://www.who.int/healthinfo/global_burden_disease/metrics_paf/en/.

2.13. SDG 3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All [WASH] services)

Indicator	Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)
Rationale	
Mandate (WHA resolution, SDG)	Attributable diarrhoea deaths are calculated by first combining information on the increased (or relative) risk of a disease resulting from exposure, with information on how widespread the exposure is in the population (in this case, the percentage of the population with exposure to unsafe water, sanitation and lack of hygiene). This allows calculation of the 'population attributable fraction' (PAF), which is the fraction of disease seen in a given population that can be attributed to the exposure, in this case lack of access to improved water, sanitation and hygiene. Applying this fraction to the total deaths from diarrhoea results in the number of diarrhoea deaths that results from inadequate water, sanitation and hygiene. Deaths from protein-energy malnutrition attributable to inadequate water, sanitation and hygiene are estimated by evaluating the impacts of repeated infectious diarrhoea episodes on nutritional status (in particular stunting). All deaths from intestinal nematode infections are attributed to inadequate water, sanitation and hygiene due to their transmission pathway.
Definition	Deaths attributable to unsafe water, sanitation and hygiene focusing on inadequate WASH services, expressed per 100,000 population. Death rates are calculated by dividing the number of deaths by the total population. Evidence from epidemiological studies have shown that exposure to unsafe water, sanitation and hygiene habits is, among others, directly linked to diarrhoeal diseases and intestinal nematode infections and other diseases. Repeated diarrhoea episodes are linked to protein-energy malnutrition. In this estimate, only the impact of diarrhoeal diseases, intestinal nematode infections, and protein-energy malnutrition are taken into account. The included diseases are the WASH attributable portions of diarrhoea (ICD-10 code A00, A01, A03, A04, A06-A09), intestinal nematode infections (ICD-10 code B76-B77, B79) and protein-energy malnutrition (ICD-10 code E40-E46).
Numerator	Total number of deaths attributed to unsafe water, unsafe sanitation and lack of hygiene
Denominator	Total population
Preferred data sources	Civil registration with complete coverage and medical certification of cause of death
Other data sources	Household surveys, special studies, sample or sentinel registration systems, population census, surveillance systems
Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).
Frequency of data collection	
Limitations	- incomplete or unusable death registration data - measurement errors
Data type	Rate
Related links	http://www.who.int/water_sanitation_health/diseases-risks/gbd_poor_water/en http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4255749/

2.14. WHA73.5 Proportion of people who have suffered a foodborne diarrhoeal episode of non-typhoidal salmonellosis

Indicator	Proportion of people who have suffered a foodborne diarrhoeal episode of non-typhoidal salmonellosis
Rationale	Foodborne diseases are highly prevalent globally. Latest WHO estimates showed that in 2010, globally 600 million cases of illness and 420 thousand deaths per year were due to foodborne diseases. This was equivalent to 33 million Disability-Adjusted Life Years (DALYs), similar to the burden caused by malaria in 2019. Vulnerable populations bear more burden such as children <5, and some regions carry higher burden such as SEAR and AFR. Over 90% of foodborne disease cases were diarrhoeal nature. Non-typhoidal *Salmonella enterica* bacteria caused an estimated 79 million cases, accounting for 59 thousand deaths globally. This single hazard is responsible for 4 million DALYs, the largest number among, and a quarter of total DALYs due to, diarrhoeal disease agents. *Salmonella enterica,* salmonellosis has a high foodborne attribution (50% or greater in most regions), and it is attributed to a range of food vehicles making it a better reflection of the safety of the overall food supply. The data available for estimation of the incidence of salmonellosis is greater, as many countries have salmonella surveillance programmes. Access to enough safe and nutritious food is key to sustaining life and promoting good health. Food safety is multifaceted as there are many hazards in many food types, spanning the entire food chain. A wide range of actors (i.e., primary food producers, transporters, processors, retailers, food handlers and finally consumers) also contribute to food safety.
Mandate (WHA resolution, SDG)	The Seventy-third World Health Assembly adopted the resolution entitled, "Strengthening efforts on food safety" (WHA73.5) in August 2020. This resolution requested WHO to monitor regularly the burden of foodborne diseases in terms of estimated incidence, mortality and DALYs. The proposed indicator, non-typhoidal salmonellosis, is therefore part of the scope of this regular estimation process requested by WHO Member States.
Definition	The estimated annual prevalence of human cases of diarrhoea caused by non-typhoidal *Salmonella enterica* bacteria that came from food, per 100,000 persons
Numerator	Total estimated number of human diarrhoea cases of foodborne non-typhoidal salmonellosis acquired domestically each year
Denominator	Total population for the given year, based on the latest available United Nations Population Division World Population Prospects (WPP)
Preferred data sources	National surveillance programs that cover the whole population (e.g., all ages, all locations), combined with the factors resulting in underestimation of the indicator by these systems
Other data sources	National health registries, national health management information system, special studies, outbreak reports, cross-sectional or longitudinal studies, expert elicitation (for percent foodborne), insurance data. For the majority of countries without national surveillance: diarrhoea envelopes and attributable fractions provided by WHO under the advice of WHO TAG, Foodborne Disease Burden Epidemiology Reference Group.
Disaggregation	By country, age (<5 and 5+ years), additional disaggregation by serotype and by antimicrobial resistance profile are also welcome.

Frequency of data collection	Every 1-2 years
Limitations	Non-typhoidal Salmonella are found in many different foods, including meat (beef, goat, lamb, pork, and other small ruminant meats), poultry meat, dairy, eggs, fish, fruits, nuts, grains, and vegetables. While this means the hazard may reflect the safety of a wider range of foods, specific interventions that target only one food commodity may only partly reduce the rate of salmonellosis in humans. Stratified results can help interpretation and better guide actions. This indicator assumes the number of infections to be identical to the number of people affected (i.e., only one infection per person per year).
Data type	Health Estimate (Period prevalence)
Related links	• WHO estimates of the global burden of foodborne diseases (https://www.who.int/publications/i/item/9789241565165). • World Health Organization Global Estimates and Regional Comparisons of the Burden of Foodborne Disease in 2010 (https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001923)

2.15. SDG 3.9.3 Mortality rate attributed to unintentional poisoning

Indicator	Mortality rate attributed to unintentional poisoning
Rationale	
Mandate (WHA resolution, SDG)	Mortality rate in the country attributed to unintentional poisoning per year is estimated. The ICD-10 codes corresponding to the indicator includes X40, X43-X44, X46-X49. The estimates for number of deaths attributed to unintentional poisoning are derived from the WHO Global Health Estimates (GHE), and the corresponding population estimates are derived from the UN World Population Prospects. Mortality rate attributed to unintentional poisoning = $$\frac{Total\ number\ of\ deaths\ attributed\ to\ \text{unintentional poisoning}}{Total\ population} \times 100{,}000$$
Definition	The mortality rate attributed to unintentional poisoning is defined as the number of deaths of unintentional poisonings in a year, divided by the population, and multiplied by 100 000.
Numerator	Total number of deaths attributed to unintentional poisoning
Denominator	Total population
Preferred data sources	Civil registration with complete coverage and medical certification of cause of death; Special studies
Other data sources	Household surveys, special studies, sample or sentinel registration systems, population census, surveillance systems

Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).
Frequency of data collection	Every 2-3 years
Limitations	- incomplete or unusable death registration data - measurement errors
Data type	Rate
Related links	WHO: http://apps.who.int/gho/data/node.wrapper.imr?x-id=2259; http://www.who.int/healthinfo/global_burden_disease/metrics_paf/en/.

2.16. SDG 6.1.1 Proportion of population using safely managed drinking water services (%)

Indicator	Proportion of population using safely managed drinking water services
Rationale	
Mandate (WHA resolution, SDG)	Household surveys and censuses currently provide information on types of basic drinking water sources listed above, and also indicate if sources are on premises. These data sources often have information on the availability of water and increasingly on the quality of water at the household level, through direct testing of drinking water for faecal or chemical contamination. These data will be combined with data on availability and compliance with drinking water quality standards (faecal and chemical) from administrative reporting or regulatory bodies. The WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP) estimates access to basic services for each country, separately in urban and rural areas, by fitting a regression line to a series of data points from household surveys and censuses. This approach was used to report on use of 'improved water' sources for MDG monitoring. The JMP is evaluating the use of alternative statistical estimation methods as more data become available.
Definition	Proportion of population using safely managed drinking water services is currently being measured by the proportion of population using an improved basic drinking water source which is located on premises, available when needed and free of faecal (and priority chemical) contamination. 'Improved' drinking water sources include: piped water into dwelling, yard or plot; public taps or standpipes; boreholes or tubewells; protected dug wells; protected springs; packaged water; delivered water and rainwater.
Numerator	Total estimated number of people using safely managed drinking water service
Denominator	Total population
Preferred data sources	Nationally representative household surveys, censuses, and administrative data. Currently the JMP database holds over 1,700 censuses and surveys. In high-income countries where household surveys or censuses do not always collect information on basic access, data are drawn from administrative records.
Other data sources	

Disaggregation	Disaggregation by place of residence (urban/rural) and socioeconomic status (wealth, affordability) is possible for all countries. Disaggregation by other stratifiers of inequality (subnational, gender, disadvantaged groups, etc.) will be made where data permit. Drinking water services will be disaggregated by service level (including no services, basic, and safely managed services) following the JMP drinking water ladder
Frequency of data collection	Biennial
Limitations	
Data type	Percentage
Related links	JMP website: www.washdata.org. JMP 2017 update and SDG baselines https://washdata.org/report/jmp-2017-report-final Safely managed drinking water thematic report https://washdata.org/report/jmp-2017-tr-smdw WHO Guidelines for Drinking Water Quality: http://www.who.int/water_sanitation_health/dwq/guidelines/en/

2.17. SDG 6.2.1 Proportion of population using (a) safely managed sanitation services and (b) a hand- washing facility with soap and water

Indicator	Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water
Rationale	
Mandate (WHA resolution, SDG)	Household surveys and censuses provide data on use of types of basic sanitation facilities listed above, as well as the presence of handwashing materials in the home. The percentage of the population using safely managed sanitation services is calculated by combining data on the proportion of the population using different types of basic sanitation facilities with estimates of the proportion of faecal waste which is safely disposed in situ or treated off-site.
Definition	The proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water is currently being measured by the proportion of the population using a basic sanitation facility which is not shared with other households and where excreta is safely disposed in situ or treated off-site. 'Improved' sanitation facilities include: flush or pour flush toilets to sewer systems, septic tanks or pit latrines, ventilated improved pit latrines, pit latrines with a slab, and composting toilets. Population with a basic handwashing facility: a device to contain, transport or regulate the flow of water to facilitate handwashing with soap and water in the household. Concepts: Improved sanitation facilities include the following: flush or pour flush toilets to sewer systems, septic tanks or pit latrines, ventilated improved pit latrines, pit latrines with a slab, and composting toilets.

	A handwashing facility with soap and water: a handwashing facility is a device to contain, transport or regulate the flow of water to facilitate handwashing. This indicator is a proxy of actual handwashing practice, which has been found to be more accurate than other proxies such as self-reports of handwashing practices.
Numerator	Total estimated number of people using safely managed sanitation services
Denominator	Total population
Preferred data sources	Nationally representative household surveys, censuses, and administrative data. Currently the JMP database holds over 1,700 surveys and censuses. In high-income countries where household surveys or censuses do not always collect information on basic access, data are drawn from administrative records. Estimates of excreta management will be collected from countries and used to adjust the data on use of basic sanitation facilities as needed. Administrative, population and environmental data can also be combined to estimate safe disposal or transport of excreta, when no country data are available. Data on disposal or treatment of excreta are limited but estimates for safe management of faecal wastes can be calculated based on faecal waste flows associated with the use of different types of basic sanitation facility. Since the handwashing with soap survey questions were standardized in 2009, over 70 DHS and MICS surveys have included the module. JMP published handwashing estimates for 12 countries in its 2014 update, for 54 countries in its 2015 update, and for 70 countries in its 2017 update. The population data used by JMP, including the proportion of the population living in urban and rural areas, are those established by the UN Population Division.
Other data sources	
Disaggregation	Disaggregation by place of residence (urban/rural) and socioeconomic status (wealth, affordability) is possible for all countries. Disaggregation by other stratifies of inequality (subnational, gender, disadvantaged groups, etc.) will be made where data permit. Sanitation services will be disaggregated by service level (including no services, basic, and safely managed services) following the JMP sanitation ladder.
Frequency of data collection	Biennial
Limitations	A framework for measuring faecal waste flows and safety factors has been developed and piloted in 12 countries (World Bank Water and Sanitation Program, 2014), and is being adopted and scaled up within the sanitation sectors. This framework has served as the basis for indicators 6.2.1 and 6.3.1. Data on safe disposal and treatment are not available for all countries. However, sufficient data were available to make global and regional estimates of safely managed sanitation services in 2017. Presence of a handwashing station with soap and water does not guarantee that household members consistently wash hands at key times, but has been accepted as the most suitable proxy. Data were available for 70 countries in 2017.
Data type	Percentage

Related links	www.washdata.org JMP website: www.washdata.org. JMP 2017 update and SDG baselines https://washdata.org/report/jmp-2017-report-final Ram, P., Practical Guidance for Measuring Handwashing Behaviour: 2013 update, World Bank Water Supply and Sanitation Programme, 2013. http://www.wsp.org/sites/wsp.org/files/publications/WSP-Practical-Guidance-Measuring-HandwashingBehavior-2013-Update.pdf"

2.18. SDG 7.1.2 Proportion of population with primary reliance on clean fuels and technology

Indicator	Proportion of population with primary reliance on clean fuels and technology
Rationale	
Mandate (WHA resolution, SDG)	The indicator is calculated as the number of people using clean fuels and technologies divided by total population, expressed as percentage. Household energy use data are routinely collected at the national and sub national levels in most countries using censuses and surveys. Household surveys used include: United States Agency for International Development (USAID)-supported Demographic and Health Surveys (DHS); United Nations Children's Fund (UNICEF)-supported Multiple Indicator Cluster Surveys (MICS); WHO-supported World Health Surveys (WHS); national population and housing censuses and other reliable and nationally representative country surveys.
Definition	The percentage of the population that relies on clean fuels and technologies as the primary source of domestic energy for cooking. "Clean" is defined by the emission rate targets and specific fuel recommendations (i.e. against unprocessed coal and kerosene) included in the normative guidance WHO guidelines for indoor air quality: household fuel combustion.
Numerator	The number of people using clean fuels and technologies for cooking, heating and lighting
Denominator	Total population
Preferred data sources	National survey, population census, household surveys
Other data sources	
Disaggregation	Location (urban/rural)
Frequency of data collection	Annual
Limitations	The indicator uses clean fuels and technologies use as a proxy for indoor air pollution, as it is not currently possible to obtain nationally representative samples of indoor concentrations of criteria pollutants, such as small particles and carbon monoxide. The indicator is based on the main type of fuel used for cooking as cooking occupies the largest share of overall household energy needs. However, many households use more than one type of fuel for cooking and, depending on climatic and geographical conditions, heating with solid fuels can also be a contributor to indoor air pollution levels.

Data type	Percentage
Related links	https://www.who.int/airpollution/data/HAP_exposure_results_final.pdf?ua=1 https://www.who.int/indoorair/publications/burning-opportunities/en/

2.19. SDG 11.6.2 Annual mean levels of fine particulate matter (e.g., PM2.5 and PM10) in cities (population weighted)

Indicator	Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted)
Rationale	
Mandate (WHA resolution, SDG)	Although PM is measured at many thousands of locations throughout the world, the amount of monitors in different geographical areas vary, with some areas having little or no monitoring. In order to produce global estimates at high resolution (0.1° grid-cells), additional data is required. Annual urban mean concentration of PM2.5 is estimated with improved modelling using data integration from satellite remote sensing, population estimates, topography and ground measurements.
Definition	The mean annual concentration of fine suspended particles of less than 2.5 microns in diameters (PM2.5) is a common measure of air pollution. The mean is a population-weighted average for urban population in a country, and is expressed in micrograms per cubic meter [µg/m3].
Numerator	Sum of levels of fine particulate matter in monitored locations
Denominator	Number of monitored locations
Preferred data sources	Special studies
Other data sources	
Disaggregation	
Frequency of data collection	Every 2-3 years
Limitations	Urban/rural data: while the data quality available for urban/rural population is generally good for high-income countries, it can be relatively poor for some low- and middle income areas. Furthermore, the definition of urban/rural may greatly vary by country. Grid-size: The grid size used for the model is 0.1° x 0.1° (10 x 10 km close to the equator, but smaller towards the poles). This resolution may cause limitations when considering local situations. However finer resolutions are planned for future studies. Conversion from PM10: Where measurements of PM2.5 are not available, PM10 measurements are used after conversion to PM2.5 using country or regional conversion factors. Conversion factors range between 0.3-0.8 depending on location. Localized conversion factors are likely to be more accurate but the ability to calculate them relies on localized data being available. The potential for inaccuracies in conversion factors means that model outputs for areas using large numbers of converted values may be less accurate than those based directly on measurements of PM2.5 and extra care should be taken in their interpretation. Model calibration in data-poor areas: The model produces a calibration equation for each country using country level data as a priority, with

	regional data being used to supplement local information for countries without ground monitoring data. It is acknowledged that the estimates for data-poor countries may be relatively imprecise and this imprecision can result in apparently abrupt changes in air pollution levels at borders with data-poor countries. For enhanced accuracy of modelled data it is important that countries continue and/or improve their ground measurements.
Data type	Mean
Related links	www.who.int/gho/phe

2.20. WHA 66.10 Prevalence of obesity (%)

Indicator	Prevalence of obesity
Rationale	
Mandate (WHA resolution, SDG)	Prevalence of obesity = $\frac{Number\ of\ persons\ who\ are\ obese}{Total\ number\ of\ persons\ in\ the\ survey\ that\ were\ measured} \times 100\%$
Definition	For 5-19 years, obesity is defined as body mass index (BMI)-for-age above two standard deviations of the WHO Growth Reference for School-aged Children and Adolescents median. For ages 20 years and older, obesity is defined as BMI of 30 kg/m2 or higher. BMI is calculated by dividing the subject's weight in kilograms by their own height in meters squared.
Numerator	Number of persons who are obese
Denominator	Total number of persons in the survey that were measured
Preferred data sources	Nationally representative population-based household or school-based surveys with height and weight measurements of adults aged 20 years and older and school-age children and adolescents aged 5–19 years. Other sources of data include national nutrition surveillance systems.
Other data sources	Data sets of FAO and UN Statistical office
Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., mother's education, wealth quintile).
Frequency of data collection	Annual or at least every 3-5 years based on survey availability in countries.
Limitations	Survey estimates come with levels of uncertainty due to both sampling and non-sampling error (e.g. measurement technical error, recording error etc.). Another limitation, especially for the school-age children and adolescent age group is the representativeness of the sample.
Data type	Prevalence
Related links	WHO: http://who.int/chp/gshs/en/; http://www.who.int/dietphysicalactivity/childhood/en/

2.21. SDG 3.6.1 Death rate due to road traffic injuries

Indicator	Death rate due to road traffic injuries
Rationale	
Mandate (WHA resolution, SDG)	Our model is based on the quality of data we received. As a health organization, we rely primarily on the submission of vital registration data from countries' Ministries of Health to WHO (through the official channels). These data, on all causes of death, are then analysed by our colleagues in the Health Information Systems department to decide on how good the data are, that is, determining if there is good completeness and coverage of deaths for all causes. We classified the countries on 4 categories or groups namely, Group1: Countries with death registration data (good vital/ death registration data) Group2: Countries with other sources of information on causes of death Group3: Countries with population less than 150 000 Group4: Countries without eligible death registration data.
Definition	Death rate due to road traffic injuries as defined as the number of road traffic fatal injury deaths per 100,000 population.
Numerator	Number of deaths due to road traffic crashes
Denominator	Total population
Preferred data sources	For the road traffic deaths, we have two sources of data. Data from Global Status Report on Road Safety survey and Vital registration or certificate deaths data that WHO receive every year from member states (ministries of health).
Other data sources	
Disaggregation	Types of road users, age, sex, income groups and WHO regions
Frequency of data collection	Biennial
Limitations	There are no vital registration data for all countries to make comparison against the data received on the survey. We published only confidence intervals for countries that have poor completeness of vital registration data. Also, we cannot collect road traffic data every year using this methodology outlined in the Global status report.
Data type	Rate
Related links	http://www.who.int/violence_injury_prevention http://www.who.int/violence_injury_prevention/road_safety_status/2015/en/

2.22. WHA75 (11) Proportion of population aged 15+ with healthy dietary pattern

Indicator	Proportion of population aged 15+ with healthy dietary pattern
Rationale	Noncommunicable diseases (NCDs) such as cardiovascular disease, diabetes, cancer and chronic respiratory diseases are a global crisis, taking the lives of 41 million people prematurely each year, and inflicting daily hardship for those at risk or living with an NCD. According to the Global Burden of Disease (GBD), non-communicable diseases (NCDs) accounted for 63.8% of all Disability-Adjusted Life Years (DALYs), globally in 2019. This global estimate masks the disparity in regions. The regions with the highest burden attributable to NCDs were Europe and the Western Pacific with 83.8% and 82% of all DALYs respectively. Healthy diets are essential to better nutrition, which is related to improved infant, child and maternal health, well-functioning immune systems, safer pregnancy and better birth outcomes, lower risk of non-communicable diseases (NCDs) (such as diabetes, cardiovascular disease, and cancer), and longevity. Globally the risks associated with poor diet accounts for 12.9% of all NCD DALYs, with the Eastern Mediterranean (14.7%) and the Western Pacific region (14.2%) with the greatest risk. WHO diet recommendations are available for several foods, including fruit, vegetables, pulses, whole grains, sugar and salt. The risks linked with these foods account for 96.3% of the total NCD DALYs attributable to diet, if we include sodium, which alone accounts for 24% globally. This ranges from 86.4% in the Americas to 100% in the Eastern Mediterranean Region. Quantitative food consumption data, although preferable to evaluate dietary profiles, are challenging and expensive to collect. Qualitative data, collected through simpler questionnaires will greatly increase the frequency between data collection and allow for more regular monitoring. This dichotomous-response-based indicator is a proxy to measure the healthy diets, based on “uncontested” food groups, aligned with the foods mentioned above. While its nature will not allow to strongly measure the adherence to the WHO recommendations, it will depict countries’ tendances towards healthy diet behaviours, as the proportion of the population’s likelihood to adhere to the WHO diet recommendations. Stratifying the indicator by adequacy (protect) versus moderation (risk) related foods will enhance interpretability and better inform policy implications.
Mandate (WHA resolution, SDG)	WHA57.17 Global strategy on diet, physical activity and health WHA 65.6 Global action plan for the prevention and control of noncommunicable diseases 2013-2020 stablishes NCD targets https://www.who.int/publications/i/item/9789241506236 SDGs 2 and 3 (https://digitallibrary.un.org/record/821651?ln=en):

	• 2.2 By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons • 3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being • 3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease WHA75(11) In 2022, the Seventy-fifth World Health Assembly adopted recommendations for the prevention and management of obesity over the life course and related targets, which were accompanied by an acceleration plan that clarifies how WHO will support Member States in implementing these recommendations.
Definition	Proportion of individuals aged 15+ in the sample consuming ALL of the following: - Any fruit - Any vegetable - Any whole grains, legumes or nuts - Moderate sugar intake (No sugar-sweetened beverages AND not more than one of other sweetened foods) - No ultra-processed salty snack - No processed meat
Numerator	Number of individuals aged 15+ in the sample consuming all of the following: - Any fruit - Any vegetable - Any whole grains or legumes - Moderate sugar intake (No sugar-sweetened beverages AND not more than one of other sweetened foods) - No ultra-processed salty snack - No processed meat
Denominator	Total number of individuals aged 15+ in the sample
Preferred data sources	• Harvard, GAIN and GALLUP Dietary Qualitative Survey (DQQ) • Nationally representative Food Consumption Surveys (24-hour recall individual-level data)
Other data sources	• Household Income and Expenditure Surveys
Disaggregation	• Adequacy (Any fruit & any vegetable & any whole grains, legumes or nuts) • Moderation (No sugar-sweetened beverages & not more than one of other sweetened foods & no ultra-processed salty snack & no processed meats)
Frequency of data collection	• Harvard, GAIN and GALLUP Dietary Qualitative Survey (DQQ) is an ongoing data collection currently in its second round of collection. 56 countries have already conducted DQQ in 2021-2022 and 92 countries expected by the end of 2023 • Food Consumption and Household Income and Expenditure surveys are conducted every 3-5 years in most countries

Limitations	• Although 24-hour recall is an accepted reference method for a population-level dietary assessment, data are prone to measurement error, as are all self-reported dietary assessment methods • Non-quantitative dietary data does not allow the comprehensive assessments of dietary intake of individuals • This dichotomous indicator, while are proxies measuring whether a given individual consumed a diet consistent with some of the WHO healthy diet recommendations with respect to adequacy and moderation, it does not directly measure adequacy levels of intake • The food groups include do not cover all WHO diet guidelines
Data type	Primary Data (Prevalence)
Related links	Healthy Diets Monitoring Initiative: https://www.who.int/initiatives/healthy-diets-monitoring-initiative-(hdmi) WHO Dietary Guidelines https://www.who.int/news-room/fact-sheets/detail/healthy-diet FAO/WHO Global Individual Food Consumption Data Tool (GIFT) - https://www.fao.org/gift-individual-food-consumption/en Harvard, GAIN and GALLUP Dietary Qualitative Survey (DQQ) – https://www.dietquality.org/

2.23. SDG 16.2.1 Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month

Indicator	Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month
Rationale	
Mandate (WHA resolution, SDG)	Number of children aged 1-17 years who are reported to have experienced any physical punishment and/or psychological aggression by caregivers in the past month divided by the total number of children aged 1-17 in the population multiplied by 100
Definition	Proportion of children aged 1-17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month is currently being measured by the Proportion of children aged 1-14 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month.
Numerator	Number of children aged 1-17 years who are reported to have experienced any physical punishment and/or psychological aggression by caregivers in the past month multiplied by 100
Denominator	The total number of children aged 1-17 in the population
Preferred data sources	Household surveys such as UNICEF-supported MICS and DHS that have been collecting data on this indicator in low- and middle-income countries since around 2005. In some countries, such data are also collected through other national household surveys.
Other data sources	
Disaggregation	Sex, age, income, place of residence, geographic location
Frequency of data collection	

Limitations	There is an existing, standardized and validated measurement tool (the Parent-Child version of the Conflict Tactics Scale, or CTSPC) that is widely accepted and has been implemented in a large number of countries, including high-income countries. Definitions of both physical punishment and psychological aggression will need to be very clearly defined for countries but this should not be a problem as there is a wealth of available literature and research on the violent punishment of children and General Comment No.13 on the Convention of the Rights of the Child (CRC) also provides a definition for “corporal” or “physical” punishment as well as "mental violence".
Data type	Percentage
Related links	https://data.unicef.org/topic/child-protection/violence/violent-discipline/

2.24. WHA71 (6) Insufficiently physically active

2.24.a. Prevalence of insufficiently physically active adults

Indicator	Prevalence of insufficiently physically active adults
Rationale	People who are insufficiently physically active have a 20-30% increased risk of all-cause mortality compared to those who engage in at least 150 minutes of moderate-intensity activity per week, or equivalent. Participation in this recommended amount of physical activity is estimated to reduce the risk of ischaemic heart disease by approximately 30%, the risk of diabetes by 27%, and the risk of breast and colon cancer by 21-25%. Additionally, physical activity lowers the risk of stroke, hypertension and depression. It is a key determinant of energy expenditure and thus fundamental to energy balance and weight control.
Mandate (WHA resolution, SDG)	WHA71 (6) (2018). In May 2018 the WHA adopted the Global Action Plan on Physical Activity 2018 – 2030 (GAAPA), which included a target of “a 15% relative reduction in the global prevalence of physical inactivity in adults and in adolescents by 2030”. The proposed indicator is used to track this target.
Definition	"Percentage of adults aged 18+ years not meeting any of the following criteria: – 150 minutes of moderate-intensity physical activity per week – 75 minutes of vigorous-intensity physical activity per week – an equivalent combination of moderate- and vigorous-intensity physical activity accumulating at least 600 MET-minutes* per week Minutes of physical activity can be accumulated over the course of a week. *MET refers to metabolic equivalent. It is the ratio of a person's working metabolic rate relative to the resting metabolic rate. One MET is defined as the energy cost of sitting quietly, and is equivalent to a caloric consumption of 1 kcal/kg/hour. Physical activities are frequently classified by their intensity, using the MET as a reference."
Numerator	Number of respondents where all 3 of the following criteria are true: (1) Weekly minutes* of vigorous activity < 75 mins. (2) Weekly minutes* of moderate activity < 150 mins. (3) Weekly MET-minutes** < 600.

	* Weekly minutes is calculated by multiplying the number of days on which vigorous/moderate is done by the number of minutes of vigorous/moderate activity per day. ** Weekly MET-minutes is calculated by multiplying the weekly minutes of vigorous activity by 8 and the number of weekly minutes of moderate activity by 4 and then adding these two results together.
Denominator	All respondents of the survey aged 18+ years.
Preferred data sources	Population-based (preferably nationally representative) survey
Other data sources	
Disaggregation	Age, Sex, other relevant socio-demographic stratifiers where available
Frequency of data collection	At least every 2 to 5 years
Limitations	Potential limitations include: - bias through self-report, including over-reporting of activity - misunderstanding/ -interpretation of questions and/ or intensity of physical activity - limited validity of survey instruments
Data type	Prevalence
Related links	

2.24.b. Prevalence of insufficiently physically active adolescents

Indicator	Prevalence of insufficiently physically active adolescents
Rationale	Physical activity provides fundamental health benefits for children and youth, including increased physical fitness (both cardiorespiratory fitness and muscular strength), reduced body fatness, favorable cardiovascular and metabolic disease risk profiles, enhanced bone health and reduced symptoms of depression. Available evidence supports the hypothesis that maintaining high amounts and intensities of physical activity starting in childhood and continuing into adult years will enable people to maintain a favorable risk profile and lower rates of morbidity and mortality from cardiovascular disease and diabetes later in life. An overall evaluation of the evidence suggests that important health benefits can be expected to accrue in most children and youth who accumulate 60 or more minutes of moderate to vigorous physical activity daily.
Mandate (WHA resolution, SDG)	WHA71 (6) (2018). In May 2018 the 71st World Health Assembly adopted the Global Action Plan on Physical Activity 2018 – 2030 (GAAPA), which included a target of “a 15% relative reduction in the global prevalence of physical inactivity in adults and in adolescents by 2030”. The proposed indicator is used to track this target.
Definition	Percentage of adolescents participating in less than 60 minutes of moderate to vigorous intensity physical activity daily. Adolescents are defined as 10 – 19 year olds or according to country definition.

Numerator	Number of respondents for whom the number of days per week with <60 minutes of moderate to vigorous intensity activity is <7 days
Denominator	All adolescent respondents of the survey
Preferred data sources	School-based or population-based (preferably nationally representative) survey
Other data sources	
Disaggregation	Age, Sex, other relevant socio-demographic stratifiers where available
Frequency of data collection	At least every 5 years
Limitations	Potential limitations include: - bias through self-report, including over-reporting of activity - misunderstanding/ -interpretation of questions and/ or intensity of physical activity - limited validity of survey instruments
Data type	prevalence
Related links	

2.25. SDG 3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older

Indicator	Age-standardized prevalence of current tobacco use among persons aged 15 years and older
Rationale	
Mandate (WHA resolution, SDG)	Prevalence of current tobacco use = $\frac{Number\ of\ respondents\ aged\ 15+\ years\ currently\ using\ any\ tobacco\ product\ (smoke}{Number\ of\ survey\ respondents\ aged\ 15+\ years} \times 100\%$
Definition	The indicator is defined as the percentage of the population aged 15 years and over who currently use any tobacco product (smoked and/or smokeless tobacco) on a daily or non-daily basis. Tobacco use means use of smoked and/or smokeless tobacco products. "Current use" means use within the previous 30 days at the time of the survey, whether daily or non-daily use. Tobacco products means products entirely or partly made of the leaf tobacco as raw material intended for human consumption through smoking, sucking, chewing or sniffing. "Smoked tobacco products" include cigarettes, cigarillos, cigars, cheroots, bidis, pipes, shisha (water pipes), roll-your-own tobacco, kretek and any other form of tobacco that is consumed by smoking.

	"Smokeless tobacco product" includes moist snuff, creamy snuff, dry snuff, plug, dissolvables, gul, loose leaf, red tooth powder, snus, chimo, gutkha, khaini, gudakhu, zarda, quiwam, dohra, tuibur, nasway, naas, naswar, shammah, toombak, paan (betel quid with tobacco), iq'mik, mishri, tapkeer, tombol and any other tobacco product that consumed by sniffing, holding in the mouth or chewing.
Numerator	Number of current tobacco users aged 15+ years. "Current users" includes both daily and non-daily users and smoked or smokeless tobacco.
Denominator	All respondents of the survey aged 15+ years.
Preferred data sources	Population-based (preferably nationally representative) survey.
Other data sources	
Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).
Frequency of data collection	Annual or at least every 5 years
Limitations	- Bias through self-report, including under-reporting of tobacco use - Misunderstanding/ -interpretation of questions - Limited validity of survey instruments - Representativeness of the sample Raw data collected through nationally representative population-based surveys in the countries are used to calculate comparable estimates for this indicator. Information from subnational surveys are not used. In some countries, all tobacco use and tobacco smoking may be equivalent, but for many countries where other forms of tobacco are also being consumed, smoking rates will be lower than tobacco use rates to some degree.
Data type	Prevalence
Related links	WHO: http://www.who.int/tobacco/surveillance/survey/gats/en/; http://www.who.int/chp/steps/en/index.html.

2.26. WHA 66.10 Prevalence of raised blood pressure in adults aged ≥18 years

Indicator	Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure of >140 mmHg and/or diastolic blood pressure >90 mmHg) and mean systolic blood pressure
Rationale	
Mandate (WHA resolution, SDG)	Prevalence of raised blood pressure

Definition	
Numerator	(Number of respondents aged 18+years with systolic blood pressure ≥140 mmHg or diastolic blood pressure ≥90 mmHg)/(Number of survey respondents aged 18+years)×100%
Denominator	
Preferred data sources	
Other data sources	Systolic blood pressure ≥140 and/or diastolic blood pressure ≥90 among persons aged 18+ years.
Disaggregation	Number of respondents with systolic blood pressure ≥140mmHg or diastolic blood pressure ≥90mmHg. Ideally three blood pressure measurements should be taken and the average systolic and diastolic readings of the second and third measures should be used in this calculation.
Frequency of data collection	All respondents of the survey aged 18+ years.
Limitations	Population-based (preferably nationally representative) survey in which blood pressure was measured, not self-reported.
Data type	
Related links	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).

2.27. SDG 3.5.2 Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol

Indicator	Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol
Rationale	
Mandate (WHA resolution, SDG)	Recorded alcohol per capita (15+) consumption of pure alcohol is calculated as the sum of beverage-specific alcohol consumption of pure alcohol (beer, wine, spirits, other) based on data collection by WHO from different sources. The first priority in the decision tree is given to government statistics ; second are country-specific data in the public domain from data providers supported by the alcohol industry based on results of the field work at country level or data from the International Organisation of Vine and Wine (OIV); third is the Food and Agriculture Organization of the United Nations' statistical database (FAOSTAT); and fourth is data from industry-supported data in the public domain based on desk reviews. To make the conversion into litres of pure alcohol, the alcohol content (% alcohol by volume) is as follows: Beer (barley beer 5%), Wine (grape wine 12%; must of grape 9%, vermouth 16%), Spirits (distilled spirits 40%; spirit-like 30%), and Other (sorghum, millet, maize beers 5%; cider 5%; fortified wine 17% and 18%; fermented wheat and fermented rice 9%; other fermented beverages 9%). Unrecorded alcohol consumption refers to alcohol which is not taxed and is outside the usual system of governmental control, such as home or informally produced alcohol (legal or illegal), smuggled alcohol, surrogate alcohol (which is alcohol not intended for human consumption), or alcohol obtained through cross-border shopping (which is recorded in a

	different jurisdiction). Unrecorded alcohol consumption was estimated as a percentage of total alcohol consumption. Country-level proportions of unrecorded alcohol consumption were estimated using a regression analysis with input data collected by WHO from different sources. Data sources included expert judgements from a WHO survey, nominal expert group Delphi surveys, and WHO STEPS surveys. Tourist consumption takes into consideration alcohol purchased and consumed by tourists to a country and alcohol purchased and consumed when people are visiting countries other than their home country. For total alcohol per capita consumption by sex, the proportion of alcohol consumed by men versus women (from surveys) and the demographics (from UN population data) were used. Population data came from the UN World Population Prospects. Total alcohol per capita consumption = $\frac{Sum\ of\ recorded\ and\ unrecorded\ alcohol\ consumed\ in\ a\ population\ during\ a\ calendear\ year}{Midyear\ resident\ population\ aged\ 15{+}years\ in\ the\ same\ calendar\ year}$
Definition	Consumption of pure alcohol (ethanol) in litres per person aged 15+ years during one calendar year.
Numerator	Sum of recorded and unrecorded alcohol consumed in a population during a calendar year, adjusted for tourist consumption, in litres.
Denominator	Midyear resident population aged 15+ for the same calendar year.
Preferred data sources	Administrative reporting systems for recorded APC and survey data for unrecorded APC. The priority of data sources for recorded alcohol per capita consumption should be given to government statistics on sales/taxation of alcoholic beverages during a calendar year or data on production, export and import of alcohol in different beverage categories. For countries, where the governmental sales or production data is not available, the preferred data source would be country specific and publicly available data from the private sector, including alcohol producers or country specific data from the Food and Agriculture Organization of the United Nations statistical database (FAOSTAT), which may also include the estimates of unrecorded alcohol consumption. Data sources for unrecorded alcohol consumption include survey data, customs or police data, and expert opinions.
Other data sources	Data sets of FAO and UN Statistical office
Disaggregation	By age, sex.
Frequency of data collection	Annual
Limitations	- gaps in administrative records of sales or production, import, export of alcoholic beverages - surveys may be subject to under-reporting of alcohol consumption, - mis-interpretation of questions and/or size of a standard drink, or associated with validity of the survey instruments
Data type	Volume (litres per capita)
Related links	WHO: http://apps.who.int/gho/data/node.gisah.GISAH?showonly=GISAH

2.28. Proportion of a country's population living in a Healthy Municipality, City or Region (%)

Indicator	Proportion of country's population living in a Healthy Municipality, City or Region (%)
Rationale	The WHO Healthy Cities programme is guided by a set of attributes, values and principles. These are described in this document Healthy Cities: Effective Approach to a Rapidly Changing World. It provides a platform and mechanism for engaging and working with national/local/municipal governments and communities on issues impacting health and well-being. Countries increasingly include Healthy Cities approaches in national legislation, health policies and plans. Political statements, charters and declarations have been adopted by mayors and other local political leaders, expressing commitment to achieve the Healthy Cities values, principles and goals. Example of key issues that should be addressed by Healthy Cities are: addressing the social determinants of health and health inequalities; creating supportive environments for health for all; investing in creating healthy places; understanding the specificity of the urban and built environment and its positive and negative impacts on health and well-being. From WHO Health Promotion Glossary of Terms 2021: A healthy city is not necessarily one that has achieved a particular health status. It is a city that puts health high on the political and social agenda and builds a strong movement for public health at the local level with health equity at its centre. The healthy cities approach recognizes the need to work in collaboration across public, private, voluntary and community sector organizations. This way of working prioritizes policies that: create co-benefits between health and well-being and other city policies; support social inclusion by harnessing the knowledge, skills and priorities of cities' diverse populations through strong community engagement; create healthy built and natural environments; and re-orient health and social services to optimize fair access, placing people and communities at the centre.
Mandate (WHA resolution, SDG)	1. WHA Decision A76(22): Achieving well-being: a global framework for integrating well-being into public health utilizing a health promotion approach 2. AFR: Resolution AFR/RC73/R4 Regional multisectoral strategy to promote health and well-being, 2023-2030 in the WHO African Region (implicit) 3. AMR: Is the Technical Secretariat of the Healthy Municipalities, Cities and Communities Movement in the Region of the Americas 4. EMR: Eastern Mediterranean Region's Vision 2023 5. EUR: European Programme of Work 2020-2025 6. SEAR: Resolution SEA/RC72/R4 on the South-East Asia Regional Plan of Action for the WHO Global Strategy on Health, Environment and Climate Change 2020-2030 WPR: WPR/RC61.R6 on Healthy Settings and WPR/RC66.R5 on Urban Health
Definition	Percentage of the country's population living in a municipality, city or region that is a registered member of the WHO Regional Networks for Healthy Municipalities, Healthy Cities or Regions for Health.

Numerator	Population of the municipality, city or region that is a current member of the WHO Regional Networks for Healthy Municipalities, Healthy Cities or Regions for Health
Denominator	Population of the countries that have a municipality, city or region that is a current member of the WHO Regional Networks for Healthy Municipalities, Healthy Cities or Regions for Health
Preferred data sources	Numerator will be through completion of data collection form by WHO Regional Offices: • Healthy Municipalities, Cities and Communities Movement - PAHO/WHO | Pan American Health Organization • WHO European Healthy Cities Network • Regions for Health Network (RHN) (who.int) • Healthy Cities Network - UGHW • Alliance for Healthy Cities (alliance-healthycities.com) • About (who.int) Denominator will be using data from World Population Prospects of UN DESA.
Other data sources	
Disaggregation	• WHO Region • Municipality, city or region
Frequency of data collection	Every two years (2024, 2026, 2028)
Limitations	• There may be networks of municipalities and cities that are not part of a regional network and not captured. • Membership can change year to year. • Network membership may not mean concrete actions are undertaken.
Data type	Proportion (%)
Related links	

2.29. Proportion of countries with national-level mechanisms or platforms for societal dialogue for health (%)

Indicator	Proportion of countries with national-level mechanisms or platforms for societal dialogue for health (%)
Rationale	Enabling people to address their issues of concern that affect their health and well-being requires national and local mechanisms for dialogue to influence policy and design responsive programs. National platforms for societal dialogue provide opportunities for creating awareness of concerns that affect health and well-being, for enabling common understanding, negotiating, influencing policies, informing actions, and strengthening responsiveness of health systems. This can be achieved through a bottom-up and top-down approach that bridges the gap between policy-makers' priorities and needs of communities through direct participation of societies, their representatives or committees, or elected citizens in decision-making processes.
Mandate	The mandate is derived from the Sustainable Development Goals (SDGs) 3 and 11; the Alma-Ata Declaration (1978), the Declaration of Astana on Primary Health Care (2018), and the

(WHA resolution, SDG)	WHA Decision A76(22): Well-being placing health promotion/community engagement at the center of social development towards UHC.
Definition	Societal dialogue is a process that brings people and decision-makers together and involves communication, negotiation, and collaboration among representatives of societies, elected citizens, and the public at large. The focus of this indicator is on national-level institutionalized mechanisms that may be accompanied by a legal framework and is led by the central government, and may be directly with the population, through communities or through civil society to inform policy-making or decision-making on health matters. The following are examples of mechanisms for societal dialogue: 1. Participatory spaces (e.g. citizen assemblies, forums, public hearings, town hall meetings) 2. Participatory budgeting systems 3. Public consultations (e.g. through digital mediums) 4. Policy dialogues, consultative meetings, stakeholder consultations and focus groups 5. Citizen panels, citizen juries, deliberative polls, scenario workshops 6. Institutionalized mechanisms with a legal framework (e.g. health council, health committees, district committees, citizen advisory boards, representation in steering groups)
Numerator	Number of countries with mechanisms or platforms for societal dialogue for health at the national level
Denominator	Total number of countries/Member States (194)
Preferred data sources	Member States through a health promotion survey exercise
Other data sources	
Disaggregation	By country
Frequency of data collection	2024 and 2027
Limitations	There are many forms of public engagement. Clear guidance on the indicator description will be provided.
Data type	Proportion (%)
Related links	Policy dialogue: What it is and how it can contribute to evidence-informed decision-making Community engagement: a health promotion guide for universal health coverage in the hands of the people (who.int) WHO framework for meaningful engagement Evaluation of the WHO Community Engagement research initiative Social participation for Universal Health Coverage Technical paper Minimum Quality Standards and Indicators for Community Engagement

3. PROVIDE HEALTH

Table 2. Overview of 58 outcome indicators

SDG / WHA	Outcome Indicators
SDG 3.8.1	Coverage of essential health services
WHA72.2	PHC-oriented governance & policy composite
WHA72.2	*Existence of national strategy, policies and plans oriented to PHC and UHC meeting criteria*
WHA72.2	*Existence of health sector coordination mechanisms for multistakeholder participation, including communities, civil society and the private sector (meeting criteria)*
WHA72.2	Institutional capacity for essential public health functions (meeting criteria)
WHA72.2	Health facility density & distribution (by type & level of care)
WHA72.2	Integrated services and models of care composite indicator
WHA72.2	*Package of services for UHC is defined*
WHA72.2	*Roles and functions of service delivery platforms are defined*
WHA72.2	*Existence of an empanelment system*
WHA72.2	*Existence of system to promote first contact accessibility*
WHA72.2	*Existence of systems for referral, counter-referral and emergency transfer*
WHA72.2	*Multi-disciplinary team-based service delivery*
WHA72.2	Service utilization rate (primary care visits, emergency care visits, hospital admissions)
WHA72.2	% of population reporting perceived barriers to care
WHA72.2	Service availability & readiness index (% facilities with service availability, capacities & readiness (WASH, IPC, availability of meds, vaccines, diagnostics, priority medical devices, priority assistive products) to deliver UHC package)*
WHA72.2	*Service readiness (% of facilities with service capacities & readiness to deliver UHC package)*
WHA72.2	*Availability of essential medicines as per national list, by type/level*
WHA72.2	*Availability of vaccines as per national list, by type/level*
WHA72.2	*Availability of essential in vitro diagnostics as per national list, by type/level*
WHA72.2	*Availability of priority medical devices as per national list, by type/level*
WHA72.2	*Availability of priority assistive products as per national list, by type/level*
	Gender equality advanced in and through health
WHA72.2	People-centredness of primary care (patient experiences, perceptions, trust)
SDG 3.c.1	Health worker density and distribution (by occupation, subnational, facility ownership, facility type, age, sex)
WHA64.9	Government domestic spending on health (1) as a share of general government expenditure, and (2) per capita
	Access to health products index
WHA67.20	Improved regulatory systems for health products (medicines, vaccines, medical devices including diagnostics)
WHA 64.9	Government domestic spending on PHC as a share of total PHC expenditure
	Existence of national digital health strategy, costed implementation plan, legal frameworks to support safe, secure and responsible use of digital technologies for health
	SCORE index
WHA 71.1	% of health facilities using point of service digital tools that can exchange data through use of national registry and directory services
SDG 3.3.1 / WHA 75.20	Prevalence of active syphilis in individuals 15 to 49 years of age (%)
SDG 3.3.1 / WHA 75.20	Number of new HIV infections per 1,000 uninfected population, by sex, age, and key populations

SDG / WHA	Outcome Indicators
SDG 3.3.2	Tuberculosis incidence per 100,000 population
SDG 3.3.3	Malaria incidence per 1,000 population
	Vector-borne disease incidence
SDG 3.3.4/ WHA 75.20	Hepatitis B incidence per 100,000 population
WHA 75.20	Hepatitis C incidence per 100,000 population
SDG 3.3.5	Number of people requiring interventions against neglected tropical diseases
SDG 3.4.1	Mortality rate attributed to cardiovascular disease, cancer, diabetes, or chronic respiratory disease
WHA75 (11)	Prevalence of controlled diabetes in adults aged 30-79 years
SDG 3.4.2	Suicide mortality rate
SDG 3.5.1	Coverage of treatment interventions (pharmacological, psychosocial, and rehabilitation and aftercare services) for substance use disorders
WHA72/2019/ REC/1	Service coverage for people with mental health and neurological conditions
SDG 3.d.2	Percentage of bloodstream infections due to selected antimicrobial-resistant organisms
WHA 74 (12)	Effective refractive error coverage (eREC)
WHA66 (10)	Prevalence of controlled hypertension, among adults aged 30-79 years
WHA68.7	Patterns of antibiotic consumption at national level
WHA73 (2)	Cervical cancer screening coverage in women aged 30 - 49 years, at least once in lifetime
WHA 67.10	Postnatal Care Coverage (PNC)
WHA 67.10	*PNC Newborn*
WHA 67.10	*PNC woman*
SDG 3.1.1	Maternal mortality ratio
SDG 3.1.2	Proportion of births attended by skilled health personnel
SDG 5.6.1	Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care
SDG 5.2.1	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual, or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
WHA 67.15	Proportion of health facilities that provide comprehensive post-rape care as per WHO guidelines
SDG 3.2.1	Under-five mortality rate
SDG 3.2.2	Neonatal mortality rate
WHA 67.10	Stillbirth rate (per 1000 total births)
	Obstetric and gynaecological admissions owing to abortion
SDG 3.7.1	Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods
SDG 3.7.2	Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group
SDG 3.b.1	Proportion of the target population covered by all vaccines included in their national programme
SDG 4.2.1	Proportion of children aged 24–59 months who are developmentally on track in health, learning, and psychosocial well-being, by sex
SDG 5.6.2	Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education
	Treatment of acutely malnourished children
WHA 74.5	Proportion of population entitled to essential oral health interventions as part of the health benefit packages of the largest government health financing schemes
WHA 73 (12)	Percentage of older people receiving long-term care in residential care facilities or at home
SDG 5.3.2	Proportion of girls and women aged 15 – 49 who have undergone female genital mutilation

SDG / WHA	Outcome Indicators
SDG 3.8.2	Proportion of population with large household expenditures on health as a share of total household expenditure or income
	Incidence of catastrophic out-of-pocket health spending (SDG indicator 3.8.2 and regional definitions where available) (SDG indicator 3.8.2)
	Impoverishing out-of-pocket health spending (related to SDG indicator 1.1.1 and regional definitions where available)
WHA64.9	Out-of-pocket payments as a share of current spending on health

3.1. SDG 3.8.1 Coverage of essential health services

Indicator	Coverage of essential health services
Rationale	
Mandate (WHA resolution, SDG)	Coverage of essential health services [SDG 3.8.1] The index is computed with geometric means, based on the methods used for the Human Development Index. The calculation of the 3.8.1 indicator requires first preparing the 14 tracer indicators so that they can be combined into the index, and then computing the index from those values. The 14 tracer indicators are first all placed on the same scale, with 0 being the lowest value and 100 being the optimal value. For most indicators, this scale is the natural scale of measurement, e.g., the percentage of infants who have been immunized ranges from 0 to 100 percent. However, for a few indicators additional rescaling is required to obtain appropriate values from 0 to 100, as follows: • Rescaling based on a non-zero minimum to obtain finer resolution (this "stretches" the distribution across countries): prevalence of non-raised blood pressure and prevalence of nonuse of tobacco are both rescaled using a minimum value of 50%. rescaled value = (X-50)/(100-50)*100 • Rescaling for a continuous measure: mean fasting plasma glucose, which is a continuous measure (units of mmol/L), is converted to a scale of 0 to 100 using the minimum theoretical biological risk (5.1 mmol/L) and observed maximum across countries (7.1 mmol/L). rescaled value = (7.1 - original value)/(7.1-5.1)*100 Note that in countries with, the tracer indicator for use of insecticide-treated nets is dropped from the calculation. • Maximum thresholds for rate indicators: hospital bed density and health workforce density are both capped at maximum thresholds, and values above this threshold are held constant at 100. These thresholds are based on minimum values observed across OECD countries. rescaled hospital beds per 10,000 = minimum(100, original value / 18*100) rescaled physicians per 1,000 = minimum(100, original value / 0.9*100) rescaled psychiatrists per 100,000 = minimum(100, original value / 1*100) rescaled surgeons per 100,000 = minimum(100, original value / 14*100) Once all tracer indicator values are on a scale of 0 to 100, geometric means are computed within each of the four health service areas, and then a geometric mean is taken of those four values. If the value of a tracer indicator happens to be zero, it is set to 1 (out of 100) before computing the geometric mean.
Definition	Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population). The indicator is an index reported on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage.

Numerator	
Denominator	
Preferred data sources	Many of the tracer indicators of health service coverage are measured by household surveys. However, administrative data, facility data, facility surveys, and sentinel surveillance systems are utilized for certain indicators. Each indicator has different data sources.
Other data sources	
Disaggregation	Geographic location, household wealth. Equity is central to the definition of UHC, and therefore the UHC service coverage index should be used to communicate information about inequalities in service coverage within countries. This can be done by presenting the index separately for the national population vs disadvantaged populations to highlight differences between them.
Frequency of data collection	Data collection varies from every 1 to 5 years across tracer indicators. The UHC SCI tracers are compiled and aggregated biannually.
Limitations	The tracer indicators are meant to be indicative of service coverage, not a complete or exhaustive list of health services and interventions that are required for universal health coverage. The 14 tracer indicators were selected because they are well-established, with available data widely reported by countries (or expected to become widely available soon). Therefore, the index can be computed with existing data sources and does not require initiating new data collection efforts solely to inform the index.
Data type	Index (0-100)
Related links	https://unstats.un.org/sdgs/metadata/files/Metadata-03-08-01.pdf. Individual tracer indicators are available here: http://www.who.int/healthinfo/universal_health_coverage/UHC_Tracer_Indicators_Metadata.pdf

3.2. WHA72.2 PHC-oriented governance & policy composite

3.2.a. Existence of national strategy, policies and plans oriented to PHC and UHC meeting criteria

Indicator	Existence of National strategy, policies and plans oriented to PHC and UHC meeting criteria
Rationale	The development of sound national and subnational health policies, strategies and plans (NHPSP) through intersectoral (whole-of-government) and intersectoral inclusive policy dialogue with all health stakeholders (whole-of-society) are necessary to address common challenges to health agendas, including: the under-prioritization of health, funding inconsistency and the lack of predictability of both domestic and external resources for health; budget underspending; and misallocation of resources. They must be well prioritized and reflect the needs and the demand for health services, with resource allocation orientated toward PHC and UHC objectives. They need to clearly specify health sector goals and be anchored in strong political agreements to improve consistency and predictability. NHPSPs must be well translated into relevant legal instruments, operational plans and budgets that

	will allow for full implementation. They also need to be well monitored and transparently evaluated for increased accountability and transparency.
Mandate (WHA resolution, SDG)	WHA 72.2
Definition	The country has a national health sector policy, strategy and plan oriented to PHC and UHC based on the following attributes: • Based on sound evidence-based analysis of the health situation, including quantitative and qualitative data • Demonstrates that it is comprehensive, coherent and well-balanced (e.g., NCD, CD, MCH, HSS) • Has been developed/revised within the past five years in line with the health policy planning cycle • Demonstrates clear priorities, objectives, targets and indicators that prioritize PHC for UHC allowing for regular monitoring and evaluation • Is developed and reviewed through a regular and transparent system of review of the strategy/plan with broad involvement of key stakeholders, including other government ministries/institutions, donors, international agencies, civil society, communities, private sector, etc.) • Is accompanied by an effective, continued and inclusive government-led mechanism for governance, coordination and accountability for implementation of the national health strategy /plan • Promotes the delivery of integrated health services with an emphasis on primary care and essential public health functions at both facility and community level, inclusive of private health entities • Includes a section on addressing the broader determinants of health, with links to other sectors • Includes strategic actions to promote and empower individuals and communities through social participation and community engagement approaches in decision-making processes and the delivery of services to improve health equity for the most marginalised and vulnerable populations • Identifies specifically the legal and institutional arrangements and policy mechanisms needed to implement the NHPSP as part of strategic priorities/action points • Is translated into operational plans and budgets including how resources will be deployed to achieve outcomes and allocated to subnational level and non-state actors The attribute score attained by a country divided by the total attribute score possible (%) is interpreted as progress along a maturity scale (from emerging/nascent maturity levels at the lower end of the scale to mature/sustainable levels at the higher end of the maturity scale) .
Numerator	Attribute score attained
Denominator	Total attribute score possible

Preferred data sources	Qualitative assessment based on key informant(s) and/or desk review of country documents, including national health strategic plans, PHC-specific plans, national health annual operational plans and budgets, national development plans and policy and legal frameworks.
Other data sources	
Disaggregation	Not applicable
Frequency of data collection	Biennial
Limitations	
Data type	Percent (%)
Further information and related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020 (https://www.who.int/publications/i/ item/9789240017832, accessed 17 August 2021). Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/250221, accessed 23 August 2021). 2.World Health Organization. Joint Assessment of National Health Strategies and Plans (JANS): Joint Assessment Tool, Frequently Asked Questions, Quality Assurance Checklist, 2014. Geneva: World Health Organization; 2015. (https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Tools/JANS/JANS_2014_English_WEB__1_.pdf, accessed 16 August 2021).

3.2.b. Existence of health sector coordination mechanisms for multistakeholder participation, including communities, civil society and the private sector (meeting criteria)

Indicator	Existence of health sector coordination mechanisms for multistakeholder participation, including communities and civil society (meeting criteria)
Rationale	A key role of the Ministry of Health is to plan, initiate, coordinate and oversee the priority-setting process, where relevant, through health sector coordination mechanisms. Policymakers must thus lead the process, ensure broad and meaningful stakeholder participation, ensure that the priorities that are set reflect stakeholder input in a balanced way, and be held accountable for the results. The process must be transparent, with clear roles and responsibilities, especially when it comes to evaluating and discussing evidence from different angles and viewpoints.
Mandate (WHA resolution, SDG)	WHA 72.2

Definition	A national health sector coordination mechanism, possibly complemented by sub-topic coordination mechanisms, exists meeting the following criteria: • Responsible for coordinating, monitoring and implementing health-, PHC and/or UHC strategies and policies within the national health sector policy, strategies and plans • The coordination mechanism promotes bottom-up planning, monitoring and evaluation processes with all relevant stakeholders at sub-national and local levels • Participation includes consultation with a broad range of stakeholders, including: o Other government ministries and institutions o Local authorities o Health insurance bodies and other regulatory and supervisory authorities o Parliamentarians, members of the parliamentary health committee o Academia and research institutes o Provider organizations/associations o Health worker associations, patient group o Civil society organizations, community representatives, patient and advocacy groups, o Private sector o UN agencies and other international organisations operating within the national context • The coordination mechanism ensures meaningful participation from communities and civil society to influence debates • The coordination mechanism demonstrates transparency and accountability for the range of health activities defined by national health policies, strategies and plans • The coordination mechanism/authority has the relevant legal/institutional basis to operate in the most efficient and transparent, with clear mandates, roles and responsibilities, especially when it comes to managing potential conflict-of-interest situations • The coordination mechanism/authority is adequately capacitated, including sufficient budget and staff The mandate includes coordination of activities within the public sector as well as oversight and regulation of the private sector where feasible. The attribute score attained by country divided by the total attribute score possible (%) is interpreted as progress along a maturity scale (from emerging/nascent maturity levels at the lower end of the scale to mature/sustainable levels at the higher end of the maturity scale).
Numerator	Attribute score attained
Denominator	Total attribute score possible
Preferred data sources	Qualitative assessment based on interview with key informant and /or desk review of country documents.

Other data sources	
Disaggregation	Not applicable
Frequency of data collection	Biennial
Limitations	
Data type	Percent (%)
Related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. Primary Health Care Performance Initiative (PHCPI). Primary health care progression model (https://improvingphc.org/primary-health-care-progression-model, accessed 16 August 2021). Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020 (https://www.who.int/publications/i/item/9789240017832, accessed 17 August 2021). World Health Organization. Voice, agency, empowerment - handbook on social participation for universal health coverage. Geneva, World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240027794, accessed 29 January 2024)

3.3. WHA72.2 Institutional capacity for essential public health functions (meeting criteria)

Indicator	Institutional capacity for essential public health function (meeting criteria)
Rationale	Essential public health functions represent the spectrum of competences and actions that are required to reach the central objective of public health — improving the health of populations. Providing and maintaining essential public health functions (EPHFs) is a cornerstone for public health and resilient systems. The COVID-19 pandemic has exposed weaknesses in the public health capacities necessary for resilient health systems. It is important to have a dedicated national entity or structure (e.g., standalone national public health institute, semi-autonomous institution under a national health authority, department within the MoH, network of agencies with the responsibility to carry out public health functions collectively, etc.) with a clear mandate for coordinating the planning and delivery of essential public health functions in the country. Without a dedicated responsible entity(ies), these functions will not be carried out, to the detriment of public health.
Mandate (WHA resolution, SDG)	WHA 72.2

Definition	There is a dedicated national entity (e.g. standalone national public health institute (NPHI), semi-autonomous institution under a national health authority, department within the Ministry of Health, network of agencies with the responsibility to carry out public health functions collectively, etc.) with a clear mandate for coordinating the planning and delivery of essential public health functions in the country and has the following attributes: • The national entity develops policies and interventions that address the country's public health problems • The national entity is a public institution operating as part of the government or with the concurrence of the government • The national entity is the main source of technical and scientific information of the Ministry of Health, lawmakers and other parts of government • The national entity has adequate human and financial resources to carry out its core functions • The national entity has adequate infrastructure support (computer, communications, access to laboratories) • The national entity coordinates activities with other national agencies at national and subnational level • The national entity has a defined workplan with a responsibility to carry out the following public health functions: o Monitoring and evaluation of health status, service utilisation, and surveillance of risk factors and threats to health o Public health emergency management o Assuring quality and access to health services, health protection, including environmental occupational, food safety and other hazards o Health promotion and action to address social determinants and health inequity, including through community engagement o Disease prevention, including early detection of illness o Community engagement for advocacy and social mobilization for health o Advancing public health research to inform policy and practice o Assuring effective health governance, regulation and public health legislation o Supporting efficient and effective health systems planning, financing, and management for population health o Ensuring adequate quality and quantity of public health workforce o Ensuring equitable access to and rational use of essential medicines and other health technologies The attribute score attained by country divided by the total attribute score possible (%) is interpreted as progress along a maturity scale (from emerging/nascent maturity levels at the lower end of the scale to mature/sustainable levels at the higher end of the maturity scale).
Numerator	Attribute score attained
Denominator	Total attribute score possible

Preferred data sources	Qualitative assessment based on interview with key informant and/or desk review of country documents, e.g., public health policies, national public health act, etc.
Other data sources	
Disaggregation	Not applicable
Frequency of data collection	Biennial
Limitations	
Data type	Percent (%)
Related links	International Association of National Public Health Institutes (IANPHI) Framework for the Creation and Development of National Public Health Institutes, IANPHI 2007) World Health Organization. Essential public health functions, health systems and health security: developing conceptual clarity and a WHO roadmap for action. Geneva: World Health Organization; 2018. (https://apps.who.int/iris/handle/10665/272597, accessed 17 August 2021). World Health Organization. Primary health care: closing the gap between public health and primary care through integration. Geneva; World Health Organization; 2018. (https://apps.who.int/iris/handle/10665/326458, accessed 30 August 2021). Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO.

3.4. WHA72.2 Health facility density & distribution (by type & level of care)

Indicator	Health facility density and distribution (by type and level of care)
Rationale	Provides an idea of geographic accessibility to health services. Availability of health facilities, especially facilities that provide primary care services is critical for achieving UHC. This indicator is also a key measure of equity as it demonstrates the levels of physical access to health services.
Mandate (WHA resolution, SDG)	WHA 72.2
Definition	Total number of health facilities (including primary care facilities) per 10 000 population, disaggregated by managing authority.
Numerator	Number of facilities in public and private sectors

Denominator	Total population
Preferred data sources	Routine facility information system – facility database/master facility list, geospatial modelling
Other data sources	National population-based survey
Disaggregation	Facility type (as relevant to context), including, primary care facilities (e.g., GP practices, health centres, community health posts), specialty outpatient facilities (including polyclinics), first-level hospitals, second-level hospitals, specialty, hospitals, long-term care facilities, continuing care facilities, traditional medicine, etc.; Managing authority (public, private); Sub-National; Residence area type
Frequency of data collection	Annual
Limitations	
Data type	Ratio (reported as per 10 000 population)
Related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. 2018 Global reference list of 100 core health indicators (plus health-related SDGs). Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf?sequence=1&isAllowed=y, accessed 16 August 2021).

3.5. WHA72.2 Integrated services and models of care composite indicator

3.5.a. Package of services for UHC is defined

Indicator	Package of services for UHC is defined
Rationale	The concept of PHC is rooted in a whole-of-society approach that ensures meeting population health needs throughout the life course but also addresses different health service needs such as prevention and promotion of health services. To meet this broad requirement, countries must formulate services for UHC that addresses these health needs. The exercise of specifying a UHC package is a value-laden process, requiring decision-makers and system stewards to establish a strategic policy position and equitable framework for protected access to health services when faced with competing priorities. The services for UHC should be defined based on a transparent process, based on explicit criteria, informed by local service delivery capacity and engage a wide range of relevant stakeholders.

Mandate (WHA resolution, SDG)	WHA 72.2
Definition	There is a package of services for universal health coverage which defines a desired set of health interventions to de delivered to a population that meets following attributes: • Package includes the following kinds of interventions: o Promotion and prevention o Self-care services o Emergency and critical care o Surgical interventions o Rehabilitation o Palliative care • Package includes the following categories of services (for specific services, see https://uhcc.who.int): o Foundations of care (includes common signs and symptoms in primary care-as well as core continuity and coordination services (see https://uhcc.who.int/, "Foundations of care" section) o Reproductive and sexual health o Growth, development and ageing (Includes interventions on healthy development, nutrition, physical activity, and sleep) o Communicable diseases o Non-communicable diseases o Mental health, neurological and substance use disorders o Violence and injury • Services in the package are mapped to specific service delivery platforms • Selection of services in the package addresses disease burden and other national priorities including risk factor profiles and projections • The package includes and designates key services needed for readiness to respond to emergency events for which the country is at risk • The process for development of the service package involves a wide range of stakeholders (such as public and private service practitioners, subnational health service managers, health workers, people requiring health services and their families, community leaders and donor agencies) • There is a mechanism for routine revision of the package (to ensure it meets changing population health needs) as part of national planning processes. The attribute score attained by country divided by the total attribute score possible (%) is interpreted as progress along a maturity scale (from emerging/nascent maturity levels at the lower end of the scale to mature/sustainable levels at the higher end of the maturity scale). **Key terms:** A package of services for universal health coverage ("UHC package") is a set of health interventions to which a population is guaranteed access through a range of government assurance mechanisms, such as direct financing or direct provision for

	some groups, mandatory contribution and pre-payment schemes, and regulatory structures that constrain what public and private entities must pay for or deliver.
Numerator	Attributes score attained
Denominator	Total attribute score possible
Preferred data sources	Qualitative/key informant survey and/or desk review with verification from key country documents
Other data sources	
Disaggregation	Not applicable
Frequency of data collection	Biennial
Limitations	
Data type	Percent (%)
Related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. World Health Organization and United Nations Children's Fund. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240017832, accessed 17 August 2021). World Health Organization. UHC Compendium (https://www.who.int/universal-health-coverage/compendium, accessed 17 August 2021). World Health Organization. Integrating health services: brief. Geneva: World Health Organization; 2018. (https://apps.who.int/iris/handle/10665/326459, 30 August 2021). World Health Organization. Making fair choices on the path to universal health coverage. Final report of the WHO Consultative Group on Equity and Universal Health Coverage. Geneva: World Health Organization; 2014. (https://iris.who.int/bitstream/handle/10665/112671/9789241507158_eng.pdf?sequence=1) World Health Organization. Primary health care: closing the gap between public health and primary care through integration. Geneva: World Health Organization; 2018. (https://apps.who.int/iris/handle/10665/326458, accessed 30 August 2021). World Health Organization. Universal health coverage (UHC) – priority benefits package. https://www.emro.who.int/uhc-pbp/types-of-packages/index.html)

3.5.b. Roles and functions of service delivery platforms are defined

Indicator	Roles and functions of service delivery platforms are defined
Rationale	Service delivery platforms are settings or levels of health service delivery. The platforms can include public and private health facilities (for example health posts, clinics, health centres, mobile clinics, emergency care units, first and second referral facilities, other entities (for example, home-based care, schools, community centres, long-term care facilities) and telemedicine modalities such as telephone follow-up and virtual consultations. The organization of service delivery platforms should promote integrated health services, prioritizing primary care and public health functions and ensuring adequate coordination between them. At the level of individual health care services, health systems need to be reoriented to facilitate access to services closer to where people live (for example, home-based and community-based care, primary care in long-term care facilities, step-down units for rehabilitation in local hospitals, dedicated emergency care units at comprehensive health centres and first-level hospitals), taking into consideration context (for example, living conditions, public transport, availability of emergency transportation and pre-hospital care), people's preferences and cost-effectiveness.
Mandate (WHA resolution, SDG)	WHA 72.2

Definition	Roles and functions of service delivery platforms are clearly defined, including:
	• Platform type:
	  ○ Community-based services (e.g. health post, mobile clinics, outreach, campaigns, etc.)
	  ○ General outpatient services (e.g. facility at primary care level)
	  ○ Prehospital emergency car- (e.g. ambulance transport)
	  ○ First referral level (e.g. district or general hospital)
	  ○ Second referral level (e.g., regional, specialized or national hospitals)
	• Functionality of platforms are specified (which services are delivered and how)
	• Distribution (where they are located) and population mapping (catchment areas or administrative boundaries mapped to the platforms) of these platforms are known

Numerator	Attributes score attained
Denominator	Total attribute score possible
Preferred data sources	Qualitative/key informant survey and/or desk review with verification from key country documents
Other data sources	
Disaggregation	Not applicable
Frequency of data collection	Biennial

Limitations	
Data type	Percent (%)
Related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. World Health Organization and United Nations Children's Fund. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240017832, accessed 17 August 2021). World Health Organization. UHC Compendium (https://www.who.int/universal-health-coverage/compendium, accessed 17 August 2021). World Health Organization. Integrating health services: brief. Geneva: World Health Organization; 2018. (https://apps.who.int/iris/handle/10665/326459, accessed 30 August 2021). World Health Organization. The transformative role of hospitals in the future of primary health care. Geneva: World Health Organization; 2018. (https://apps.who.int/iris/handle/10665/326296, accessed 30 August 2021).

3.5.c. Existence of an empanelment system

Indicator	Existence of an empanelment system
Rationale	Having a defined practice population by means of a registered patient list system creates an incentive for primary care practitioners as well as the population to provide and receive services on a continuous basis with the same provider. Registering with a specific practitioner has been found to contribute to accountability by making clear who is responsible for service coordination. Ongoing services from the same provider contributes to quality of care. Patient list systems can be defined based on different criteria, including geographic empanelment, insurance-based empanelment, individual choice or specific diagnoses.
Mandate (WHA resolution, SDG)	WHA 72.2
Definition	An empanelment system exists and can be measured by the following attributes: □ Proportion of the population that is empaneled to a practitioner, care team or facility □ Assignments are clearly communicated to users' populations and practitioners □ Frequency at which patient panels are updated □ Patients can choose and/or switch the facility/practitioner/team to which they are empaneled

	Key terms: Empanelment (sometimes also called rostering) is the assignment of populations to specific health care facilities, teams, or practitioners who are responsible for the health needs and delivery of coordinated care in that population.
Numerator	Attributes score attained
Denominator	Total attribute score possible
Preferred data sources	Qualitative/key informant survey and/or desk review with verification from key country documents
Other data sources	
Disaggregation	Not applicable
Frequency of data collection	Biennial
Limitations	
Data type	Percent (%)
Related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. World Health Organization and United Nations Children's Fund. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240017832, accessed 17 August 2021). Bearden T, Ratcliffe HL, Sugarman JR et al. Empanelment: A foundational component of primary health care [version 1; peer review: approved] Gates Open Research 2019, 3:1654 (https://doi.org/10.12688/gatesopenres.13059.1, accessed 4 October 2021) Primary Health Care Performance Initiative. Primary Health Care Progression Model Assessment Tool (measure 27 – empanelment). 2019. (https://improvingphc.org/sites/default/files/PHC-Progression%20Model%202019-04-04_FINAL.pdf; accessed 20 April 2021). World Health Organization Regional Office for Europe. Indicator passport - WHO European Primary Health Care, Impact, Performance and Capacity Tool. Copenhagen: World Health Organization Regional Office for Europe; 2019. (https://www.euro.who.int/en/health-topics/Health-systems/health-services-delivery/publications/2019/indicator-passport-who-european-primary-health-care,-impact,-performance-and-capacity-tool-phc-impact-2019, accessed 20 April 2021).

3.5.d. Existence of system to promote first contact accessibility

Indicator	Existence of system to promote first contact accessibility
Rationale	Primary health care promotes primary care as the first point of contact. First contact accessibility measures the ability and capacity of a PHC system to ensure primary care practitioners can serve as the first point of contact for most conditions and are responsible for the delivery of primary care services as well as the coordination and referral of care to other sites and platforms. The ease of access to a primary care provider will ensure health services are provided at the appropriate levels and reduce or remove use of emergency, secondary and tertiary services as first points of contact, which can be costly and inefficient.
Mandate (WHA resolution, SDG)	WHA 72.2
Definition	A system exists to promote first contact access to primary care and emergency care which includes: - Financial incentives that promote primary care (e.g., removal of out-of-pocket payments and fee structures) as first point of contact for most care - Standards of practitioner education include competencies for primary and emergency care - Appropriate skill-mix for first contact practitioners across delivery platforms/levels - Conditional access to specialist care coordinated through a longitudinal primary care relationship - Monitoring of people's experience of first-contact access - Information on where patients receive care (with and without referral) that is available to policy makers and planners - Dedicated emergency units meeting minimal functional criteria are established at all first-level hospitals. - Users are able to access emergency care for time-sensitive conditions without requirement for referral. Key terms: First contact refers to a person's initial engagement with the health system for a given episode of care. In a PHC-oriented model of care, governance and financing policies/mechanisms position primary care providers as the first point of contact for most health needs and ensure that timely emergency care is directly accessible 24 hours per day. There are other measures for this indicator such as: a comprehensive essential package of services; easily accessible primary care; empanelment that promotes first contact accessibility. These are not included here as they are measured separately, but this indicator should be examined in that holistic context.
Numerator	Attributes score attained
Denominator	Total attribute score possible
Preferred data sources	Qualitative/key informant survey and/or desk review with verification from key country documents

Other data sources	
Disaggregation	Not applicable
Frequency of data collection	Biennial
Limitations	
Data type	Percent (%)
Related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. World Health Organization and United Nations Children's Fund. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240017832, accessed 17 August 2021). World Health Organization. Continuity and coordination of care: a practice brief to support implementation of the WHO Framework on integrated people-centred health services. Geneva: World Health Organization; 2018. (https://apps.who.int/iris/handle/10665/274628, accessed 30 August 2021). World Health Organization Regional Office for Europe. Glossary of terms: WHO European Primary Health Care Impact, Performance and Capacity Tool (PHC-IMPACT). Copenhagen: World Health Organization. Regional Office for Europe; 2019 (https://apps.who.int/iris/handle/10665/346481). Accessed 4 July 2023

3.5.e. Existence of systems for referral, counter-referral and emergency transfer

Indicator	Existence of systems for referral, counter-referral and emergency transfer
Rationale	A critical model of care element is two-way referral system that ensure primary care facilities (as the first point of contact for most people) can refer seamlessly to other service delivery platforms. Functioning referral and counter-referral systems – including shared protocols for patient referral, counter-referral and emergency transfer – contribute to strong linkages across all levels of care. The delivery of coordinated health services depends on the accessibility and exchange of information among those involved in the care of an individual. Referral protocols ensure that primary care facilities (as the first point of contact for most people) can refer and receive counter-referral seamlessly with other service delivery platforms. Functional referral systems are critical to achieve health service equity, accessibility and quality, and these include the use of referral letters.
Mandate (WHA resolution, SDG)	WHA 72.2

Definition	Explicit protocols and structured communication mechanisms for referral, counter-referral and emergency transfer are in place, including for reporting and feedback among primary care and other practitioners, to promote coordination.
	
	Referral systems should include:
	• Explicit agreements between referring and receiving institutions, including among public and private facilities
	• Active follow-up of referrals, counter-referrals and emergency transfer
	• Practitioner training on early recognition, referral, counter-referral and emergency transfer protocols
	• Protocols and standardized forms for referral, counter-referral and emergency transfer, including:
	  • Condition-specific referral criteria
	  • Referral checklists, pathways and/or algorithms
	  • Clinical decision-making support
	
	Key terms: Referral is the targeted direction of an individual to the appropriate facility or practitioner for a specific health need. Counter-referral may occur when an individual is referred back to a primary care provider or first level hospital for continued care following a procedure in secondary or tertiary care.

Numerator	Attributes score attained
Denominator	Total attribute score possible
Preferred data sources	Qualitative/key informant survey and/or desk review with verification from key country documents
Other data sources	
Disaggregation	Not applicable
Frequency of data collection	Biennial
Limitations	
Data type	Percent (%)
Related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. World Health Organization and United Nations Children's Fund. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240017832, accessed 17 August 2021).

	World Health Organization. Continuity and coordination of care: a practice brief to support implementation of the WHO Framework on integrated people-centred health services. Geneva: World Health Organization 2018. (https://apps.who.int/iris/handle/10665/274628, accessed 23 August 2021). WHO European Primary Health Care, Impact, Performance and Capacity Tool. Copenhagen: World Health Organization Regional Office for Europe; 2019. (https://www.euro.who.int/en/health-topics/Health-systems/health-services-delivery/publications/2019/indicator-passport-who-european-primary-health-care,-impact,-performance-and-capacity-tool-phc-impact-2019, accessed 17 August 2021).

3.5.f. Multi-disciplinary team-based service delivery

Indicator	Multi-disciplinary team-based service delivery
Rationale	Intra and across-sector teams can allow for improved collaboration and knowledge exchange between practitioners working in different settings. Close collaboration between different primary care professionals optimizes the treatment of individuals and therefore increases the strength of primary care. Regardless of the mode of teamwork that is applied, there should be some form of structural communication among primary care professionals treating the same individual.
Mandate (WHA resolution, SDG)	WHA 72.2
Definition	Existence of multidisciplinary team-based service delivery approaches (looking at extent and scope) in primary care settings. Key terms: Multidisciplinary care teams may include general or specialist doctors and nurses, as well as nutritionists, social care workers and others who contribute to coordinated, multi-modal care of an individual with complex health issues. Across-sector teams can allow for improved collaboration and knowledge exchange between practitioners working in different settings, which could include other generalist medical practitioners, nurse, social worker, psychologist, dietician, pharmacist, or public health professional. Multi-disciplinary team-based service delivery approaches may be supported by: - Explicit protocols and procedures for the convening and functioning of a multidisciplinary team, including criteria for patient eligibility. - Regular team meetings to evaluate an ongoing management plans for eligible individuals. - Roles and responsibilities are explicitly defined and understood by all team members and supported by accountability mechanisms. Multidisciplinary care programs can be made available to only a limited number of patients, those with multiple comorbidity and complex health and social needs (e.g., for long-term conditions) or with targeted conditions (e.g., diabetes clinic in a primary care centre). In other cases, a multidisciplinary approach is systematically available to all patients (i.e., patients are registered or empaneled to teams and not to individuals).

Numerator	Attributes score attained
Denominator	Total attribute score possible
Preferred data sources	Qualitative/key informant survey and/or desk review with verification from key country documents
Other data sources	
Disaggregation	Not applicable
Frequency of data collection	Biennial
Limitations	
Data type	Percent (%)
Related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. World Health Organization and United Nations Children's Fund. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240017832, accessed 17 August 2021). World Health Organization. Building the primary health care workforce of the 21st century. Geneva: World Health Organization; 2018. (https://apps.who.int/iris/handle/10665/328072, accessed 16 August 2021).

3.6. WHA72.2 Service utilization rate (primary care visits, emergency care visits, hospital admissions)

Indicator	Service utilization rate (primary care visits, emergency care visits, hospital admissions)
Rationale	Utilization of care can be a predictor of access to primary care. While cultural factors and incentive structures can play a role in how often people seek care, low utilization can signal issues related to equitable access to care. For example, OECD average for doctor's consultation is between 6.5 and 6.8 visits per person in a year (OECD Health at a glance 2019). During public health events outpatient visit utilization needs frequent monitoring to assure timely detection of service disruption. Utilization of emergency primarily shows the access to emergency services for acute time-sensitive conditions. However, in some settings emergency services can be used for preventable or treatable conditions. It is important to capture this, as emergency department services are costly services that can burden the health system if used for non-

	time-sensitive conditions. During public health events emergency unit utilization needs frequent monitoring to assure timely detection of service disruption. Hospital admissions (discharges) is another measure of utilization of health services. High hospital admission/discharge rates can also signal a failure of PHC service delivery that has necessitated hospital admissions (a measure of this is also captured in the indicator "admissions for ambulatory-sensitive conditions". During public health events hospital admissions need frequent monitoring to assure timely detection of service disruption.
Mandate (WHA resolution, SDG)	WHA 72.2
Definition	Number of primary care (outpatient health facility) visits (e.g., to facilities or doctors) per person per year; number of emergency department visits per 1 000 population; and number of patients who are admitted to or leave a hospital after staying at least one night per 1 000 population (includes death following inpatient care but excludes same-day discharges)
Numerator	Total number of visits
Denominator	Per person in a given year and per 1 000 population
Preferred data sources	Population-based survey; can also be collected through RHIS if the RHIS includes all facilities in the country (public and private)
Other data sources	
Disaggregation	Subnational; Age; Sex
Frequency of data collection	Annual
Limitations	
Data type	
Related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020 (https://www.who.int/publications/i/ item/9789240017832, accessed 17 August 2021). National Committee for Quality Assurance: Measuring Quality, improving health care. Emergency Department Utilization (https://www.ncqa.org/hedis/measures/emergency-department-utilization/, accessed 23 August 2021). Agency for Healthcare Research and Quality. 2015. Measures of Care Coordination: Preventable Emergency Department Visits

	(https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure2.html, accessed 23 August 2021). Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016 (https:// apps.who.int/iris/handle/10665/250221, accessed 23 August 2021). 2018 Global Reference List of 100 Core Health Indicators (plus health-related SDGs). Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/259951, accessed 20 April 2021).

3.7. WHA72.2 % of population reporting perceived barriers to care

Indicator	% of population reporting perceived barriers to care (geographic, socio-cultural, financial)
Rationale	Perceived barriers to access can negatively impact the use of health services, especially for marginalized and vulnerable populations. A perceived barrier during one visit can impact on future use of services. Addressing barriers to access and use of health services is critical for ensuring equitable delivery and use of health services. Assessments of barriers to health services and unmet needs can be one example of PHC-oriented research that contributes to the reduction of health inequities.
Mandate (WHA resolution, SDG)	WHA 72.2
Definition	Percentage of target population who report barriers to accessing care when they have a health care need
Numerator	Number of people interviewed who report having had a problem accessing care when they had a health care need, including: □ Getting permission to go for treatment □ Getting money for treatment □ Distance to the health facility □ Not wanting to go alone
Denominator	Total number of people with a perceived health need
Preferred data sources	Population-based surveys
Other data sources	
Disaggregation	Sex; Residence area type
Frequency of data collection	

Limitations	
Data type	Percent (%)
Related links	Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020 (https://www.who.int/publications/i/item/9789240017832, accessed 17 August 2021). Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO.

3.8. WHA72.2 Service availability & readiness index (% facilities with service availability, capacities & readiness (WASH, IPC, availability of meds, vaccines, diagnostics, priority medical devices, priority assistive products) to deliver UHC package)

3.8.a. Service availability (% of facilities with availability of services as per UHC package)

Indicator	Service availability (% of facilities with availability of services as per UHC package)
Rationale	The UHC service package addresses the health needs of the society. The availability of health services should be aligned with a country's defined UHC package. This indicator measures assess the extent to which specific services are offered and available in the relevant health care settings (for example, primary care, hospital and long-term care).
Mandate (WHA resolution, SDG)	WHA 72.2, WHA67.22
Definition	Percentage of facilities/units offering services according to national defined UHC package. Specific services will depend on the country context and should align with the services included in the UHC package, such as: Percentage of facilities/units offering services according to national defined UHC package. Specific services will depend on the country context and should align with the services included in the UHC package, such as: □ Foundations of care ○ Core functions ○ Integrated approach to common conditions □ Reproductive and sexual health ○ Pregnancy and birth ▪ Family planning, Antenatal care, Prevention of mother-to-child transmission of HIV; ▪ Basic emergency obstetric and neonatal care (BEmONC);

	▪ Comprehensive emergency obstetric and neonatal care (CEmONC), post-abortion care; ▪ Essential newborn care; o Sexual health and family planning □ Growth, development and ageing o Infant, child and adolescent growth and development o Nutrition, physical activity and sleep o Special considerations at the end of life ▪ Palliative care services o Special considerations in older people o Disabilities □ Communicable diseases o Communicable disease prevention ▪ Immunization o Communicable diseases (excluding NTDs) ▪ HIV counselling and testing; ▪ HIV/AIDS care and support services; ▪ Antiretroviral prescription and client management; ▪ Sexually transmitted infections diagnosis or treatment; ▪ Tuberculosis services (diagnosis, treatment prescription or treatment follow-up) ▪ Malaria diagnosis or treatment; ▪ Childhood respiratory infections and diarrheal diseases o Neglected Tropical Diseases □ Non communicable Diseases o Blood disorders o Cancers ▪ Cervical cancer screening o Cardiovascular disease o Chronic musculoskeletal disorders o Chronic respiratory diseases o Congenital abnormalities o Digestive diseases o Endocrine, metabolic, and autoimmune disorders o Genitourinary disorders o Sense organ diseases o Skin and hair diseases o Skin and subcutaneous diseases □ Mental health, neurological and substance abuse disorders o Mental disorders o Neurological disorders o Substance use disorders □ Violence and injury o Injury ▪ Envenomation injuries ▪ Mechanical injury ▪ Poisoning, toxic and environmental injuries (including drowning)

	○ Interpersonal violence; □ Rehabilitative services □ Basic and comprehensive surgical care, including caesarean section, laparotomy and open fracture; □ Services available 24 hours a day (for emergencies) with either a health care worker present at the facility at all times or officially on call for the facility at all times □ Emergency units with acuity-based triage ○ Nutrition services
Numerator	Number of facilities offering the total package of services for their specific health-care setting; Number of facilities offering each service
Denominator	Total number of facilities surveyed
Preferred data sources	Facility survey; Facility census; Routine health information system (RHIS)
Other data sources	
Disaggregation	Facility type (as relevant to context): including primary care facilities (e.g., GP practices, health centres, community health posts), first-level hospitals, second-level hospitals, specialty hospitals, long-term care facilities, continuing care facilities, etc.); Managing authority (public, private); Subnational; Residence area type
Frequency of data collection	
Limitations	
Data type	Percent (%)
Related links	World Health Organization. UHC Compendium (https://www.who.int/universal-health-coverage/compendium, accessed 17 August 2021). World Health Organization. Service Availability and Readiness Assessment. (https://www.who.int/data/data-collection-tools/service-availability-and-readiness-assessment-(sara)?ua=1, accessed 16 August 2021). The DHS Program. Service Provision Assessment. September 2020. (https://dhsprogram.com/publications/publication-spaq1-spa-questionnaires-and-manuals.cfm, accessed 18 August 2021). World Health Organization. Harmonized Health Facility Assessment. March 2021. (https://www.who.int/data/data-collection-tools/harmonized-health-facility-assessment/introduction, accessed 16 August 2021). Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO.

3.8.b. Service readiness (% of facilities with service capacities & readiness to deliver UHC package)

Indicator	Service readiness (% facilities with WASH, IPC, systems for quality & safety, resilience, availability of medicines, vaccines, diagnostics, priority medical device, and priority assistive products)*
Rationale	One of the goals of UHC is the ability to provide quality health services to the population that meet their needs without financial hardships. Service capacity and readiness (as defined by facilities meeting minimum standards to deliver services) is a necessary component of quality health services. The ability of facilities to provide quality services to those accessing care is dependent on the facility having adequate supplies and staffing. Some of the components of these indicators are measured separately as part of this framework. However, this measure combines the different components to give a combined measure of service readiness as well as examining separately the different components to see where minimum standards are (or are not) being met.
Mandate (WHA resolution, SDG)	WHA 72.2
Definition	Percentage of facilities that have the required capacities to deliver services, including: • Availability of health and care workers, • Availability of health products (see metadata below), • Availability of internet connectivity, • Availability of power, • Availability of communications systems, • Availability of basic water and sanitation (WASH), • Meet IPC and patient safety requirements, • Have access to emergency transport • Have systems for quality improvement *Also covered in section 3.2
Numerator	Number of health facilities that have the required capacities to provide services (all capacities; by individual capacity)
Denominator	Total number of facilities surveyed
Preferred data sources	Facility survey
Other data sources	
Disaggregation	Facility type (as relevant to context): including primary care facilities (e.g., GP practices, health centres, community health posts), first-level hospitals, second-level hospitals, specialty hospitals, long-term care facilities, continuing care facilities, etc.); Managing authority: public, private; Subnational; Residence area type
Frequency of data collection	

Limitations	
Data type	Percent (%)
Related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. 2018 Global reference list of 100 core health indicators (plus health-related SDGs). Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf?sequence=1&isAllowed=y, accessed 16 August 2021). From existing health facility survey tools such as World Health Organization's SARA and HHFA, and DHS program's SPA. World Health Organization. Service Availability and Readiness Assessment (https://www.who.int/data/datacollection-tools/service-availability-and-readiness-assessment-(sara)?ua=1, accessed 16 August 2021). The DHS Program. Service Provision Assessment. September 2020 (https://dhsprogram.com/publications/publication-spaq1-spa-questionnaires-and-manuals.cfm, accessed 18 August 2021). World Health Organization. Harmonized Health Facility Assessment. March 2021 (https://www.who.int/data/data-collection-tools/harmonized-health-facility-assessment/introduction, accessed 16 August 2021). To note: WHO is currently revising its facility survey modules to incorporate additional elements of PHC measurement and will provide recommended scoring methodology.

3.8.c. Availability of essential medicines as per national list, by type/level

Indicator	Availability of essential medicines as per national list, by type/level
Rationale	Access to medicines is a composite multidimensional concept that is composed of the availability of medicines and the affordability of their prices. Information on these two dimensions has been collected and analysed since the 54th World Health Assembly in 2001, when Member States adopted the WHO Medicines Strategy (resolution WHA54.11). This resolution led to the launch of the joint project on Medicine Prices and Availability by WHO and the international non-governmental organization Health Action International (HAI/WHO), as well as a proposed HAI/WHO methodology for collecting data and measuring components of access to medicines. To this day, this methodology has been widely implemented to produce useful analyses of availability and affordability of medicines, however the two dimensions have been evaluated separately.
Mandate	WHA 72.2; WHA 54.11; SDG 3.b.3

(WHA resolution, SDG)	
Definition	Percentage of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis. The indicator is a multidimensional index reported as a proportion (%) of health facilities that have a defined core set of quality-assured medicines that are available and affordable relative to the total number of surveyed health facilities at national level. A medicine is available in a facility when it is found in this facility by the interviewer on the day of data collection (based on the following list): <u>Noncommunicable diseases (NCD) - respiratory</u> Salbutamol inhaler (or alternative inhaled beta-2 agonist e.g. terbutaline) Beclomethasone inhaler (or alternative inhaled corticosteroid e.g. budesonide, fluticasone, mometasone) <u>NCD - diabetes</u> Gliclazide (or alternative sulphonylurea e.g. glibenclamide, glimepiride, glipizide) Metformin Insulin (human, soluble) Insulin (analogue, long-acting) <u>NCD - cardiovascular</u> Any two of the following antihypertensives: – Amlodipine (or alternative dihydropyridine calcium channel blocker e.g. felodipine, nifedipine, lercanidipine) – Enalapril (or alternative ACE inhibitor e.g. captopril, lisinopril, perindopril, ramipril) – Hydrochlorothiazide (or alternative thiazide/thiazide-like diuretic e.g. chlorthalidone, chlorothiazide, indapamide) – Bisoprolol (or alternative beta-blocker e.g. atenolol, carvedilol, metoprolol) Simvastatin (or alternative statin e.g. atorvastatin, fluvastatin, lovastatin, pravastatin) Acetylsalicylic acid (aspirin) Furosemide <u>NCD - oncology</u> <u>Cyclophosphamide</u> <u>Cisplatin</u> <u>Docetaxel</u> <u>Imatinib</u> <u>Rituximab</u> <u>Tamoxifen</u> <u>Pain and palliative care</u> Morphine Paracetamol Ibuprofen

	Mental health and substance use Fluoxetine (or alternative SSRI e.g. Citalopram, escitalopram, fluvoxamine, paroxetine, sertraline) Nicotine replacement therapy Neurology Carbamazepine Levetiracetam Levodopa + carbidopa or levodopa + benserazide Anti-infective medicines Antibacterials: – Gentamicin – Amoxicillin – Ceftriaxone or cefotaxime – Benzathine benzylpenicillin or procaine benzylpenicillin – Nitrofurantoin Anti-fungals – Fluconazole – Nystatin Antituberculosis – Ethambutol + isoniazid + pyrazinamide + rifampicin – Delamanid Anti-malarials – Artesunate injection One of the following oral artemisinin-based combination therapies (ACT): – Artemether + lumefantrine – Artesunate + amodiaquine – Artesunate + mefloquine – Dihydroartemisinin + piperaquine – Artesunate + sulfadoxine + pyrimethamine; Antiretrovirals (ARV) One of the following combination ARV first-line treatment regimens for HIV: – Dolutegravir + lamivudine + tenofovir disoproxil fumarate – Efavirenz + emtricitabine + tenofovir disoproxil fumarate – Efavirenz + lamivudine + tenofovir disoproxil fumarate Pre-exposure prophylaxis for HIV – Tenofovir disoproxil fumarate or emtricitabine + tenofovir disoproxil fumarate Antivirals for hepatitis C

	One of the following pangenotypic treatment regimens for hepatitis C: – Sofosbuvir + daclatasvir – Sofosbuvir + velpatasvir – Glecaprevir + pibrentasvir Maternal and child health (MCH) MCH - Contraceptives One of the following contraceptives: – Ethinylestradiol + levonorgestrel combined oral contraceptive – Levonorgestrel (including emergency contraceptives) – Medroxyprogesterone acetate injection – Progesterone-releasing implant (etonogestrel or levonorgestrel) MCH- Perinatal care – Oxytocin – Magnesium sulphate – Chlorhexidine gel (for umbilical cord care) Other/general Oral rehydration salts + zinc sulphate Ferrous salt + folic acid Folic acid Ready-to-use therapeutic food (RUTF) Chronic kidney disease Erythropoietin Anaesthesia Halothane or isoflurane or sevoflurane Ketamine or propofol Antiallergics and medicine used in anaphylaxis Epinephrine injection or dexamethasone injection Thyroid hormones Levothyroxine A medicine is affordable when no extra daily wages are needed for the lowest-paid unskilled government sector worker to purchase a monthly dose treatment of this medicine after fulfilling basic needs represented by the national poverty line. Affordability is measured as a ratio of 1) the sum of the national poverty line and the price per daily dose of treatment of the medicine, over 2) the lowest-paid government worker salary. This measures the number of extra daily wages needed to cover the cost of the medicines in the core set and that can vary between 0 and infinity.

Numerator	Number of facilities that have a core set of relevant essential medicines available and affordable
Denominator	Total number of surveyed facilities per country
Preferred data sources	Facility survey
Other data sources	
Disaggregation	Facility type (as relevant to context): including primary care facilities (e.g., GP practices, health centres, community health posts), first-level hospitals, second-level hospitals, specialty hospitals, long-term care facilities, continuing care facilities, etc.; Managing authority: public, private; Subnational; Residence area type
Frequency of data collection	
Limitations	
Data type	Percent (%)
Related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020 (https://www.who.int/publications/i/ item/9789240017832, accessed 17 August 2021). Model List of Essential Medicines, 23rd List, 2023. Geneva: World Health Organization; 2023 ((https://iris.who.int/handle/10665/371090, accessed 6 February 2024). United Nations Department of Economic and Social Affairs Statistics Division. United Nations Sustainable Development Goals Indicators Metadata repository (https://unstats.un.org/sdgs/metadata/, accessed 20 April 2021). 2018 Global reference list of 100 core health indicators (plus health-related SDGs). Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf?sequence=1&isAllowed=y, accessed 18 August 2021).

Note: Sub-national level indicator prioritized for reporting in sub-set of countries only

3.8.d. Availability of vaccines as per national list, by type/level

Indicator	Availability of vaccines as per national list, by type/level
Rationale	Immunization saves millions of lives every year. Immunization currently prevents 3.5-5 million deaths every year from diseases like diphtheria, tetanus, pertussis, influenza and measles. Immunization is a key component of primary health care and an indisputable human right. It's also one of the best health investments money can buy. Vaccines are also critical to the prevention and control of infectious disease outbreaks. They underpin global health security and will be a vital tool in the battle against antimicrobial resistance.
Mandate (WHA resolution, SDG)	SDG 3.b.3, WHA67.22
Definition	Percentage of health facilities that have the recommended vaccines (all, by vaccine), including: • BCG • Hepatitis B • Polio • DTP-containing vaccine • Haemophilus influenzae type-b • Pneumococcal (Conjugate) • Rotavirus • Measles • Rubella • HPV *This list summarizes the WHO recommendations for routine vaccination. Country specific schedules should be based on local epidemiologic, programmatic, resource and policy considerations.
Numerator	Percentage of health facilities that have received at least the total forecasted quantity for any given supply period of the recommended vaccines (all and by vaccine)
Denominator	Total number of facilities surveyed
Preferred data sources	Facility survey;
Other data sources	
Disaggregation	Facility type (as relevant to context): including primary care facilities (e.g., GP practices, health centres, community health posts), first-level hospitals, second-level hospitals, specialty hospitals, long-term care facilities, continuing care facilities, etc.; Managing authority: public, private; Subnational; Residence area type
Frequency of data collection	
Limitations	
Data type	Percent (%)

Related links	Table 1: Summary of WHO Position Papers – Recommendations for Routine Immunization (https://cdn.who.int/media/docs/default-source/immunization/immunization_schedules/table_1_feb_2023_english.pdf?sfvrsn=c7de0e97_11&download=true, accessed 6 February 2024) Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO.

Note: Sub-national level indicator prioritized for reporting in sub-set of countries only

3.8.e. Availability of essential in vitro diagnostics as per national list, by type/level

Indicator	Availability of essential in vitro diagnostics as per national list, by type/level
Rationale	The crucial role of IVDs has become widely acknowledged in a diverse range of areas including case finding treatment, test of cure, outbreak response, surveillance, disease elimination, certification, and vaccine efficacy evaluation. Access to essential in vitro diagnostics is a central component of quality health services and indispensable to advance UHC, address health emergencies and promote healthier populations.
Mandate (WHA resolution, SDG)	WHA 76.5
Definition	Percentage of health facilities with availability of appropriate, functional and regularly used set of essential IVDs for their health care facility level on a sustainable basis, based on the WHO's model list of essential IVDs (EDL 4). The indicator is a multidimensional index reported as a proportion (%) of health facilities that have a sample set of quality-assured IVDs that are available, functional and used, relative to the total number of surveyed health facilities at national level. This sample set of IVDs is comprised of 12 type of IVDs (taken from the more than 200 IVDs found in the EDL) that would be used in all countries. An in vitro diagnostic test is available in a community setting or health facility when it is found in this setting/facility by the interviewer on the day of data collection (based on the following list): The EDL is presented by health care facility level in two tiers: I. Community and health settings without laboratories *I.a. General IVDs for community and health settings without laboratories* • Glucose (dipstick/glucose meter) • Urinalysis test strips (dipstick) • Human chorionic gonadotrophin - rapid diagnostic test (RDT) *I.b. Disease-specific IVDs for community and health settings without laboratories (See WHO EDL 4 for detailed information)*

	• Combined HIV antibody/p24 antigen (RDT) • Antibodies to Treponema pallidum (RDT) II. In health settings with laboratories *II.a. General IVDs for use in clinical laboratories* • Culture • Albumin • Complete blood count (CBC) *II.b. Disease-specific IVDs for use in clinical laboratories (See WHO EDL 4 for detailed information)* • Papanicolaou (Pap) smear test • Prostate Specific Antigen (PSA) • Lipid profile Antibodies to hepatitis C virus
Numerator	Number of surveyed health facilities with an appropriate set of essential in vitro diagnostic tests
Denominator	Total number of surveyed facilities
Preferred data sources	Facility survey
Other data sources	
Disaggregation	Facility type (as relevant to context): including primary care facilities (e.g., GP practices, health centres, community health posts), first-level hospitals, long-term care facilities, continuing care facilities, etc.); Managing authority: public, private; Subnational; Residence area type
Frequency of data collection	Annual
Limitations	
Data type	
Related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020 (https://www.who.int/publications/i/ item/9789240017832, accessed 17 August 2021). 2018 Global Reference List of 100 Core Health Indicators (plus health-related SDGs). Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/259951, accessed 20 April 2021).

	The selection and use of essential in vitro diagnostics: report of the third meeting of the WHO Strategic Advisory Group of Experts on In Vitro Diagnostics, 2022 (including the third WHO model list of essential in vitro diagnostics). Geneva: World Health Organization; 2023 (https://iris.who.int/bitstream/handle/10665/373322/9789240081093-eng.pdf?sequence=1, accessed 05 February 2024). World Health Organization. Electronic Model List of Essential In Vitro Diagnostics Platform (https://edl.who-healthtechnologies.org/, accessed 05 February 2024). 2018 Global Reference List of 100 Core Health Indicators (plus health-related SDGs). Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/259951, accessed 20 April 2021).

Note: Sub-national level indicator prioritized for reporting in sub-set of countries only

3.8.f. Availability of priority medical devices as per national list, by type/level

Indicator	Availability of priority medical devices as per national list, by type/level
Rationale	Access to good quality, affordable, and appropriate health products is indispensable to advance UHC, address health emergencies, and promote healthier populations.
Mandate (WHA resolution, SDG)	WHA60.29, WHA68.15, WHA76.5, WHA76.3, WHA75(25)
	Percentage of health facilities with current stock of the below equipment and products that are available and functional (* indicates specific to referral facility or hospital) Note: for the facility assessments, this list should be read in conjunction with the indicator 32. Availability of essential in vitro diagnostics (IVDs), as per national list, by type/level, considering that IVDs are also medical devices and are the ones used for testing, single-use or laboratory tests which are used along with other diagnostic medical devices like blood pressure measurement or imaging. The medical devices, should be of good quality, safely used by trained staff and should include the consumables and good maintenance to allow full performance. WHO continuously updates the WHO Priority Medical devices (PMD) list which includes more than 2500 types of medical devices (February 2024), including medical equipment and single use devices and related health products. MeDevIS is the Medical devices information system that includes all of the WHO PMDs. The following list includes a sample of those that are required by service delivery platforms in alignment with the WHO Universal Health Coverage Compendium (UHCC) where they are linked to the health interventions. Each of the higher levels of care should include the medical devices used in the previous levels. The health facility should have a functional inventory system to allow monitoring the status of the capital investment and thus the collection of information for this indicator can be facilitated.

	General outpatient (health post, health center) Capital Medical equipment used for Clinical examination, (diagnostic, measurement, or monitoring) • Scale, infant, child, adult • Blood pressure measurement device, automated • Thermometer, digital • Stethoscope • Light, examination • Height board/stadiometer • Pulse oximeter • Measuring tape • Otoscope • Ophthalmoscope • Oxygen concentrator Single use / consumables: • Examination gloves, latex, single use • Alcohol swabs • Bandages, • Adhesive tape • Infusion set, intravenous • Syringes • Sterile gauze and swabs **Prehospital emergency care- (e.g. ambulance transport)** • Aspirator • Patient monitor multiparameter • Defibrillator • Stretcher • Oxygen supply and mask • Ventilator transport • Infusion pump • Tourniquet • Scissors and clamps Single use: • Endotracheal tube (adult) • Endotracheal tube (pediatric) • Intravenous cannula (any size) • Catheter intravenous • Sutures • Oropharyngeal cannula

	• Syringes **First referral level - (e.g. district or general hospital)** • Oxygen system or Oxygen tank with pressure gauge and regulator • Flowmeter, oxygen therapy • Humidifier • Oxygen delivery devices (connecting ties, mask, nasal prongs) Consumable Supplies • Suture, absorbable • Needles, suturing • Blood giving set • Splinting set, extremities • Casts, set and materials • Urinary catheter, straight • Urinary catheter, with bulb • Urine collection bag Diagnostic imaging technology (often reported as density per million population) • X-ray, general; fixed/mobile/portable • Ultrasound scanner • Electrocardiogram (ECG) Medical Equipment for treatments • Phototherapy device • Incubator, newborn • Anaesthesia system* • Table, operating • Surgical instruments, basic surgery set General equipment: • Autoclave, electric • Dry-heat sterilizer • Refrigerators (vaccines, medicines, blood) • Lamp, Surgical (for outpatient surgeries) **Second referral level - (e.g., regional, specialized or national hospitals)** • Monitor multiparameter, advanced • Ultrasound scanner advanced • Angiography system • Endoscopy system • Magnetic Resonance Imaging • Xray system, mammography • X-Ray system fluoroscopy

	• Intra-aortic balloon pump • Anesthesia system, advanced • Surgical microscope • Laparoscopic system • Hemodialysis unit • Radiotherapy unit • Tonometer • Phacoemulsification unit • Specialized surgical sets •
Numerator	Number of facilities with the equipment, supply or commodity
Denominator	Total number of facilities surveyed
Preferred data sources	Facility survey
Other data sources	
Disaggregation	• Type of equipment, supply, commodity • Platform type: (same as the UHCC) oGeneral outpatient services- (e.g. health post, health center) oPrehospital emergency care- (e.g. ambulance transport) oFirst referral level - (e.g. district or general hospital) oSecond referral level - (e.g., regional, specialized or national hospitals and specialized diagnostic or treatment centers) • Managing authority: public, private • Subnational • Residence area type
Frequency of data collection	
Limitations	
Data type	Percent (%)
Related links	1. World Health Organization and United Nations Children's Fund. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240017832, accessed 17 August 2021). 2. World Health Organization. Management and safe use of medical devices. (https://www.who.int/teams/health-product-and-policy-standards/assistive-and-medical-technology/medical-devices/management-use, accessed 23 August 2021). 3. World Health Organization. Management and safe use of medical devices (https://www.who.int/teams/health-product-and-policy-standards/assistive-and-medical-technology/medical-devices/management-use, accessed 6 February 2024.).

4. World Health Organization. MeDevIS (Priority Medical Devices Information System) open access WHO electronic database of Medical Devices and related health products (https://medevis.who-healthtechnologies.org/ , accessed 6 February 2024) ().
5. World Health Organization. Interagency list of priority medical devices for essential interventions for reproductive, maternal, newborn and child health. World Health Organization, 15 June 2016 (https://www.who.int/publications/i/item/9789241565028, accessed on 6 September 2021).
6. World Health Organization. WHO list of priority medical devices for cancer management. World Health Organization, 17 February 2017 (https://www.who.int/publications/i/item/9789241565462, accessed on 6 September 2021.
7. World Health Organization. WHO List of Priority Medical Devices for management of cardiovascular diseases and diabetes. World Health Organization, 2021 (https://apps.who.int/iris/bitstream/handle/10665/341967/9789240027978-eng.pdf, accessed on 6 September 2021).
8. World Health Organization. WHO List of Priority medical devices list for the COVID-19 response and associated technical specifications. World Health Organization, 19 November 2020 (https://www.who.int/publications/i/item/WHO-2019-nCoV-MedDev-TS-O2T.V2, accessed on 6 September 2021).
9. World Health Organization. WHO general medical devices (https://www.who.int/health-topics/medical-devices#tab=tab_1, accessed on 6 September 2021).
10. World Health Organization. WHO prioritizing medical devices. (https://www.who.int/activities/prioritizing-medical-devices, accessed on 6 September 2021
11. WHO Package of eye care interventions https://www.who.int/publications/i/item/9789240048959, accessed 6 February 2024.
12. World Health Organization. Service Availability and Readiness Assessment. (https://www.who.int/data/data-collection-tools/service-availability-and-readiness-assessment-(sara)?ua=1, accessed 16 August 2021).
13. The DHS Program. Service Provision Assessment. September 2020. (https://dhsprogram.com/publications/publication-spaq1-spa-questionnaires-and-manuals.cfm, accessed 18 August 2021).
14. World Bank. Service Delivery Indicators. (https://datatopics.worldbank.org/sdi/, accessed 19 August 2021).
15. World Health Organization. Harmonized Health Facility Assessment. March 2021. (https://www.who.int/data/data-collection-tools/harmonized-health-facility-assessment/introduction, accessed 16 August 2021).
16. Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO.

Note: Sub-national level indicator prioritized for reporting in sub-set of countries only

3.8.g. Availability of priority assistive products as per national list, by type/level

Indicator	Availability of priority assistive products as per national list, by type/level
Rationale	The primary purpose of assistive products such as wheelchairs, hearing aids, prostheses, spectacles, or apps that support communication and cognition is to maintain or improve an individual's functioning and independence, thereby promoting their well-being. They enable people to live healthy, productive, independent, and dignified lives, and to participate in education, the labour market and civic life. WHO estimates that today 2.5 billion people need one or more assistive products. Major groups of users of assistive technology include people with disabilities, people with health conditions, older people experiencing functional decline. With a global ageing population and a rise in noncommunicable diseases, this number will rise beyond 3.5 billion by 2050, with many older people needing two or more products as they age. While supporting independence and well-being, assistive products can also help to prevent or reduce the effects of secondary health conditions, such as lower limb amputation in people with diabetes. They can also reduce the need and impact on carers and mitigate the need for formal health and support services. Moreover, access to appropriate assistive products can have a tremendous impact on community development and economic growth.
Mandate (WHA resolution, SDG)	WHA 71.8
Definition	Percentage of health facilities with availability of a supply of appropriate priority assistive products, based on the WHO's Priority Assistive Products List (APL) or National Priority Assistive Product list where this exists The indicator is a multidimensional index reported as a proportion (%) of health facilities that have a supply of appropriate priority assistive products that are available for provision to those in need, relative to the total number of surveyed health facilities at the national level. An assistive product is available in a community setting or health facility when it is found in the setting/facility by the interviewer on the day of data collection (based on the following list): I. Community level (community-based services; self-testing and self-care services; worker visits at home or health posts). • Walking aids • Continence products • Pill organizers • Reading glasses

	II. Primary health care level (general outpatient services – clinic settings or outreach; general outpatient services in clinic settings; periodic schedulable services delivered by skilled health workers in home, schools, workplace or public space). • Walking aids • Continence products • Pill organizers • Reading glasses III. Secondary health care level (first referral hospital – district hospital; outpatient services at first referral level; emergency unit services at first referral level; inpatient services at first referral level; diagnostic laboratory and medical imaging services within a first referral level) • Low vision products • Therapeutic footwear • Wheelchairs (manual/push-type) • Pressure relief cushions/mattresses IV. Tertiary health care level (second referral level and above - regional and national hospitals; advanced outpatient services at second referral level and above; Advanced emergency unit services at second referral level and above; Advanced inpatient services at second referral level and above; Diagnostic laboratory and medical imaging services within a second level referral and above). • Low vision products • Therapeutic footwear • Wheelchairs (manual/push-type) • Pressure relief cushions/mattresses • Prosthesis
Numerator	The number of surveyed health facilities with an appropriate set of priority assistive products available.
Denominator	Total number of surveyed facilities
Preferred data sources	Facility survey
Other data sources	N/A
Disaggregation	Facility type (as relevant to context): including primary care facilities (e.g., GP practices, health centres, community health posts), first-level hospitals, long-term care facilities, continuing care facilities, etc.); Managing authority: public, private; Subnational; Residence area type
Frequency of data collection	Biennial
Limitations	Only a sub-set of priority assistive products have been included as a proxy of availability.

	This information not as yet included in health facility surveys and this needs to be addressed.
Data type	Percent (%)
Related links	World Health Organization, USAID & International Disability Alliance. (2016). Priority assistive products list: improving access to assistive technology for everyone, everywhere. World Health Organization. https://iris.who.int/handle/10665/207694. World Health Organization & United Nations Children's Fund (UNICEF). (2022). Global report on assistive technology. World Health Organization. https://iris.who.int/handle/10665/354357 Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO.

Note: Sub-national level indicator prioritized for reporting in sub-set of countries only

3.9. Gender equality advanced in and through health

Indicator	Gender equality advanced in and through health
Rationale	The SDGs is an indivisible framework with an overriding mandate to 'Leave No-One Behind'. As such, the interaction between SDG 5 and SDG 3 is of fundamental importance to achieve both goals. Similarly, achievement of gender equality in the field of public health is central to advance country commitments, as expressed in Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Beijing Platform for Action and International Conference on Population and Development Programme for Action (ICPD). Gender inequalities cover a range of issues related to harmful gender norms, gender roles and stereotypes that underly inequalities in power. These impact health and wellbeing in a variety of ways, including, amongst others, risks and access to health services; prioritization of health issues within the health system; gender equalities within the health and care workforce; and gender responsive health policies, programmes and services. Gender equality in health also refers to the ways in which health, and the design and delivery of health policies, programmes and services, impact upon societal gender norms and wider equal opportunities and capacities throughout the life course. Hence, it is necessary to monitor several indicators to assess progress towards advancing gender inequality in and through health. Here, the UN list of gender relevant SDG indicators is mapped against the GPW 14 results framework indicators to establish a holistic monitoring framework.

	See comments against each indicator in the annex for a fuller rationale for the selection of each indicator.
Mandate (WHA resolution, SDG)	SDG Target 5.1: End all forms of discrimination against women and girls everywhere SDG Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
Definition	Gender equality gaps closed on gender relevant SDG indicators included in the GPW 14 results framework. Countries will be considered to have progressed towards gender equality if they have achieved a measurable progress towards advancing gender equality in at least xx gender relevant GPW indicators, including at least xx from each of the following domains: - Mortality and morbidity throughout the life course - Quality of life and healthy development - Health systems and services - Bodily autonomy and integrity Indicators included in each of these domains include: - those for which progress towards closing gaps by sex in health outcomes and in access to services can be monitored. - sex specific indicators related to key areas of autonomy and gender inequalities in power relevant to health. The relevant indicators will primarily contemplate gender relevant SDG indicators already included in the GPW 14 results framework across the three pillars (see annex). Exceptional inclusions are made for the following reasons: - An additional indicator (4.4.1) from the list of gender relevant SDG indicators, given its significance to both gendered inequalities in power at a structural level, as well as within the health and care workforce; - Three SDG indicators (3.3.3, 3.3.5 and 3.d.2) included in the GPW 14 results framework but not within the list of gender relevant SDG indicators, given their significance to women's health (see additional comments in annex) Indicators for which insufficient sex disaggregated data is currently reported may be excluded. For those indicators measured according to progressive closure of gaps by sex, proportional reduction of absolute inequality between the indicator in the sex at greatest disadvantage compared to the advantaged sex will be measured. For sex specific indicators, overall progress towards achievement of the indicator will be measured. Since all these indicators are already measured by countries for SDG and/or GPW reporting, no new data collection is required.
Numerator	Number of gender relevant GPW 14 indicators from each domain for which countries report an advance in closing gender equality gaps (see above) (*draft, TBD)*

Denominator	Total of gender relevant indicators (with sex disaggregated data where relevant) (*draft, TBD)*
Preferred data sources	As GPW source indicators.
Other data sources	
Disaggregation	Sex (at a minimum)
Frequency of data collection	Every two years
Limitations	a. Limited to those gender related SDG indicators already included in the GPW 14 results framework, hence indicators measuring broader structural inequalities affecting health are likely to be excluded; b. Poor/irregular data disaggregation and/or poor data quality
Data type	
Related links	Gender relevant SDG indicators

3.10. WHA72.2 People-centredness of primary care (patient experiences, perceptions, trust)

Indicator	People centredness of primary care (patient experiences, perceptions, trust)
Rationale	Patient-reported experiences provide critical insight into the quality of care received. The experience of the patient is an important quality outcome in its own right that can complement other, more commonly used clinical measures in building a picture of whether quality care was received. Such data, especially when disaggregated into specific aspects such as those outlined in the indicator definition, can be used to inform health workers and health service leadership on key quality challenges within the service and to support design and monitoring of quality improvement efforts. A comprehensive understanding of the patient perspective on care received requires insight into the three inter-related areas listed within the definition. Patient experience data informs descriptively from the patient perspective on the care received, with those same aspects explored from a patient satisfaction angle to understand the degree to which patients believe their expectations were met during their experience. Similarly, the focus on health system responsiveness assesses the ability of the health system to meet the legitimate expectations of the population regarding the non-medical and nonfinancial aspects of care, a factor which has been found to improve other measures of health, for example through increasing compliance and care seeking behaviour. This indicator aims to broadly reflect perceptions of health care from the patient perspective based on their experience of care received. Patient experience here is measured by the 5 primary care functions -- “5-Cs”: first contact accessibility, continuity, coordination, comprehensiveness and people-centredness. In addition to the 5-Cs, this indicator also examines domains of perceptions of provider competence and safety.

Mandate (WHA resolution, SDG)	WHA 72.2
Definition	Percentage of patients whose overall patient experience scores (and individual domain scores) elicited a score of 0 (worst possible experience) to 100 (best possible experience) (different ranges will be examined, e.g. 0-20; 21-40; 41-60; 61-80; 81-100) Patient-reported experiences addresses some of the key domains of core primary care functions through the lens of the patient and includes the following domains: • First contact accessibility □ usual source of care □ access throughout day and week □ geographical barriers □ affordability □ waiting time □ ease of use • Comprehensiveness □ life course (adults and children) □ preventative care □ self-management support (PaRIS) □ home visits • Continuity □ interpersonal □ longitudinal □ management □ informational • Coordination □ parallel (care plan) □ sequential (referrals) • People-centredness □ access to social support networks □ autonomy □ choice □ provider □ facility □ confidentiality □ dignity □ physical privacy □ compassion □ courtesy □ prompt attention □ quality of basic amenities □ shared decision making □ supporting health and health care capabilities □ involvement of carers, family and community

	◻ trust • Safety • Professional competence ◻ communication ◻ cultural ◻ technical
Numerator	Number of patients' whose overall and domain scores ranged between 0-20; 21-40; 41-60; 61-80; 81-100 (other ranges might be examined)
Denominator	Total number of patients interviewed
Preferred data sources	Population-based survey or clients sample based on patients sampling frame created by study staff during a facility visit (as part of an exit-interview during a facility survey OR a phone interview after in-person sampling)
Other data sources	
Disaggregation	• When collected through population-based survey **and** facility surveys: ◻ Age ◻ Sex ◻ Subnational ◻ Residence area type • For exit interview during facility surveys only: ◻ Facility type (as relevant to context): including primary care facilities (e.g., GP practices, health centres, community health posts), first-level hospitals, second-level hospitals, specialty hospitals, long-term care facilities, continuing care facilities, etc.)
Frequency of data collection	
Limitations	
Data type	Percent (%)
Related links	Health at a Glance 2019: OECD Indicators. Paris: OECD Publishing; 2019. https://doi.org/10.1787/4dd50c09-en (https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2019_4dd50c09-en, accessed 20 April 2021). Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO.

	Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020 (https://www.who.int/publications/i/item/9789240017832, accessed 17 August 2021). Johns Hopkins Primary Care Policy Center Primary Care Assessment Tools (https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/pca_tools.html, accessed 19 August 2021). OECD. Patient-reported indicator survey (PaRIS). Patient and Provider Questionnaires. Technical Materials 2021 (https://www.oecd.org/health/paris/, accessed 18 September 2021).

Note: Sub-national level indicator prioritized for reporting in sub-set of countries only

3.11. SDG 3.c.1 Health worker density and distribution (by occupation, subnational, facility ownership, facility type, age, sex)

Indicator	Health worker density and distribution (by occupation, subnational, facility ownership, facility type, age, sex)
Rationale	A health workforce (HWF) of adequate size and skill mix is critical to the attainment of any population health goal. This includes the achievement of universal health coverage (UHC) and the health-related targets of the United Nations Sustainable Development Goals (SDGs). Yet countries globally are affected by multifaceted challenges, such as difficulties in HWF education and training, deployment, performance and retention. Suboptimal allocation of health workers is one of the main challenges that directly influences the availability, accessibility, quality and performance of national health services, and may leave populations with inadequate access to the health services they need. The concept of a multidisciplinary primary health and care workforce that was articulated in the Declaration of Alma-Ata is as valid and relevant today as it was 40 years ago. To progress toward UHC, SDG and other health outcomes, countries will need a health and care workforce that is aligned with population and community health needs and which can adjust to the growing demand driven by rapid demographic, epidemiological, economic, social and political changes. The health and care workforce includes all occupations engaged in providing health promotion, disease prevention, treatment, rehabilitation and palliative care services, the public health workforce, and those engaged in addressing the social determinants of health. Ensuring that all occupations play an effective role in the PHC team, including through role optimization and role substitution, can transform traditional models of service provision. Preparing the health and care workforce to work toward the attainment of a country's health objectives represents one of the most important challenges for its health system.
Mandate (WHA resolution, SDG)	SDG 3.c.1, WHA63.16, WHA69.19, WHA73.9, WHA74.15, WHA74.14
Definition	Number of health workers per 10 000 population by occupation

Numerator	Number of health workers by occupation
Denominator	Total population as estimated by the UN Statistics Division.
Preferred data sources	NHWA
Other data sources	
Disaggregation	**Note**: * and underlined disaggregation indicate areas with better data availability By Occupation: (ISCO-08 codes included in parentheses) Medical Doctors (221)* • Generalist medical practitioners (2211) • Specialist medical practitioners (2212) Nursing and midwifery professionals and associate professionals (222&322)* • Nursing professionals and associate professionals (2221&3221)* • Midwifery professionals and associate professionals (2222&3222)* • Dentists (2261) • Pharmacists (2262) • Environmental and occupational health and hygiene professionals (2263) • Physiotherapists (2264) • Dietitians and nutritionists (2265) • Audiologists and speech therapists (2266) • Optometrists and ophthalmic opticians (2267) • CHWs (3253) • Traditional and complementary medicine professionals (223) (see complete list in NHWA Handbook second edition) For GPW14, it is suggested to use the health workforce density and distribution of medical doctors, nursing and midwifery personnel as a proxy. The following additional disaggregation factors will be used by occupation (incl. reference to NHWA indicators, see NHWA Handbook second edition for further details): • Subnational (1st level administrative) (NHWA indicator 1-02) • Age (NHWA indicator 1-03)* • Sex (NHWA indicator 1-04) * • Facility ownership (public/private) (NHWA indicator 1-05)* • Facility type (NHWA indicator 1-06)* Facility type are based on System of Health Account classification: • Hospitals (HP.1) • Residential long-term care facilities (HP.2) • Providers of ambulatory health care (HP.3) (including facilities, community services, individual providers) • Ancillary services (HP.4) (including transportation, emergency rescue, laboratories and others) • Retailers (HP.5) (including pharmacies) • Providers of preventive care (HP.6)

Frequency of data collection	Annual
Limitations	Data on health workers tend to be more complete for the public health sector and may underestimate the active workforce in the private, military, nongovernmental organization and faith-based health sectors. In many cases, information maintained at the national regulatory bodies and professional councils is not updated. Depending on the nature of the original data source, stock (numerator) of health workers may include practising workers only or all registered (licensed to practice) workers. As data is not always published annually for each country, the latest available data has been used. Due to the differences in data sources, considerable variability remains across countries in the coverage, periodicity, quality and completeness of the original data. Densities are calculated using the latest national population estimates from the United Nations Population Division's World Population Prospects database and may vary from densities produced by the country.
Data type	Ratio (per 10 000 population)
Related links	Universal Health Coverage. Geneva: World Health Organization; 2023 (https://www.who.int/health-topics/universal-health-coverage#tab=tab_1, accessed 27 July 2023). Global strategy on human resources for health: Workforce 2030. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf, accessed 27 July 2023). Horton R, Araujo EC, Bhorat H, Bruysten S, Jacinto CG, McPake B et al. Final report of the expert group to the High-level commission on health employment and economic growth. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/bitstream/handle/10665/250040/9789241511285-eng.pdf, accessed 27 July 2023). National health workforce accounts: a handbook, 2nd ed. Geneva: World Health Organization; 2023. (https://iris.who.int/handle/10665/374320, accessed 23 February 2024). Licence: CC BY-NC-SA 3.0 IGO Building the primary health care workforce of the 21st century. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/328072, accessed 16 August 2021).

3.12. WHA64.9 Government domestic spending on health (1) as a share of general government expenditure, and (2) per capita

Indicator	a. Government domestic spending on health as a share of general government expenditure (gghed%gge) b. Government domestic spending on health per capita (gghed_pc).

Rationale	Indicator a illuminates the priority of health within public spending, reflecting the government's tangible commitment to prioritize health through effective resource allocation. Indicator b reflects the amount of money that government spent on health from domestic sources in per capita terms. When considered alongside gghed%gge, The two indicators provide a more comprehensive picture of the absolute financial commitment and the relative prioritization of health within the government expenditure. It is especially useful in the light of challenging macro-fiscal landscape anticipated in many countries in the upcoming years. It recognizes that a higher priority alone may not guarantee the maintenance of government spending on health at levels seen in previous years due to the decrease of the overall government spending.
Mandate (WHA resolution, SDG)	WHA64 (WHA64.9) 'Sustainable health financing structures and universal coverage". SDG 1.a.2 Microsoft Word - A64_R1_COV+PRELIMS-en.docx (who.int)
Definition	a. Domestic General Government Health Expenditure (GGHE-D) divided by General Government Expenditure (GGE) b. Domestic General Government Health Expenditure (GGHE-D) divided by total population
Numerator	a. Domestic General Government Health Expenditure (GGHE-D)
Denominator	a. General Government Expenditure (GGE)
Preferred data sources	WHO Global Health Expenditure Database
Other data sources	
Disaggregation	NA
Frequency of data collection	Annual data collection
Limitations	Data reporting with 2-year time lag, and very few countries reporting t-1 data.
Data type	a. Percentage (%) b. Number
Related links	https://apps.who.int/nha/database/Home/Index/en

3.13. Access to health products index

Indicator	Health product access index
Rationale	Access to health products (medicines, vaccines, medical devices including diagnostics, assistive products, blood and other products of human origin) diagnostics and other health products) is a core element of providing quality health services that people need. The health product access index is designed to summarize data from existing essential health service coverage indicators to reduce duplication and reporting burden.
Mandate (WHA resolution, SDG)	WHA60.29, WHA67.22, WHA71.8, WHA76.5 SDG target 3.8: achieve universal health coverage (UHC), including financial risk protection, access to quality essential healthcare services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.
Definition	Health services coverage indicators, that involve the use of any or a combination of health products are selected as tracer indicators (Table 1) to construct the health product access index. The index is computed with geometric means, using the mean scores calculated for

	each tracer indicator group (or category of product) that is linked to the use of different health products. The index is reported on a unitless scale of 0 to 100, with 100 being the optimal value
Numerator	The country score is calculated using existing national information for each tracer indicator.
Denominator	The denominator will depend on actual number of tracer indicators per category of product used for the calculation of the overall country score.
Preferred data sources	Facility reporting system Health facility surveys Household surveys Administrative data
Other data sources	Official country response to the different types WHO surveys.
Disaggregation	Full disaggregation of the index may not be possible as not all tracer indicators have data that allow for disaggregation.
Frequency of data collection	Annual As the reporting frequency for selected tracer indicators may not be every year, extrapolation from existing time series data may be used to compute values for the missing year(s).
Limitations	These tracer indicators are meant to be indicative of access to health products and, not a complete or exhaustive list of all health products required to deliver essential health services, under universal health coverage. The 19 tracer indicators were selected because they are well-established, with available data widely reported by countries (or expected to become widely available soon). Therefore, the index can be computed with existing data sources and does not require initiating new data collection.
Data type	Index
Related links	https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage

Table 1. Tracer Indicator Name	**Category**
1. Prevalence of cervical cancer screening among women aged 30-49 years (%)	Device + diagnostic
2. Women accessing antenatal care (ANC) services who were tested for syphilis (%), reported	Diagnostic
3. New cases tested for RR-/MDR-TB (%)	Diagnostic
4. Women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods (%)	Device + Medicines
5. Tuberculosis treatment coverage	Diagnostic + medicines
6. Tuberculosis effective treatment coverage	Diagnostic + medicines
7. Estimated antiretroviral therapy coverage among people living with HIV (%)	Diagnostic + medicines
8. Antenatal care attendees positive for syphilis who received treatment (%), reported	Diagnostic + medicines

9. Neonates protected at birth against neonatal tetanus (PAB) (%)	Vaccine + device
10. Pneumococcal conjugate vaccines (PCV3) immunization coverage among 1-year-olds (%)	Vaccine + device
11. Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	Vaccine + device
12. Hepatitis B (HepB3) immunization coverage among 1-year-olds (%)	Vaccine + device
13. Hib (Hib3) immunization coverage among 1-year-olds (%)	Vaccine + device
14. Polio (Pol3) immunization coverage among 1-year-olds (%)	Vaccine + device
15. Measles-containing-vaccine first-dose (MCV1) immunization coverage by the nationally recommended age (%)	Vaccine + device
16. Measles-containing-vaccine second-dose (MCV2) immunization coverage by the nationally recommended age (%)	Vaccine + device
17. HPV immunization coverage estimates among primary target cohort (9-14 years old girls) (%)	Vaccine + device
18. Population with access to an insecticide-treated bed net (ITN) for malaria protection (%)	Vector control product
19. Prevalence of met need of assistive products (%)	Assistive products

3.14. WHA67.20 Improved regulatory systems for health products (medicines, vaccines, medical devices including diagnostics)

Indicator	Improved regulatory systems for targeted health products (medicines, vaccines, medical devices including diagnostics)
Rationale	National Regulatory Authorities (NRAs) are the gatekeepers of the supply of medicines and other health products, mandated to ensure their quality, safety, and efficacy. They work within a legal framework and set of regulatory functions spanning the product lifecycle, from clinical trials oversight, marketing authorization and registration, licensing establishments, regulatory inspections, testing products, post-marketing surveillance, and safety monitoring. However, many countries still lack this basic building block of a well-functioning health system as clearly articulated in Resolution WHA67.20 on regulatory systems strengthening for medical products (2014). This Resolution emphasized the WHO mandate and requested both WHO and Member States to invest more in this area and to address all health products and technologies, particularly in low and middle-income countries. According to WHO database on regulatory systems strengthening activities, about 70% of member states have suboptimal regulatory systems, and especially the low- and middle-income countries. The situation in these countries can be extremely challenging. NRAs are

	often overburdened and under-staffed, with fragmented structures or insufficient legal and regulatory frameworks resulting into infiltration on the market of substandard and falsified (SF) medical products. SF medical products undermines public health goals, causes deaths, promotes antimicrobial resistance, erodes public confidence on health care services and workforce.
Mandate (WHA resolution, SDG)	WHA67.20 on Regulatory Systems Strengthening for medical products (2014)
Definition	Improved regulatory capacity measured against the WHO Global Benchmarking Tool GBT indicators and implementation of recommendations according to their Institutional Development Plans (IDPs) for each of the health product streams (medicines, vaccines, medical devices and IVDs,
Numerator	ML achieved per product stream and function
Denominator	The highest maturity level achievable as per GBT as per product
Preferred data sources	Benchmarking reports and implementation of Institutional Development Plans (IDPs) according to WHO Global Benchmarking Tool (GBT)
Other data sources	N/A
Disaggregation	N/A
Frequency of data collection	Annually
Limitations	Readiness of countries to invest in regulatory systems strengthening based on international good regulatory practices
Data type	Numerical or % implementation of GBT indicators
Related links	WHO global benchmarking tool for evaluation of national regulatory system of medical products (revision VI) (https://iris.who.int/bitstream/handle/10665/341243/9789240020245-eng.pdf?sequence=1) Manual for benchmarking of the national regulatory system of medical products and formulation of institutional development plans (who.int) Evaluating and publicly designating regulatory authorities as WHO listed authorities Operational guidance for evaluating and publicly designating regulatory authorities as WHO listed authorities Manual for the performance evaluation of regulatory authorities seeking the designation as WHO-listed authorities

3.15. WHA 64.9 Government domestic spending on PHC as a share of total PHC expenditure

Indicator	Government domestic spending on PHC as a share of total PHC expenditure (phc_gghed%PHC).
Rationale	This indicator captures the extent government spending in overall PHC spending. Government spending on PHC services plays a crucial role in equitable accessibility of services and alleviating the financial burden on households related to payments for PHC services.
Mandate	*Political declaration of the high-level meeting on universal health coverage (Resolution adopted by the General Assembly on 10 October 2019) https://undocs.org/en/A/RES/74/2*

(WHA resolution, SDG)	
Definition	Primary Health Care Expenditure (PHC) funded by Domestic General Government Expenditure divided by PHC Expenditure
Numerator	Domestic General Government Expenditure on PHC
Denominator	PHC Expenditure
Preferred data sources	WHO Global Health Expenditure Database
Other data sources	
Disaggregation	NA
Frequency of data collection	Annual data collection
Limitations	Data reporting with 2-year time lag.
Data type	Percentage (%)
Related links	https://apps.who.int/nha/database/Home/Index/en

3.16. Existence of national digital health strategy, costed implementation plan, legal frameworks to support safe, secure and responsible use of digital technologies for health

Indicator	Existence of national digital health strategy, costed implementation plan, and legal frameworks to support safe, secure and responsible use of digital technologies for health.
Rationale	The World Health Organization defines digital health as the systematic application of information and communication technologies (ICT), computer science, and data to support informed decision-making by individuals, the health workforce, and health systems, to strengthen resilience to disease and improve health and wellness. While the use of digital tools for health can have a positive impact on health service delivery, it can also fail to support, promote, and improve population health if the technologies and data generated from those technologies are fragmented and not appropriately managed. Having a strategy for digital health will enable a country to logically lay out a plan to achieve its goals around digital transformation of the health sector. The use of digital health tools and resulting data should be strategic, support national health goals and be closely linked to the national M&E and HIS plans.
Mandate (WHA resolution, SDG)	WHA 71.1
Definition	National digital health strategy, costed implementation plan, and legal frameworks exists, measured against the following criteria: • Includes a vision, strategic objectives and key activities on digital health • Includes a timeline for achieving strategic objectives • Specifies financing and a costed implementation plan • Specifies organizational roles, responsibilities, and accountable parties • Includes a blueprint of the health enterprise architecture • Includes description of health data standards for exchange • Includes a policy and legal framework for health data exchange • Includes a policy for use of digital tools at the point of service • Includes a strategy and policy on telehealth/telemedicine • Includes a strategy and policy on cybersecurity of digital health systems

	• Includes a strategy and policy on privacy protection of health data • Specifies alignment with national health strategy • Specifies alignment with HIS strategy The attribute score attained by country divided by the total attribute score possible (%) is interpreted as progress along a maturity scale (from emerging/nascent maturity levels at the lower end of the scale to mature/sustainable levels at the higher end of the maturity scale).
Numerator	Attribute score attained
Denominator	Total attribute score possible
Preferred data sources	Qualitative assessment based on country surveys, interview with key informant and/or desk review of country documents.
Other data sources	Global Digital Health Monitor (https://monitor.digitalhealthmonitor.org/map)
Disaggregation	Not applicable
Frequency of data collection	Biennial
Limitations	A proxy for implementation, but not a direct measure of digital transformation implementation.
Data type	Qualitative
Related links	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020 (https://iris.who.int/handle/10665/337641, accessed 2 February 2024). 2018 Global Reference List of 100 Core Health Indicators (plus health-related SDGs). Geneva: World Health Organization; 2018 (https://iris.who.int/handle/10665/259951, accessed 2 February 2024). Global strategy on digital health 2020-2025. Geneva: World Health Organization; 2021 (https://iris.who.int/handle/10665/344249, accessed 2 February 2024). World Health Organization & International Telecommunication Union. National eHealth strategy toolkit. Geneva: International Telecommunication Union; 2012 (https://iris.who.int/handle/10665/75211, accessed 2 February 2024). Digital technologies: shaping the future of primary health care. Geneva: World Health Organization; 2018

	(https://iris.who.int/handle/10665/326573accessed 2 February 2024). Digital implementation investment guide (DIIG) : integrating digital interventions into health programs. Geneva: World Health Organization; 2020 (https://iris.who.int/handle/10665/334306, accessed 2 February 2024). Consolidated telemedicine implementation guide. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/364221, accessed 2 February 2024). Classification of digital interventions, services and applications in health: a shared language to describe the uses of digital technology for health, 2nd ed. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/373581, accessed 2 February 2024).

3.17. SCORE index

Indicator	SCORE Composite Indicator
Rationale	The SCORE Composite Indicator provides a comprehensive measure of the effectiveness and efficiency of a country's health information systems. It integrates multiple aspects of health data management, from surveillance to workforce capacity and reporting, allowing for a holistic view of health system performance and progress.
Mandate (WHA resolution, SDG)	
Definition	The SCORE Composite Indicator is a weighted average of five scaled input indicators, each normalized to a value between 0 and 1 using Max-Min normalization. These indicators include: 1. S2.2: Indicator and event-based surveillance systems based on IHR standards 2. C1.1: Completeness of birth and death registration 3. O3.2: Health workforce 4. R1.2: Annual report on progress 5. E1.1: National health plans and budget
Numerator	Sum of the weighted, normalized scores of the five input indicators.
Denominator	Number of input indicators (5).
Preferred data sources	SCORE Data
Other data sources	Annual Health Statistics, Health Strategy, UNSD data base, SPARS, JEE
Disaggregation	Data should be disaggregated by County
Frequency of data collection	Data should be collected on an annual basis to monitor progress and make timely adjustments to health policies and programs.
Limitations	• Data quality and availability may vary between countries including Missing Data. • Inconsistent data collection methodologies can affect comparability. • Dependence on the accuracy and completeness of national health reports.

Data type	Quantitative
Related links	https://www.who.int/data/data-collection-tools/score

3.18. WHA 71.1 % of health facilities using point of service digital tools that can exchange data through use of national registry and directory services

Indicator	% of health facilities using point of service digital tools that can exchange data through use of national registry and directory services (by type)
Rationale	This indicator captures the implementation of digital transformation through the extent of digital tool adoption at the point of service, within a broader national system that supports standards-based interoperability and access to canonical, national registries and databases of reusable information. The existence and use of such systems and the ability of countries to effectively track and govern use of those systems are widely understood as signs of advanced digital health maturity, and nationally-scaled digital transformation in health. The inability to report on this indicator is in and of itself an indication of the extent, or lack thereof, to which digital health transformation has been implemented. This recommendation is enshrined in multiple WHO and ITU technical guidance and guidelines and is consistent with the recommendations of the Member-State Global Strategy on Digital Health 2020-2025 and national registries are a foundational architectural component of a digital health transformation strategy.
Mandate (WHA resolution, SDG)	WHA 71.1
Definition	Health facilities are here defined based on their function, size, type of care they provide, and their level within a country's health system. For the purposes of this indicator, they are operationalized in the Geolocated Health Facilities Data initiative by facility type. "Point of service" digital tools are defined by the *Classification of digital interventions, services and applications in health: a shared language to describe the uses of digital technology for health, 2nd ed.* They are defined as "Systems that facilitate the provision and delivery of healthcare services to persons at the point of care. They include software capabilities that enable healthcare providers to access, record and update individuals' health information as well as interactively communicate with them." These include: • Communication systems • Community-based information systems, • Decision-support systems, • Diagnostics information systems, • Electronic medical record systems, • Laboratory information systems, • Personal Health Records, • Pharmacy Information systems, and • Telehealth systems

	"Registries and directories" are defined by the *Classification of digital interventions, services and applications in health: a shared language to describe the uses of digital technology for health, 2nd ed* as systems that serve as a central authority for maintaining specific sets of data. They provide software capabilities or services that are canonical/master lists, which are enforced by specific governance mechanisms. Registry and directory services include: • Census and population information systems, • Civil registration and vital statistics systems, • Facility management information systems, • Health facility registries, • Health worker registry, • Identification registries and directories, • Immunization information systems, • Master patient index, • Product catalogues • Public key directories • Terminology and classification systems
Numerator	Number of health facilities using point of service digital tools that can exchange data through the use of national registry and directory services
Denominator	Total number of health facilities
Preferred data sources	Digital Health Atlas, Global Digital Health Monitor, nationally conducted facility surveys
Other data sources	
Disaggregation	Facility type, point of service system type, registries and directories type (as per the *Classification of digital interventions services and applications in health*)
Frequency of data collection	Biennial
Limitations	
Data type	Numeric
Related links	Global strategy on digital health 2020-2025. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/344249, accessed 25 August 2021). World Health Organization & International Telecommunication Union. National eHealth strategy toolkit. Geneva: International Telecommunication Union; 2012 (https://apps.who.int/iris/handle/10665/75211, accessed 19 August 2021). International Classification of Diseases (https://icd.who.int/en, accessed 6 February 2024) Geo-Located Health Facilities Database (https://www.who.int/data/GIS/GHFD, accessed 6 February 2024) WHO Classification of digital interventions, services and applications in health. Geneva: World Health Organization; 2023 (https://iris.who.int/handle/10665/373581, accessed 6 February 2024)

	Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2022. License: CC BY-NC-SA 3.0 IGO. Operational framework for primary health care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2020 (https://www.who.int/publications/i/ item/9789240017832, accessed 17 August 2021). 2018 Global Reference List of 100 Core Health Indicators (plus health-related SDGs). Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/259951, accessed 20 April 2021). Harmonized health facility assessment (HHFA). https://www.who.int/data/data-collection-tools/harmonized-health-facility-assessment/introduction Digital technologies: shaping the future of primary health care. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/326573, accessed 30 August 2021).

Note: Sub-national level indicator prioritized for reporting in sub-set of countries only

3.19. WHA 75.20 Prevalence of active syphilis in individuals 15 to 49 years of age (%)

Indicator	Prevalence of active syphilis in individuals 15 to 49 years of age (%)
Rationale	Syphilis is a common curable sexually transmitted infection (STI) with serious health implications if not treated. Syphilis can also be transmitted from a pregnant woman to her baby and if when untreated lead to serious adverse pregnancy outcomes. Estimates of prevalence and incidence of syphilis are important for monitoring syphilis treatment and prevention programmes and for advocating for funding for syphilis programming and for the development of new treatments and prevention tools.
Mandate (WHA resolution, SDG)	Triple elimination - elimination of mother-to-child transmission (EMTCT) of HIV, syphilis and hepatitis B virus (HBV)
Definition	Prevalence of active syphilis in individuals 15 to 49 years of age.
Numerator	Estimated number of individuals 15 to 49 years of age with active syphilis
Denominator	Number of individual 15 to 49 years of age
Preferred data sources	Modeled estimates based on STI prevalence data generated using Spectrum-STI, a statistical model that estimates syphilis prevalence and incidence trends in different populations in a country and sums the populations together based on relative population size to generate national estimates over time. Prior to generating population estimates all prevalence data are

	standardized to ensure that they reflected active syphilis, defined as concurrent positivity on both a non-treponemal (e.g., Rapid Plasma Reagin (RPR) or Venereal Disease Research Laboratory (VDRL) test) and a treponemal test.
Other data sources	Prevalence of syphilis in pregnant women collected through routine health information systems.
Disaggregation	Sex, population
Frequency of data collection	Every 2 years
Limitations	Modeled estimates based on available data
Data type	Prevalence (%)
Related links	https://apps.who.int/gho/data/node.main.CONGENITALSYPHSTI?lang=en

3.20. SDG 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age, and key populations

Indicator	Number of new HIV infections per 1000 uninfected population, by sex, age and key populations
Rationale	
Mandate (WHA resolution, SDG)	Longitudinal data on individuals are the best source of data but are rarely available for large populations. Special diagnostic tests in surveys or from health facilities can be used to obtain data on HIV incidence. HIV incidence is thus modelled using the Spectrum software.
Definition	The number of new HIV infections per 1,000 uninfected population, by sex, age and key populations as defined as the number of new HIV infections per 1000 person-years among the uninfected population.
Numerator	Number of new HIV infections by sex, age and key populations
Denominator	Total uninfected population by sex, age and key populations
Preferred data sources	Spectrum modelling, household or key population surveys with HIV incidence-testing
Other data sources	Other possible data sources: Regular surveillance system among key populations.
Disaggregation	General population, Key populations (men who have sex with men, sex workers, people who inject drugs, transgender people, prisoners), Age groups (0-14, 15-24, 15-49, 50+ years), for key populations (< 25, 25+ years), mode of transmission (including mother-to-child transmission), place of residence, sex
Frequency of data collection	Data sources are compiled all year long. The spectrum models are created in the first three months of every year and finalized by June.

Limitations	
Data type	Rate
Related links	https://www.unaids.org/en/dataanalysis/datatools/spectrum-epp UNAIDS Global AIDS Monitoring: Indicators for monitoring the 2016 United Nations Political Declaration on Ending AIDS Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030 http://www.unaids.org/sites/default/files/media_asset/2017-Global-AIDS-Monitoring_en.pdf . UNAIDS website for relevant data and national Spectrum files http://aidsinfo.unaids.org/ Consolidated Strategic Information Guidelines for HIV in the Health Sector. Geneva: World Health Organization; https://www.who.int/hiv/pub/guidelines/en/ A description of the methodology is available at: http://www.unaids.org/sites/default/files/media_asset/Estimates_methods_2018.pdf

3.21. SDG 3.3.2 Tuberculosis incidence per 100,000 population

Indicator	Tuberculosis incidence per 100 000 population
Rationale	
Mandate (WHA resolution, SDG)	Estimates of incidence for each country are derived using one or more of the following approaches, depending on available data: (i) incidence = case notifications/estimated proportion of cases detected; (ii) capture-recapture modelling; (iii) incidence = prevalence/duration of condition.
Definition	Tuberculosis incidence is defined as the estimated number of new and relapse TB cases (all forms of TB, including cases in people living with HIV) arising in a given year, expressed as a rate per 100 000 population.
Numerator	Estimated number of new and relapse TB cases (all forms of TB, including cases in people living with HIV) arising in a given year
Denominator	Total population
Preferred data sources	High-quality surveillance systems in which underreporting is negligible, and strong health systems so that under-diagnosis is also negligible
Other data sources	Annual case notifications, assessments of the quality and coverage of TB notification data, national surveys of the prevalence of TB disease and information from death (vital) registration systems
Disaggregation	By country, sex, age (children vs adults).

Frequency of data collection	Annual
Limitations	Uncertainty in indicator values
Data type	Rate
Related links	https://unstats.un.org/sdgs/metadata/files/Metadata-03-03-02.pdf

3.22. SDG 3.3.3 Malaria incidence per 1,000 population

Indicator	Malaria incidence per 1 000 population
Rationale	
Mandate (WHA resolution, SDG)	
Definition	The number of new cases of malaria per 1,000 people at risk each year. The number of malaria cases was estimated by one of the following two methods: Method 1: Method 1 was used for countries and areas outside Africa and for low-transmission countries and areas in Africa: Afghanistan, Bangladesh, Bolivia (Plurinational State of), Botswana, Brazil, Cambodia, Colombia, Dominican Republic, Eritrea, Ethiopia, French Guiana, Gambia, Guatemala, Guyana, Haiti, Honduras, India, Indonesia, Lao People's Democratic Republic, Madagascar, Mauritania, Myanmar, Namibia, Nepal, Nicaragua, Pakistan, Panama, Papua New Guinea, Peru, Philippines, Rwanda, Senegal, Solomon Islands, Timor-Leste, Vanuatu, Venezuela (Bolivarian Republic of), Viet Nam, Yemen and Zimbabwe. Estimates were made by adjusting the number of reported malaria cases for completeness of reporting, the likelihood that cases were parasite positive, and the extent of health service use. The procedure, which is described in the World malaria report 2008 (5), combines data reported by NMPs (reported cases, reporting completeness and likelihood that cases are parasite positive) with data obtained from nationally representative household surveys on health service use. Briefly: T = (a + (c x e))/d x (1+f/g+(1−g−f)/2/g) where: a is malaria cases confirmed in public sector b is suspected cases tested c is presumed cases (not tested but treated as malaria) d is reporting completeness e is test positivity rate (malaria positive fraction) = a/b f is fraction seeking treatment in private sector g is fraction seeking treatment in public sector No treatment seeking factor: (1-g-f) Cases in public sector: (a + (c x e))/d Cases in private sector: (a + (c x e))/d x f/g Method 2 Method 2 was used for high-transmission countries in Africa and for some countries in the WHO Eastern Mediterranean Region in which the quality of surveillance data did not permit a robust estimate from the number of reported cases: Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Gabon, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Sierra Leone, Somalia, South Sudan, Sudan, Togo, Uganda, United Republic of Tanzania and Zambia. In this method, estimates of the number of malaria cases were derived from information on parasite prevalence obtained

	from household surveys. First, data on parasite prevalence from nearly 60 000 survey records were assembled within a spatiotemporal Bayesian geostatistical model, along with environmental and sociodemographic covariates, and data distribution on interventions such as insecticide-treated mosquito net (ITNs), antimalarial drugs and indoor residual spraying (IRS). The geospatial model enabled predictions of Plasmodium falciparum prevalence in children aged 2–10 years, at a resolution of 5 × 5 km2 , throughout all malaria endemic African countries for each year from 2000 to 2018.1 Second, an ensemble model was developed to predict malaria incidence as a function of parasite prevalence. The model was then applied to the estimated parasite prevalence in order to obtain estimates of the malaria case incidence at 5 × 5 km2 resolution for each year from 2000 to 2018.1 Data for each 5 × 5 km2 area were then aggregated within country and regional 1 For methods on the development of maps by the Malaria Atlas Project, see https://www.map.ox.ac.uk/making-maps/. boundaries, to obtain both national and regional estimates of malaria cases For more details see World Malaria Report 2019 as referenced in links below.
Numerator	Total estimated number of new cases of malaria
Denominator	Total population
Preferred data sources	Country surveillance systems (number of suspected cases, number of tested cases, number of positive cases by method of detection and by species as well as number of health facilities that report those cases)
Other data sources	Representative household surveys
Disaggregation	Country
Frequency of data collection	Annual
Limitations	The estimated incidence can differ from the incidence reported by a Ministry of Health which can be affected by (1) completeness of reporting (2) extent of malaria diagnostic testing, (3) use of private health facilities not included in reporting systems, and (4) estimation only where malaria transmission occurs.
Data type	Rate
Related links	https://www.who.int/publications-detail/world-malaria-report-2019 https://unstats.un.org/sdgs/metadata/files/Metadata-03-03-03.pdf

3.23. Vector-borne disease incidence

Indicator	Estimated number of cases of vector borne diseases: - Mosquitoes: malaria, dengue, chikungunya, zika, yellow fever, Japanese encephalitis, west Nile fever, Lymphatic filariasis, - Blackflies: Onchocerciasis - Sandflies: leishmaniasis - Triatomine bugs: Chagas disease - Tsetse flies: Human African trypanosomiasis - Snails: schistosomiasis

	-Copepods: Dracunculiasis - Culucoides midges: Oropouche virus
Rationale	Vector-borne diseases pose a significant global public health challenge, particularly in tropical and subtropical regions. These diseases, transmitted by vectors such as mosquitoes, ticks, and flies, contribute substantially to the global burden of disease, causing high levels of morbidity and mortality. They strain health systems, especially in low- and middle-income countries with limited resources, and lead to significant economic losses through healthcare expenditures, reduced productivity, and impacts on agriculture. Moreover, vector-borne diseases perpetuate a cycle of poverty, exacerbating socioeconomic disparities and hindering development efforts. Accurate estimation of annual cases is crucial for effective vector control programs and resource allocation. It informs the planning and implementation of interventions aimed at reducing disease transmission and improving health outcomes. Monitoring these diseases supports progress towards Sustainable Development Goal 3 (Good Health and Well-being) and aligns with World Health Organization goals for disease elimination, control and prevention of epidemics. Furthermore, understanding disease patterns helps in identifying emerging and re-emerging threats, particularly under the influence of climate change, environmental suitability, mass migration and underscores the need for innovation in vaccines, treatments, and public health strategies to combat these complex health challenges effectively. Complete data on malaria cases reported through surveillance systems are the best source of data but are rarely available for large populations at high quality and accuracy. Reported data on malaria cases generally need to be adjusted for extent of health service use (treatment seeking), underreporting and lack of case confirmation (the likelihood that cases are parasite positive). WHO compiles data on reported confirmed cases of malaria and suspected cases tested with microscopy or RDT, submitted by national malaria control programmes. Underreporting is reported or estimated by countries. The extent of health service use (treatment seeking) data were obtained from nationally representative household surveys on health service use.
Mandate (WHA resolution, SDG)	Malaria: WHA68.2 (2015) Global technical strategy and targets for malaria 2016–2030 A74/55 (2021) Global technical strategy and targets for malaria 2016–2030 WHA74.9 Recommitting to accelerate progress towards malaria elimination Neglected tropical diseases WHA73 (33) - Road map for neglected tropical diseases 2021–2030 WHA66.12 (2013) on neglected tropical diseases, Decision EB146(9) of the Executive Board at its 146th session Ending the neglect to attain the Sustainable Development Goals: A road map for neglected tropical diseases 2021–2030, accessible at: https://www.who.int/publications/i/item/9789240010352
Definition	Estimated Number of Cases of Vector-Borne Diseases (Climate Sensitive) refers to the approximate count of individuals who contract diseases transmitted by specific vectors, such

	as mosquitoes, blackflies, sandflies, triatomine bugs, tsetse flies, and snails, within a specific time frame, usually annually. These diseases are significantly influenced by climatic factors such as temperature, precipitation, and humidity. The estimates are derived from epidemiological data, surveillance reports, and mathematical models to account for both reported cases and underreporting in various regions. For malaria, Cconfirmed cases for countries and areas outside Africa, and for low-transmission countries and areas in Africa are adjusted for extent of health service use (treatment seeking), underreporting and lack of case confirmation (the likelihood that cases are parasite positive). In high transmission areas in which the quality of surveillance data does not permit a robust estimate from the number of reported cases, but good data on parasite prevalence is available, the number of cases is estimated from parasite prevalence through a spatio-temporal statistical model. The range in brackets shown with the point estimate in the data tables represent the 95% uncertainty intervals.
Numerator	Estimated number of new cases of vector borne diseases reported per year
Denominator	
Preferred data sources	1 - Ministries of Health : National Programme , surveillance systems: Integrated Disease surveillance and Response systems, annual reports. 2 - Disease-specific surveys and specially commissioned studies to adjust for completeness where significant data gaps persist.
Other data sources	Institute for Health Metrics and Evaluation
Disaggregation	By country and WHO region Gender, age-groups, geolocation (rural, urban)
Frequency of data collection	Annual
Limitations	Operational challenges for timeliness and completeness of reporting by member states
Data type	Numeric
Related links	Global Malaria Report https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2023 Global progress report on neglected tropical diseases 2024 https://www.who.int/publications/i/item/9789240091535 Compendium of Indicators for NTD data, accessible: https://www.who.int/publications/i/item/9789240062863

3.24. SDG 3.3.4 Hepatitis B incidence per 100,000 population

Indicator	Hepatitis B incidence per 100 000 population

Rationale	
Mandate (WHA resolution, SDG)	SDG 3.3.4, WHA75.20
Definition	The number of new hepatitis B infections per 100,000 population in a given year is estimated from the prevalence of total antibodies against hepatitis B core antigen (Total anti-HBc) and hepatitis B surface antigen (HBsAg) positive among children 5 years of age, adjusted for sampling design. $\frac{\text{Number of survey participants with Total anti} - \text{HBc and HBsAg positive test}}{\text{Number in survey with Total anti} - \text{Hc/HBsAg result}}$
Numerator	Number of survey participants with Total anti-HBc and HBsAg positive test
Denominator	Number in survey with Total anti-Hc/HBsAg result
Preferred data sources	Serosurvey
Other data sources	Routinely collected hepatitis B vaccine administrative coverage data including the proportion newborn infants given the first dose within 24 hours of birth (HepB0%) and the percentage of infants having received three doses of hepatitis B vaccine (HepB3 %)
Disaggregation	By sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).
Frequency of data collection	Intermittent, dependent on population seroprevalence of HBsAg before hepatitis B immunization and infant hepatitis B vaccination coverage.
Limitations	
Data type	Rate
Related links	Hepatitis B Control Through Immunization: a Reference Guide http://iris.wpro.who.int/bitstream/10665.1/10820/3/9789290616696_eng.pdf Documenting the Impact of Hepatitis B Immunization: best practices for conducting a serosurvey http://whqlibdoc.who.int/hq/2011/WHO_IVB_11.08_eng.pdf Sample design and procedures for Hepatitis B immunization surveys: A companion to the WHO cluster survey reference manual http://whqlibdoc.who.int/hq/2011/WHO_IVB_11.12_eng.pdf

3.25. WHA 75.20 Hepatitis C incidence per 100,000 population

Indicator	Hepatitis C incidence per 100,000 population
Rationale	• This indicator measure progress towards reduction of new HCV infections and the GHSS HCV elimination impact targets by 2030.

	• Evidence-based prevention strategies and highly effective curative treatments are available for HCV infection. This indicator therefore reflects both the outcome and impact of hepatitis C prevention and treatment on new HCV infections. It monitors trends, detects possible shifts in pattern and projects the future direction of the epidemic. • High-level programme coverage of evidence-based prevention including safe injections in health-care settings, viral hepatitis testing in quality blood product services, harm reduction for PWID, as well as access to high coverage of HCV testing, diagnosis, treatment and cure, especially in populations with ongoing high rates of transmission, should result in decreasing levels of HCV incidence.
Mandate (WHA resolution, SDG)	World Health Organization
Definition	Incidence of chronic hepatitis C infection (HCV) is defined as the estimated number of new and re-infection of HCV arising in a given year. It is usually expressed as a rate per 100 000 population.
Numerator	Number of cases per year per 100,000 population.
Denominator	Total number of population at risk (or person-years exposed) *Note:* Population at risk includes those with no active infection i.e. negative HCVAb or HCV RNA
Preferred data sources	Direct estimates based on prospective or retrospective cohort studies, repeated cross-sectional studies (in specific populations), modelled estimates (based on existing programme data) ***Preferred direct measures (general population or PWID)*** (a) *Direct estimation of HCV incidence based on prospective cohort* (HCV retesting of persons who initially tested negative for HCVAb or RNA). This gold-standard method involves ascertaining new HCV cases prospectively among individuals at risk of infection, *who are followed up over time*; this approach is, however, not efficient if HCV incidence is a rare outcome. Suitable mainly if: (i) expected HCV incidence is sufficiently high to balance sample size requirements, and (ii) financial and logistical resources are available to use this approach among a representative population sample. It is important to recognize that this requires registration of people testing negative at baseline with a unique identifier (b) *Direct estimation of HCV incidence based on retrospective cohorts* (HCV retesting of persons who initially tested negative for HCVAb or RNA). This method consists of using routinely collected health data to ascertain new HCV infection cases among susceptible individuals who receive multiple HCV tests over time as part of routine care. Can be used to estimate primary HCV infection or HCV reinfection. Suitable only if: (i) expected HCV incidence is insufficient high to justify a prospective study, or (ii) financial and logistical resources are limited and do not allow for nationwide prospective surveillance among a representative sample, and (iii) high-quality and representative data collected through medical records are available. *(c) Using infectious disease models to estimate HCV incidence.* Infectious disease models can be used to generate HCV incidence estimates from prevalence data and routine programmatic surveillance data. Suitable where (i) at least two country-specific prevalence serosurveys are available, and (ii) routine surveillance data (e.g. testing and treatment coverage data as well as HCV cure rates) assumptions about HCV natural history, and HCV

	transmission are sufficiently available to inform the model inputs parameters. Where available, HCV models that have been peer-reviewed, validated and published should be used .
Other data sources	*Direct estimation based on linked repeated cross-sectional surveys*. In repeat cross-sectional surveys, a new sample of participants is recruited with each round. If some participants appear in multiple rounds and individual-level data can be linked over time, then these surveys can be used to estimate HCV incidence. This method has been used to estimate HCV incidence (primarily among PWID) in settings such as Canada, Australia, and Greece. There is a limitation in settings or populations with low baseline HCV incidence and/or large populations as very large sample sizes are necessary, and as a small proportion of individuals typically participate in multiple survey rounds. Consequently, this method is likely to be primarily applicable to populations (PWID, MSM) at risk of high incidence of HCV infection.
Disaggregation	Age, gender, HIV status, geographical location, higher risk populations or probable route of transmission (IDU, unsafe medical injections, blood transfusion, blood products r organ/tissue donations, piercing, circumcision or acupuncture)
Frequency of data collection	Estimations and cohort studies are done intermittently. Modeling estimates should be updated every two years

3.26. SDG 3.3.5 Number of people requiring interventions against neglected tropical diseases

Indicator	Number of people requiring interventions against neglected tropical diseases
Rationale	
Mandate (WHA resolution, SDG)	
Definition	Number of people requiring treatment and care for any one of the neglected tropical diseases (NTDs) targeted by the WHO NTD Roadmap, World Health Assembly resolutions and reported to WHO. Some estimation is required to aggregate data across interventions and diseases. There is an established methodology that has been tested and an agreed international standard. [http://www.who.int/wer/2012/wer8702.pdf?ua=1] 1) Average annual number of people requiring mass treatment known as preventive care (PC) for at least one PC-NTD: People may require PC for more than one PC-NTD. The number of people requiring PC is compared across the PC-NTDs, by age group and implementation unit (e.g. district). The largest number of people requiring PC is retained for each age group in each implementation unit. The total is considered to be a conservative estimate of the number of people requiring PC for at least one PC-NTD. Prevalence surveys determine when an NTD has been eliminated or controlled and PC can be stopped or reduced in frequency, such that the average annual number of people requiring PC is reduced. 2) Number of new cases requiring individual treatment and care for other NTDs: The number of new cases is based on country reports, whenever available, of new and known cases of

	Buruli ulcer, Chagas disease, cysticercosis, dengue, guinea-worm disease, echinococcosis, human African trypanosomiasis (HAT), leprosy, the leishmaniases, rabies and yaws. Where the number of people requiring and requesting surgery for PC-NTDs (e.g. trichiasis or hydrocele surgery) is reported, it can be added here. Similarly, new cases requiring and requesting rehabilitation (e.g. leprosy or lymphoedema) can be added whenever available. Populations referred to under 1) and 2) may overlap; the sum would overestimate the total number of people requiring treatment and care. The maximum of 1) or 2) is therefore retained at the lowest common implementation unit and summed to get conservative country, regional and global aggregates. By 2030, improved co-endemicity data and models will validate the trends obtained using this simplified approach. A reduction of 400 million is calculated by subtracting current year numerator by baseline year numerator (2017)
Numerator	Number of people requiring interventions against neglected tropical diseases
Denominator	NA
Preferred data sources	The number of people requiring treatment and care for NTDs is measured by existing country systems, and reported through joint request and reporting forms for donated medicines, the integrated NTD database, and other reports to WHO.
Other data sources	Develop a standard protocol for systematic data collection for NTDs through World Health Survey Plus (WHS+).
Disaggregation	Disaggregation by age is required for PC: pre-school-aged children (1-4 years), school-aged (5-14 years) and adults (= 15 years).
Frequency of data collection	Annual
Limitations	Country reports may not be perfectly comparable over time. Improved surveillance and case-finding may lead to an apparent increase in the number of people known to require treatment and care. Some further estimation may be required to adjust for changes in surveillance and case-finding. Missing country reports may need to be imputed for some diseases in some years.
Data type	Absolute number
Related links	https://unstats.un.org/sdgs/metadata/?Text=&Goal=3&Target=3.3 http://www.who.int/neglected_diseases/mediacentre/resolutions/en/ http://www.who.int/neglected_diseases/resources/NTD_Generic_Framework_2015.pdf

3.27. SDG 3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes, or chronic respiratory disease

Indicator	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory diseases
Rationale	
Mandate (WHA resolution, SDG)	
Definition	Age-specific death rates for the combined four cause categories (typically in terms of 5-year age groups30-34, 65-69). A life table method allows calculation of the risk of death between exact ages30 and70 from any of these causes, in the absence of other causes of death. The ICD codes to be included in the calculation are: cardiovascular disease: I00-I99, Cancer: C00-C97, Diabetes: E10-E14, or Chronic respiratory diseases: J30-J98. To calculate age-specific mortality rate for each 5-year age group and country, for each 5-year age range between 30 and 70: $${}^{*}_{5}M_x = \frac{Total\ deaths\ from\ four\ major\ NCD\ causes\ between\ exact\ age\ x\ and\ exact\ age\ x}{Total\ population\ between\ exact\ age\ x\ and\ exact\ age\ x+5}$$ Then translate the 5-year death rate to the probability of death in each 5-year age range: $${}^{*}_{5}q_x = \frac{{}^{*}_{5}M_x * 5}{1 + {}^{*}_{5}M_x * 2.5}$$ The probability of death from age 30 to 70 years, independent of other causes of death can be calculated as: $${}^{*}_{40}q_{30} = 1 - \prod_{x=30}^{65}(1 - {}^{*}_{5}q_x)$$
Numerator	See above
Denominator	See above
Preferred data sources	Vital registration systems which record deaths with sufficient completeness to allow estimation of all-cause death rates.
Other data sources	Sample registration systems; verbal autopsy.
Disaggregation	By sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).
Frequency of data collection	Annual
Limitations	- incomplete or unusable death registration data
Data type	Probability
Related links	WHO: http://www.who.int/gho/ncd/mortality_morbidity/ncd_premature_text/en/; http://www.who.int/healthinfo/statistics/LT_method.pdf.

3.28. WHA75 (11) Prevalence of controlled diabetes in adults aged 30-79 years

Indicator	Prevalence of controlled diabetes in adults aged 30-79 years
Rationale	In 2019, diabetes was the direct cause of 1.5 million deaths, and 48% of all deaths due to diabetes occurred in people before the age of 70 years. Another 460 000 deaths from kidney disease were caused by diabetes, and raised blood glucose concentrations caused around 20% of cardiovascular deaths globally. Between 2000 and 2019, there was a 3% increase in age-standardized mortality rates from diabetes. People with diabetes are also at increased risk of other diseases, including cardiac, peripheral arterial and cerebrovascular disease, cataracts, erectile dysfunction, and nonalcoholic fatty liver disease. They are also at an increased risk of some infectious diseases such as tuberculosis, and are likely to experience poorer outcomes.
Mandate (WHA resolution, SDG)	WHA75(11) (2022). The WHA 2022 adopted a set of diabetes related targets and associated indicators to monitor the status of diabetes management globally. The five new targets are, by 2030: • 80% of people living with diabetes are diagnosed • 80% have good control of glycaemia • 80% of people with diagnosed diabetes have good control of blood pressure • 60% of people with diabetes of 40 years or older receive statins • 100% of people with type 1 diabetes have access to affordable insulin and blood glucose self-monitoring.
Definition	Diabetes is defined as having a fasting plasma glucose value ≥7.0 mmol/L (126 mg/dl) or on medication for raised blood glucose. Control is defined as taking medication for raised blood glucose and having fasting plasma glucose value < 7.0 mmol/L (126 mg/dl).
Numerator	Number of people with diabetes with good glycaemic control (HbA1c <7.0% (53 mmol/mol), or FPG <7.0 mmol/L (126mg/dL) and (if available) a postprandial PG value <9.0 mmol/L (160 mg/dL)
Denominator	Number of people aged 30 – 79 with diabetes, as defined above.
Preferred data sources	Nationally representative population-based surveys where blood glucose is measured and diagnosis and treatment status are assessed.
Other data sources	Routine health information systems collecting patient level data.
Disaggregation	Age, sex, other relevant socio-demographic stratifiers where available
Frequency of data collection	At least every 5 years
Limitations	Potential limitations include: - measurement error - representativeness of the sample - availability of administrative data
Data type	prevalence
Related links	https://www.who.int/initiatives/the-who-global-diabetes-compact

3.29. SDG 3.4.2 Suicide mortality rate

Indicator	Suicide mortality rate
Rationale	
Mandate (WHA resolution, SDG)	
Definition	Number of suicide deaths divided by the population and multiplied by 100,000 in a country in a given period of time. Suicide deaths will be based on the following ICD-10 codes: X60-X84, Y87.0. Suicide mortality rate = $\frac{Number\ of\ deaths\ from\ suicide}{Total\ population} \times 100{,}000$
Numerator	Number of suicide deaths in a given period of time
Denominator	Total population in a given period of time
Preferred data sources	Vital registration systems which record deaths with sufficient completeness to allow estimation of cause-specific death rates.
Other data sources	Sample registration systems; verbal autopsy.
Disaggregation	By sex, age.
Frequency of data collection	Annual
Limitations	- incomplete or unusable death registration data
Data type	Rate
Related links	WHO: http://www.who.int/gho/mental_health/mental_health_indicatorbook.pdf?ua=1.

3.30. SDG 3.5.1 Coverage of treatment interventions (pharmacological, psychosocial, and rehabilitation and aftercare services) for substance use disorders

Indicator	Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders
Rationale	
Mandate (WHA resolution, SDG)	proxy-data reflecting major components of treatment systems for substance use disorders.
Definition	Substance use disorders include substance dependence and harmful pattern of substance use. Severe substance use disorders include substance dependence only.

	There are two approaches currently under development and testing towards the indicator report: 1) Estimation based on actual service utilization: $\text{Treatment coverage} = \frac{\text{Treatment demands (Number of people in contact with treatment services)}}{\text{Treatment needs (Number of people with substance use disorders)}} \times 100\%$ 2) Estimation based on composite indicator of service development:
Numerator	Number of people with substance use disorders/substance dependence in contact with treatment services in a given year
Denominator	Total number of people with substance use disorders/substance dependence in the population in a given year
Preferred data sources	WHO ATLAS on Substance Use (ATLAS-SU) and associated data collection activities; WHO Global Information System on Alcohol and Health (GISAH) and associated data collection activities; UNODC data generated through Annual Report Questionnaire (ARQ) surveys; WHO-UNODC Facility surveys; data collected through National statistical systems and health system data; population-based household surveys; GBD data for substance use dosor availability and utilization.
Other data sources	Other sources of information available from different international organizations and member states, such as administrative, project data, expert opinions, country-level targeted activities to generate and impute data. The unit is in the process of exploring feasibility and validity of the two approaches for picking up trends in the development of prevention and treatment systems for substance use disorders. Funding was secured for advancing the work on both directions with field testing of the second approach in at least 5 countries during 2019.
Disaggregation	By type of substances, substance use disorders and treatment modalities
Frequency of data collection	The frequency of data collection will remain the same: -annual data collection for illicit drugs component; -annual or at least biennial for alcohol and other substance use component; -every 3-5 years for WHO ATLAS on Substance Use collects data.
Limitations	Effective coverage estimation may not feasible or limited to few predominantly high-income countries; In case of poor or unavailable data, country estimations may be limited to the level of availability coverage.
Data type	Percentage
Related links	ATLAS-SU: http://www.who.int/gho/substance_abuse/en/ GISAH: http://www.who.int/gho/alcohol/en/ UNODC World Drug Report: https://www.unodc.org/wdr2018/ http://www.who.int/mental_health/publications/action_plan/en/ http://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/

3.31. WHA72/2019/REC/1 Service coverage for people with mental health and neurological conditions

Indicator	Service coverage for people with mental health and neurological conditions
Rationale	**Public health rationale**: • Burden: 1 billion (1 in 8) have a mental health condition; neurological disorders (e.g. stroke, migraine, dementia) are the leading cause of DALYs • Unmet need: ~70% global treatment gap for psychosis; ~90% for depression • Equity: Greater unmet need among women, lower SES groups, migrants, etc. • Crises: Population mental health directly affected by violence/conflict, COVID-19, recession, climate change **GPW-13 & SDG context**: • There are three GPW indicators relating to mental health and substance use: suicide rate (SDG 3.4.2); treatment coverage for substance use disorders (SDG 3.5.1); and alcohol use per capita (SDG 3.5.2). These provide a relevant *but insufficient* basis for tracking country-level implementation and impact. • In particular, there is a need to track changes in service coverage for priority mental and neurological conditions: psychosis (as a tracer for severe mental health conditions), depression (as a tracer for common mental health conditions), and epilepsy (as a tracer for neurological conditions). • The associated GPW-14 output being proposed is: *Support scaled-up implementation and coverage measurement of person-centred, rights-based services for key mental health and neurological conditions (psychosis, depression, epilepsy).* • The associated GPW-14 delivery milestone being proposed for 2024-25 is: *Support at least 18 low- and middle-income countries to measure and report service coverage for mental, neurological and substance use tracer conditions (psychosis, depression, epilepsy, alcohol use disorder).* • While there are indeed challenges to measure service coverage for MNS conditions (e.g. WHO proposes a revision of SDG 3.5.1 on this basis, moving to a measure of service capacity rather than service coverage for substance use disorders), recent and newly supported efforts to better estimate service coverage have been made, both through empirical studies (population-based surveys) and modelling studies; e.g., estimates of minimally adequate treatment for depression are now available for all Member States.
Mandate (WHA resolution, SDG)	The proposed indicator is in line with a specified target of: • the *Comprehensive mental health action plan 2013-2030* (WHA72/2019/REC/1): 'Service coverage for mental health conditions will have increased at least by half, by 2030' • the *Intersectoral Global Action Plan on Epilepsy and Other Neurological Disorders 2022-2031* (WHA73/10): 'By 2031, countries will have increased service coverage for epilepsy by 50% from the current coverage in 2021',
Definition	Proportion of persons with psychosis / depression * / epilepsy who are using services over the past 12 months (%) ** proposed new tracer condition within a revised UHC coverage index*
Numerator	Number of people with psychosis / depression / epilepsy in receipt of services
Denominator	Total number of people with psychosis / depression / epilepsy in the sample population
Preferred data sources	• For numerator: Facility-based routine health information systems

	• For denominator: Population-based, nationally-representative health surveys focusing on or including priority mental and neurological conditions
Other data sources	• For numerator: national registries; administrative databases • For denominator: Global Burden of Disease study (country-level prevalence) • Service coverage: Given paucity of empirical data at country level, it is proposed *ad interim* to use modelled estimates (available for depression)
Disaggregation	By age group and sex (preferably)
Frequency of data collection	Modelled estimates of minimally adequate treatment for depression have been derived for the year 2020, with the ability to re-estimate on an annual basis. Time-series estimates going back to 2000 can also be derived.
Limitations	As noted above, the preferred basis for measurement of service coverage is routine HIS for the numerator, and population-based health surveys for the denominator. Until such time that we have directly derived empirical estimates for a majority of Member States, modelled predictions can be used (so long as the model is appropriately documented and well-specified, see below).
Data type	Modelled estimates of service coverage for depression: - *Minimally adequate treatment as "either pharmacotherapy (1 month of a medication, plus 4 visits to any type of medical doctor) or psychotherapy (8 visits with any professional)". Data were sourced from Moitra and colleagues (PLoS Med, 2022), Kazdin and colleagues (Psychological Medicine, 2021), Thornicroft and colleagues (Br J Psychiatry, 2017), Le and colleagues (PLoS One, 2021), and microdata from the 1997 and 2007 Australian National Surveys of Mental Health and Wellbeing. The final dataset consisted of 205 estimates across 53 studies and 32 countries. A network meta-regression in MR-BRT ("meta-regression—Bayesian, regularized, trimmed") was used to estimate bias corrections for data that either a) used a more lenient definition of minimally adequate treatment, b) reported on antidepressant use only, or c) reported on any mental health service utilisation. A second meta-regression was then conducted in MR-BRT to estimate how minimally adequate treatment coverage varied by sex in order to sex-split any data from studies where sex-specific estimates were not available. Bias corrections and sex-splitting were then conducted on input data, which then informed a prevalence model using DisMod-MR 2.1. Age priors included 0% between ages 0 and 1 and a decreasing slope between ages 80 to 100. The healthcare access quality index was included as a country-level covariate and is significant (b = 0.0084 [95% UI: 0.0017 — 0.015]). This provided estimates of minimally adequate treatment of major depressive disorder by age, sex, location, and year.*
Further information and related links	References for data sources: - Moitra M, Santomauro D, Collins PY, Vos T, Whiteford H, Saxena S, Ferrari AJ. The global gap in treatment coverage for major depressive disorder in 84 countries from 2000-2019: A systematic review and Bayesian meta-regression analysis. PLoS Med. 2022 Feb 15;19(2):e1003901. doi: 10.1371/journal.pmed.1003901. PMID: 35167593; PMCID: PMC8846511. - Kazdin, A., Wu, C., Hwang, I., Puac-Polanco, V., Sampson, N., Al-Hamzawi, A., . . . Kessler, R. (2021). Antidepressant use in low- middle- and high-income countries: A World Mental Health Surveys report. Psychological Medicine, 1-9. doi:10.1017/S0033291721003160 - Thornicroft G, Chatterji S, Evans-Lacko S, Gruber M, Sampson N, Aguilar-Gaxiola S, Al-Hamzawi A, Alonso J, Andrade L, Borges G, Bruffaerts R, Bunting B, de Almeida JM,

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3.32. SDG 3.d.2 Percentage of bloodstream infections due to selected antimicrobial-resistant organisms

Indicator	Percentage of bloodstream infections due to antimicrobial resistant organisms
Rationale	
Mandate (WHA resolution, SDG)	
Definition	Frequency of bloodstream infection among hospital patients' due to methicillin-resistant *Staphylococcus aureus* (MRSA) and *Escherichia coli* resistant to 3rd-generation cephalosporin (e.g., ESBL- *E. coli*). Rational for selecting these two types of AMR: (i) *E. coli* and *S. aureus* are among the most common human fast-growing bacteria causing acute human infections; (ii) *E. coli* is highly frequent in both humans, animals and environment, being an excellent indicator for monitoring AMR across the sectors in line with the One Health approach; (iii) both MRSA and ESBL- *E. coli* are largely disseminated and frequently in high frequency in hospital settings all over the world. Infections with these types of AMR lead to increase in use of the last resort drugs (e.g., vancomycin for MRSA infections, and carbapenems for ESBL- *E. coli*) against which new types of AMR are emerging. WHO has defined global infection prevention and control standards and strategies. Effective control of these two types of AMR will ultimately preserve the capacity to treat infections with available antimicrobials while new prevention and treatment solutions can be developed. The WHO Global AMR Surveillance System (GLASS) supports countries to implement an AMR standardized surveillance system. At national level cases are found among patients from whom routine clinical samples have been collected for blood culture at surveillance sites according to local clinical practices, and antimicrobial susceptibility tests (AST) are performed for the isolated blood pathogens. The microbiological results (bacteria identification and AST) are combined with the patient data and related to population data from the surveillance sites. GLASS does collect information on the origin of the infection either community origin (less than 2 calendar days in hospital) or hospital origin (patients hospitalized for more than 2

	calendar days). Data are collated and validated at national level and reported to GLASS where epidemiological statistics and metrics are generated.
Numerator	Number of patients presenting with blood stream infection due to MRSA and ESBL- *E. coli* among patients seeking hospital care
Denominator	Number of patients seeking hospital care and from whom the blood specimen was taken due to suspected bloodstream infection and from whom blood specimens have been submitted for blood culture and AST.
Preferred data sources	National AMR data collected through the national AMR surveillance system and reported to GLASS.
Other data sources	Published and non-published data from national centers and research/academic institutions and from others regional surveillance networks.
Disaggregation	Data will be aggregated at the country level. Data will be analyzed and reported according to whether specimen is within 2 calendar days of admission (community origin) or after 2 calendar days of admission (hospital origin).
Frequency of data collection	Annual
Limitations	Constraints associated with in national AMR surveillance systems (number and distribution of surveillance sites and representativeness of surveillance data, sampling bias, poor diagnostic capacity, measurements errors, issues with data management).
Data type	Percent (%)
Related links	http://www.who.int/glass/en/

3.33. WHA 74 (12) Effective refractive error coverage (eREC)

Indicator	Effective refractive error coverage (eREC)
Rationale	Uncorrected refractive error is the leading cause of vision impairment in child and adult populations; at least 826 million people have distance- or near-vision impairment that could be addressed with an appropriate pair of spectacles. Correcting a person's sight with a pair of spectacles is among the most cost–effective of all health-care interventions to implement. In recognition of the large unmet need for care, coupled with the fact a highly cost–effective intervention exists (i.e. spectacles), WHO Member States endorsed the first-ever global target for refractive error at the Seventy-fourth World Health Assembly (2021). Specifically, the global target is a 40-percentage point increase in effective coverage of refractive error (eREC) by 2030.
Mandate (WHA resolution, SDG)	1. Resolution WHA73 (4) (2020) on *Integrated people-centred eye care* requested WHO to prepare rec (ommendations on global targets for 2030 for eREC. 2. Decision WHA74(12) (2021) Member States endorsed the global target of a 40-percentage point increase in eREC by 2030.

	3. UNGA resolution 75/310 (2021) on *Vision for Everyone* requests for eREC to be considered for inclusion in the global indicator framework for the Sustainable Development Goals (SDGs) at the fifty-sixth session of the United Nations Statistical Commission in 2025.
Definition	Proportion of people who have received refractive error services (i.e. spectacles, contact lenses or refractive surgery) and have a resultant good quality outcome relative to the number of people in need of refractive error services. All visual acuities are measured for distance. Presenting visual acuity (PVA) is the measure of unaided vision; or, if spectacles or contact lenses are worn to the assessment, visual acuity is measured with the person wearing them. Best-corrected visual acuity (BCVA) is assessed either by pinhole or refraction. For measuring uncorrected visual acuity (UCVA), if spectacles or contact lenses are worn to the assessment, visual acuity is measured with the person not wearing them. $$\frac{(a+b)}{(a+b+c+d)} \times 100$$
Numerator	a. Individuals with UCVA worse than 6/12 in the better eye who present with spectacles or contact lenses for distance vision and whose PVA is equal to or better than 6/12 in the better eye (“met need”). b. Individuals with a history of refractive surgery whose UCVA is equal to or better than 6/12 in the better eye (“met need”).
Denominator	a. Individuals with UCVA worse than 6/12 in the better eye who present with spectacles or contact lenses for distance vision and whose PVA is equal to or better than 6/12 in the better eye (“met need”). b. Individuals with a history of refractive surgery whose UCVA is equal to or better than 6/12 in the better eye (“met need”). c. Individuals with UCVA worse than 6/12 in the better eye who present with spectacles or contact lenses for distance vision and a PVA of worse than 6/12 in the better eye, but who improve to equal to or better than 6/12 on pinhole or BCVA (“undermet need”). d. Individuals with UCVA worse than 6/12 in the better eye who do not have distance vision correction and who improve to equal to or better than 6/12 on pinhole or BCVA (“unmet need”).
Preferred data sources	Population-based surveys.
Other data sources	Not applicable.
Disaggregation	Age, sex, geography (e.g. urban vs non-urban) and socioeconomic status.
Frequency of data collection	Every 5 years.

Limitations	The use of pinhole visual acuity to establish an individual's best-corrected visual acuity (BCVA) is not equivalent to a clinical refraction. Despite this, for feasibility considerations, most existing rapid assessment survey methodologies use pinhole visual acuity as a proxy for BCVA.
Data type	Prevalence
Related links	**Calculation methods:** • Keeping an eye on eye care: monitoring progress towards effective coverage - The Lancet Global Health 2021. • Web-based consultation on the development of feasible global targets for 2030 on integrated people-centred eye care (who.int) • WHO Eye Care Indicator Menu. https://www.who.int/publications/i/item/9789240049529 2022. **Most recent estimates of effective refractive error coverage:** • WHO Report of the 2030 targets on effective coverage of eye care https://iris.who.int/handle/10665/363158. 2022 • Effective refractive error coverage in adults aged 50 years and older: estimates from population-based surveys in 61 countries - The Lancet Global Health 2022.

3.34. WHA66 (10) Prevalence of controlled hypertension, among adults aged 30-79 years

Indicator	Prevalence of controlled hypertension, among adults aged 30-79 years
Rationale	High blood pressure is one of the world's leading risk factors for death and disability. The number of people living with hypertension (blood pressure of ≥140 mmHg systolic or ≥90 mmHg diastolic or on medication) doubled between 1990 and 2019, from 650 million to 1.3 billion. High blood pressure causes more deaths than other leading risk factors, including tobacco use and high blood sugar. Although hypertension can be prevented and treated, few countries currently do so effectively. Better hypertension management will save lives. Increasing the percentage of people whose hypertension is under control globally to 50% would prevent 76 million deaths between 2023 and 2050. Treating hypertension is one of the most important interventions to meet the Sustainable Development Goal (SDG) target 3.4 of a one third reduction in premature mortality from the leading noncommunicable diseases.
Mandate (WHA resolution, SDG)	WHA66 (10) (2013). In 2013 the WHA agreed a global target to reduce the prevalence of hypertension by 25% by 2025 (baseline 2010).
Definition	Hypertension is defined as having systolic blood pressure (SBP) ≥140 mmHg, diastolic blood pressure (DBP) ≥90 mmHg, or taking medication for hypertension. Control is defined as taking medication for hypertension and having SBP <140 mmHg and DBP <90 mmHg.
Numerator	Number of people aged 30 – 79 with controlled hypertension, defined as those taking medication for hypertension and having SBP <140 mmHg and DBP <90 mmHg.
Denominator	Number of people aged 30 – 79 with hypertension, as defined above.

Preferred data sources	Nationally representative population-based surveys where blood pressure is measured and diagnosis and treatment status are assessed.
Other data sources	Administrative data
Disaggregation	Age, sex, other relevant socio-demographic stratifiers where available
Frequency of data collection	At least every 5 years
Limitations	Potential limitations include: - measurement error - representativeness of the sample
Data type	prevalence
Related links	https://www.who.int/teams/noncommunicable-diseases/hypertension-report

3.35. WHA68.7 (2015) Patterns of antibiotic consumption at national level

Indicator	Patterns of antibiotic consumption at national level
Rationale	Narrow-spectrum beta-lactams of the Access group such as amoxicillin are the preferred treatment option for most RTI and are thought to have a lower ecologic impact regarding the selection and spread of antibiotic resistance than broader-spectrum agents such as cephalosporins, macrolides or fluoroquinolones. Access group antibiotics should therefore constitute the majority of antibiotic use in the outpatient setting and overall (as outpatient use represents the vast majority of AB sales). Broader-spectrum agents classified in the Watch group should be mostly limited to their specific recommended EML uses.
Mandate (WHA resolution, SDG)	
Definition	Proportion of Access group antibiotics as percentage of overall antibiotic sales. From data on total consumption of antibiotics, the proportion of the total, by DDD that are within the ACCESS group (EML 2017). The term consumption refers to estimates of aggregated data, mainly derived from import, sales or reimbursement databases. In the recent revision of the WHO Model List of Essential Medicines, antibiotics in the list have been grouped into three AWaRe categories: Access, Watch and Reserve. The Access category includes first and second choice antibiotics for the empirical treatment of common infectious syndromes and they should be widely available in health care settings. Antibiotics in the Watch category have a higher potential for resistance to develop and their use as first and second choice treatment should be limited. Finally, the Reserve category includes "*last resort*" antibiotics whose use should be reserved for specialized settings and specific cases where alternative treatments have failed. Data on overall consumption by AWaRe categories: ACCESS, WATCH, RESERVE, OTHER, are collected and validated at the national level and reported to WHO where epidemiological statistics and metrics are generated. Antibiotic consumption is presented using the following key indicators:

	• Quantity of antibiotics as DDD per 1000 inhabitants per day for total consumption and by pharmacological subgroup (ATC3) • Quantity of antibiotics as weight in tonnes for total consumption • Relative consumption of antibiotics as a percentage of total consumption by route of administration (oral, parenteral, rectal and inhaled) and AWaRe categories (Access, Watch, and Reserve). To measure the consumption of antimicrobials, the methodology uses the number of defined daily doses (DDDs). The DDD is the assumed average maintenance dose per day of an antimicrobial substance(s) used for its main indication in adults, and is assigned to active ingredients with an existing ATC code. As a rule, the DDDs for antimicrobials are based on treatment for infections of moderate severity. To adjust for population size, the consumption is usually presented as number of DDDs per 1000 inhabitants per day. This metric can be roughly interpreted as the number of individuals per 1000 inhabitants on antibiotic treatment per day. The volume of antibiotics consumed can be presented using two metrics: DDD and the weight of the antibiotic substances in metric tonnes (t). The second metric can be used for comparison with antimicrobial consumption in the animal sector.
Numerator	**Antibiotic consumption of ATC class J01 antibiotics plus oral metronidazole (P01AB01), oral vancomycin (A07AA09) and oral fidaxomicin (A07AA12) in defined daily doses belonging to the ACCCES group.** The number of DDDs consumed for each antibiotic substance can be calculated by dividing the amount consumed in grams of the substance by the DDD value assigned to that substance: Number of DDDs = grams of active substance /substance-specific DDD. The total amount in grams is obtained by multiplying the strength of each tablet or vial by the number of units per package and the number of packages consumed. The DDD value is mostly specified in grams, but can also be defined as MU (million units) for certain substances. For combinations of antibiotics, the DDD value is specified as UD (unit dose). One tablet or vial of a combination product with a specific strength is defined as one UD. To obtain the DDD consumed of a specific combination product, the total number of UDs is divided by the assigned DDD value. For countries that have data at the substance level and by DDD, a reverse calculation can be done using DDD values to obtain the total number of tonnes.
Denominator	**Overall antibiotic consumption/sales of ATC classes: J01 antibiotics plus oral metronidazole (P01AB01), oral vancomycin (A07AA09) and oral fidaxomicin (A07AA12) in defined daily doses** The population size for each country can be obtained from the World Bank population database for all countries, but for Member States of the ESAC-Net, specific populations indicated by the data provider (European Centre for Disease Prevention and Control) is used.
Preferred data sources	National (or sampling of) antibiotic consumption data available at national level through different sources (sales, prescribing, dispensing) Consumption data will be collated according to the *WHO methodology for a global programme on surveillance of antimicrobial consumption.* Consumption data collected through a standardized protocol comparable with the WHO methodology will also be utilized, including data collected through the European Surveillance of Antimicrobial Consumption

	Network (ESAC-Net), the Antimicrobial Medicines Consumption Network managed by the WHO Regional Office for Europe, and the surveillance programmes on antimicrobial consumption in Canada, Japan, New Zealand and the Republic of Korea. According to the WHO protocol, data are collected at the product level (proprietary and generic- products) and comprise information on the active substance(s) of the product, route of administration, strength per unit, number of units per package and total number of packages consumed.
Other data sources	Sales should be the main source of data. Other sources could include: • Import records: for example from custom records and declaration forms; • Production records from domestic manufacturers; • Wholesaler records: both procurement data by the wholesaler or sales data from wholesaler to healthcare facilities and pharmacies; • Public sector procurement: from centralized or decentralized purchasing of medicines for the public sector, e.g. records from central medical stores;
Disaggregation	Data will be aggregated at the country level – allow disaggregation at regional/district level, by antibiotic category (Access, Watch and Reserve)
Frequency of data collection	Yearly
Limitations	• Completeness / representativeness of sales data. Currently, data are collected from official channels and no data explicitly capturing antimicrobials circulating on the informal market have been obtained. Consequently, for countries in which the informal market is significant, only an incomplete picture of antibiotic consumption can be presented. • Data may be available only in certain metrics (e.g. Standard Units instead of DDD) and it is unclear how this will affect the index. • Measurement errors • Antibiotic "Black market" DDDs are not adequate for children but this will have no impact in this indicator expressed as relative proportion of DDD
Data type	Percentage
Related links	http://www.who.int/antimicrobial-resistance/global-action-plan/optimise-use/surveillance/en/ https://www.who.int/medicines/areas/rational_use/WHO_AMCsurveillance_1.0.pdf

3.36. Resolution WHA74.5. Proportion of population entitled to essential oral health interventions as part of the health benefit packages of the largest government health financing schemes

Indicator	Proportion of population entitled to essential oral health interventions as part of the health benefit packages of the largest government health financing schemes
Rationale	As a first step to implementing the mandate given to the WHO Secretariat through the resolution on oral health (WHA 74.5), WHO developed the Global strategy on oral health endorsed by the WHA75(11). The vision of the global strategy is UHC for oral health for all individuals and communities by 2030, thereby aligning it with the ambition of the Sustainable Development Goals. This vision means that all individuals and communities have access to

	essential, quality health services that respond to their needs and that they can use without suffering financial hardship. This indicator is also in line with the following target which is part of the Global oral health action plan 2023-2030 (WHA76(9): “80% of the global population is entitled to essential oral health care services”
Mandate (WHA resolution, SDG)	In 2021, Member States adopted a landmark resolution on oral health 74th World Health Assembly (WHA 74.5). By endorsing this resolution, Member States signaled their commitment to prioritize oral health as an integral part of the global health agenda in the context of NCD and UHC agendas, elevating it to the global forefront. In response to resolution on oral health, the Secretariat developed the Global strategy on oral health, adopted in May 2022 (decision WHA75(11)), and included the Global oral health action plan 2023–2030 in the report on noncommunicable diseases (NCDs) (WHA76(9)).
Definition	A proportion of population entitled to essential oral health interventions under the health benefit packages of the largest government health financing schemes. The term “largest” is defined as having the highest total population eligible to receive services. The term “government” is defined as including any public-sector scheme for health service provision, including coverage for groups such as the general population, public sector employees and/or the military. Essential oral health care covers a defined set of safe, cost-effective interventions at the individual and community levels to promote oral health, as well as to prevent and treat the most prevalent and/or severe oral diseases and conditions, including appropriate rehabilitative services and referral. Essential oral health interventions include, but are not limited to: - Routine and preventive oral health care (including oral health examination, counselling on oral hygiene with fluoride toothpaste, fluoride varnish application, glass ionomer cement as a sealant and oral cancer screening in high-risk groups, linked with timely diagnostic work-up and comprehensive cancer treatment, in settings with a significant disease burden) - Essential curative oral health care (including topical silver diamine fluoride, atraumatic restorative treatment, glass ionomer cement restoration and urgent treatment for emergency oral care and pain relief, such as non-surgical extractions and drainage of abscesses).
Numerator	Number of people entitled to essential oral health interventions under the health benefit packages of the largest government health financing schemes
Denominator	Total global population listed in World Population Prospects by the United Nations Department of Economic and Social Affairs (UN DESA)
Preferred data sources	WHO Health Technology Assessment/Health Benefit Package (HTA/HBP) Survey. The Global Health Observatory: Oral health data portal Oral health (who.int)
Other data sources	N/A
Disaggregation	By WHO Member States and by WHO Regions

Frequency of data collection	2023 2026 2029/2030
Limitations	The HTA/HBP survey will be collected on a regular basis (TBC)
Data type	Percentage
Related links	Global Oral Health Status Report: The Global Status Report on Oral Health 2022 (who.int) Global Oral Health Action Plan 2023-2030: eb152-draft-global-oral-health-action-plan-2023-2030-en.pdf (who.int) Baseline assessment of the Global Oral Health Action Plan 2023-2030: Follow-up to the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases (who.int) *The current baseline is 23%
Number of member states covered	114/194 MS
Range of years with data	Data from 2015 and 2020/2021 is available

3.37. WHA73 (2) Cervical cancer screening coverage in women aged 30 - 49 years, at least once in lifetime

Indicator	Percentage of women aged 30–49 years who have been screened with a high-performance test for cervical cancer at least once between the ages of 30 and 49 years
Rationale	As per the Regional Implementation framework, WHO recommends monitoring the following key indicator Cervical cancer service coverage should be included as a core health-care performance measure and progress should be monitored at the health facility catchment population, provincial and national levels.
Mandate (WHA resolution, SDG)	(SDG) 3, target 3.4
Definition	Percentage of women aged 30–49 years who have been screened with a high-performance test at least once between the ages of 30 and 49 years per year.
Numerator	Number of women aged 30-49 years who have been screened with high-performance test at least once each year
Denominator	Total number of women aged 30-49 years in a given calendar year
Preferred data sources	Regional implementation framework for elimination of cervical cancer as a public health problem: 2021–2030
Other data sources	Reproductive health morbidity service register, HMIS 3.8
Disaggregation	Age above 30 years; By 35 years and then by 45 years

Frequency of data collection	Annual basis
Limitations	Reporting from the private sectors
Data type	HMIS
Related links	https://hmis.gov.np/

3.38. WHA 67.10 Postnatal Care Coverage (PNC)

3.38.a. PNC Newborn

Indicator	Postnatal Care Coverage (newborn)
Rationale	The vast majority of newborn deaths take place in low- and middle-income countries, mostly at home, without skilled care that could greatly increase the infant's chances for survival (1). Children who die within the first 28 days of birth suffer from conditions and diseases associated with lack of skilled quality care at birth and immediately after birth, and the majority of these deaths are within the first few days of life. The postnatal period is defined as the time following delivery until six weeks after birth. Contact with a health-care provider during the postnatal period immediately after birth for both mother and newborn is a critical step in improving the health and survival of mothers and newborns.
Mandate (WHA resolution, SDG)	This indicator is also embedded in the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). An operational plan to take forward the implementation of this Global Strategy was adopted by the World Health Assembly in May 2016 (A69/16). In addition, it is part of the Every Newborn Action Plan (Resolution WHA 67.10).
Definition	The number of women of reproductive age with a live birth in a specified reference period where the newborn received a postnatal care (PNC) check with a health provider within two days of birth is expressed as a percentage of women in the same age range with a live birth in the same period.
Numerator	Routine: Number of newborns who received PNC within a specified time period. Population based: : Number of newborns who have postnatal contact with a health-care provider check within two days of birth.
Denominator	Routine: Number of live births in the health facility in a specified time period Population based: Total number of last live births
Preferred data sources	There are two common data sources for this indicator: a. Routinely collected administrative data b. Population-based household surveys
Other data sources	
Disaggregation	Routine: By level of facility, location of facility (e.g. urban, rural), type of health personnel and timing of health check

	Population based: Type of health personnel, place of delivery, mode of delivery, place of residence (e.g. urban, rural), sex of live birth, birth order, socioeconomic status (e.g. education level, wealth quintile), age of woman at the time of delivery, births attended by skilled health personnel, timing and location of PNC health check
Frequency of data collection	The indicator can be calculated on an annual basis if from administrative sources and every 2 to 4 years if from population-based surveys.
Limitations	Routine data: Is dependent of quality of data from administrative sources for routine data Population based surveys: Women may not be able to accurately recall details around childbirth when data are collected through household surveys. There is also a time lag as the recall period is up to 2–5 years before the survey data were collected.
Data type	Outcome
Related links	The postnatal coverage for newborns is monitored and tracked And can be found in the WHO Global Health Observatory (GHO) and the MNCAAH data portal and ENAP EPMM dashboard. https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4734 https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/mca/proportion-of-mothers-who-had-postnatal-contact-with-a-health-provider-within-2-days-of-delivery https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/ENAP-EPMM-dashboard

3.38.b. PNC woman

Indicator	Postnatal Care Coverage (woman)
Rationale	The postnatal period is defined as the time following delivery until six weeks after birth and is a critical phase in the lives of mothers and newborns. Most maternal and infant deaths occur in the first month after birth: almost half of postpartum maternal deaths occur within the first 24 hours, and 66% occur during the first week. Contact with a health-care provider during the postnatal period immediately after birth for both mother and newborn is a critical step in improving the health and survival of mothers and newborns. WHO recommends that women receive facility care for at least 24 hours after birth with two full assessments within that time period,

	as well as at least three postnatal visits on: (a) day 3 (48–72 hours of birth); (b) between days 7–14 of birth; and (c) six weeks after birth. These contacts can be made at home or in a health facility, depending on the context and the provider. Additional contacts may be needed to address issues or concerns.
Mandate (WHA resolution, SDG)	This indicator is also embedded in the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). An operational plan to take forward the implementation of this Global Strategy was adopted by the World Health Assembly in May 2016 (A69/16). In addition, it is part of the Ending Preventable Maternal Mortality and Every Newborn Action Plan coverage targets.
Definition	The number of women of reproductive age with a live birth in a specified reference period who received a postnatal/postpartum care (PNC) check with a health provider within two days of delivery is expressed as a percentage of women in the same age range with a live birth in the same period
Numerator	Routine: Number of women who received PNC in a health facility within a specified time period. Population based: Number of women aged 15–49 years with a live birth who have postnatal contact with a health-care provider within two days of birth
Denominator	Routine: Total number of deliveries in facility in a specified time period Population based: Total number of women aged 15–49 with a live birth
Preferred data sources	There are two common data sources for this indicator: a. Routinely collected administrative data b. Population-based household surveys
Other data sources	
Disaggregation	Routine: By level of facility, location of facility (e.g., urban, rural), type of health personnel and timing of health check Populations based: Type of health personnel, place of delivery, mode of delivery, place of residence (e.g. urban, rural), sex of live birth, birth order, socioeconomic status (e.g. education level, wealth quintile), age of woman at the time of delivery, births attended by skilled health personnel, timing and location of PNC health check
Frequency of data collection	The indicator can be calculated on an annual basis if from administrative sources and every 2 to 4 years if from population-based surveys.
Limitations	Routine data: Is dependent of quality of data from administrative sources for routine data Population based surveys: Women may not be able to accurately recall details around childbirth

	when data are collected through household surveys (5). There is also a time lag as the recall period is up to 2–5 years before the survey data were collected.
Data type	Outcome
Related links	The postnatal coverage for women can be monitored and tracked and can be found in the WHO Global Health Observatory (GHO) and the MNCAAH data portal and ENAP EPMM dashboard. https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4734 https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/mca/proportion-of-mothers-who-had-postnatal-contact-with-a-health-provider-within-2-days-of-delivery https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/ENAP-EPMM-dashboard

3.39. SDG 3.1.1 Maternal mortality ratio

Indicator	Maternal mortality ratio
Rationale	
Mandate (WHA resolution, SDG)	Maternal mortality ratio (SDG 3.1.1)
Definition	**The maternal mortality ratio (MMR)** is the number of maternal deaths during a given time period per 100,000 live births during the same time-period. **Maternal death** refers to the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management (from direct or indirect obstetric death), but not from accidental or incidental causes. **Pregnancy-related death** refers to the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death. **Live birth** refers to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born. **MMR** = $\frac{Total\ number\ of\ maternal\ deaths}{Total\ number\ of\ live\ births} \times 100{,}000$

Numerator	Total number of maternal deaths
Denominator	Total number of live births
Preferred data sources	Civil registration vital statistics (CRVS), health service records, household surveys, census.
Other data sources	Sample registration systems; verbal autopsy.
Disaggregation	By age, parity, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education level, wealth quintile).
Frequency of data collection	Annual (for CRVS and health service records); every 5 years or more for other sources
Limitations	Maternal death is, from an epidemiological perspective, a relatively rare event and mortality is difficult to measure accurately. Many low-income countries have no, incomplete or unusable death registry data. Modelling may be used to obtain a national estimate.
Data type	Ratio (per 100 000 livebirths)
Related links	WHO: http://www.who.int/healthinfo/statistics/indmaternalmortality/en/ WHO: https://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/. WHO: https://www.who.int/reproductivehealth/publications/monitoring/9789241548458/en/. UNSDG: https://unstats.un.org/sdgs/metadata/files/Metadata-03-01-01.pdf

3.40. SDG 3.1.2 Proportion of births attended by skilled health personnel

Indicator	Proportion of births attended by skilled health personnel
Rationale	
Mandate (WHA resolution, SDG)	
Definition	Percentage of live births for women aged 15-49 years attended by skilled health personnel (doctor, nurse or midwife). Skilled health personnel, as referenced by SDG indicator 3.1.2, are competent maternal and newborn health (MNH) professionals educated, trained and regulated to national and international standards. They are competent to: (i) provide and promote evidence-based, human-rights-based, quality, socioculturally sensitive and dignified care to women and newborns; (ii) facilitate physiological processes during labour and delivery to ensure a clean and positive childbirth experience; and (iii) identify and manage or refer women and/or newborns with complications. In addition, as part of an integrated team of MNH professionals (including midwives, nurses, obstetricians, paediatricians and anaesthetists, they perform all signal functions of emergency maternal and newborn care to optimize the health and well-being of women and newborns.

	Within an enabling environment, midwives trained to international Confederation of Midwives (ICM), standards can provide nearly all of the essential care needed for women and newborns. (In different countries, these competencies are held by professionals with varying occupational titles). The number of women aged 15-49 years with a live birth attended by a skilled health personnel (doctor, nurse or midwife) during childbirth is expressed as a percentage of women aged 15-49 years with a live birth in the same period.
Numerator	Number of live births attended by skilled health personnel (doctor, nurse or midwife) trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, childbirth and the postpartum period, to conduct deliveries on their own, and to care for newborns.
Denominator	The total number of live births of women aged 15-49 years in the same period.
Preferred data sources	National population-based surveys.
Other data sources	Routine facility information systems.
Disaggregation	Age, parity, place of residence, socioeconomic status.
Frequency of data collection	3-5 years for national population-based surveys, annual for routine facility information systems.
Limitations	Discrepancies possible if national figures are from health facilities rather than household level data. Institutional births may underestimate percentage of births with skilled attendant.
Data type	Percentage
Related links	https://unstats.un.org/sdgs/metadata/files/Metadata-03-01-02.pdf https://data.unicef.org/topic/maternal-health/delivery-care/# https://www.who.int/reproductivehealth/publications/statement-competent-mnh-professionals/en/

3.41. SDG 5.6.1 Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care

Indicator	Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care
Rationale	
Mandate (WHA resolution, SDG)	
Definition	Proportion of women aged 15-49 years (married or in union) who make their own decision on all three

	selected areas i.e. can say no to sexual intercourse with their husband or partner if they do not want; decide on use of contraception; and decide on their own health care. Only women who provide a “yes” answer to all three components are considered as women who make her own decisions regarding sexual and reproductive health. A union involves a man and a woman regularly cohabiting in a marriage-like relationship Proportion = Numerator X 100/Denominator [see numerator and denominator]
Numerator	Number of married or in union women aged 15-49 years old: – who can say “no” to sex; and – for whom the decision on contraception is not mainly made by the husband/partner; and – for whom decision on health care for themselves is not usually made by the husband/partner or someone else Only women who satisfy all three empowerment criteria are included in the numerator.
Denominator	Total number women aged 15-49 years old, who are married or in union.
Preferred data sources	Current data on the indicator are derived from nationally representative demographic and surveys (DHS). Plans are underway to broaden the data sources to include MICs and other country specific surveys.
Other data sources	
Disaggregation	Based on available DHS data, disaggregation is possible by age, geographic location, place of residence, education, and wealth quintile.
Frequency of data collection	Currently data comes from the DHS which have three to five- year cycles.
Limitations	Until recently, the indicator captured results for married and in-union women and adolescent girls of reproductive age (15–49 years old) who are using any type of contraception. In the phase of the national Demographic and Health Survey (DHS–7) and later rounds, the questionnaire are extended to respondents whether they are using contraception or not. One limitation of the data is that unmarried women and girls are not included. As of early 2020, a total of 57 countries, the majority in sub-Saharan Africa, have at least one survey with data on all three questions necessary for calculating Indicator 5.6.1. Broader data sources are needed and efforts to increase data coverage are underway. Current data on the indicator are mainly derived from the DHS and efforts are being made to include the Multiple Indicator Cluster Surveys (MICS), the Generation and Gender Survey (GGS) and other country-specific surveys. In many national contexts, household surveys, which are the main data source for this indicator, exclude the homeless and are likely to under-enumerate linguistic or religious minority groups.
Data type	Percentage

Related links	

3.42. SDG 5.2.1 Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual, or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age

Indicator	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
Rationale	
Mandate (WHA resolution, SDG)	
Definition	This indicator measures the percentage of ever-partnered women and girls aged 15-49 years who have experienced physical, sexual or psychological violence by a current or former intimate partner, in the previous 12 months. Intimate partner violence is the most common form of violence against women and girls globally. Given prevailing social norms that sanction male dominance over women, violence between intimate partners is often perceived as ordinary, particularly in the context of marriage, cohabitation or any formal or informal union. Violence against women and girls is an extreme form of gender inequality. This indicator calls for breakdown by form of violence and by age group. Countries are encouraged to compute prevalence data for each form of violence, disaggregated by age as detailed below to assist comparability at regional and global levels: 1. Physical violence: Number of ever-partnered women and girls (aged 15-49 years who experience physical violence by a current or former intimate partner in the previous 12 months divided by the number of ever-partnered women and girls (aged 15 years and above) in the population multiplied by 100. 2. Sexual violence: Number of ever-partnered women and girls (aged 15-49 years) who experience sexual violence by a current or former intimate partner in the previous 12 months divided by the number of ever-partnered women and girls (aged 15 years and above) in the population multiplied by 100. 3. Any form of physical and/or sexual violence: Number of ever-partnered women and girls (aged 15-49 years) who experience physical and/or sexual violence by a current or former intimate partner in the previous 12 months divided by the number of ever-partnered women and girls (aged 15-49 years) multiplied by 100.

Numerator	*See method of estimation / calculation*
Denominator	*See method of estimation / calculation*
Preferred data sources	The main sources of intimate partner violence prevalence data for SDG Indicator 5.2.1 comprises data from internationally comparable population-based surveys that are (1) specialized national surveys dedicated to measuring violence against women and (2) international household surveys that include a module on experiences of violence by women, such as the DHS. Where available, other dedicated surveys are included if the data are deemed comparable. Since 2015, around 135 countries had conducted violence against women national prevalence surveys or have included a module on violence against women in a DHS or other national household survey.
Other data sources	
Disaggregation	In addition to form of violence and age, income/wealth, education, ethnicity (including indigenous status), disability status, marital/partnership status, relationship with the perpetrator (i.e. current/former partner), geographic location and frequency of violence are suggested as desired variables for disaggregation for this indicator.
Frequency of data collection	
Limitations	Comparability: The availability of comparable data remains a challenge in this area as many data collection efforts have relied on different survey methodologies, used different definitions of partner or spousal violence and of the different forms of violence and different survey question formulations. Furthermore, diverse age groups are often utilized. Willingness to discuss experiences of violence and understanding of relevant concepts may also differ according to the cultural context and this can affect reported prevalence levels. Regularity of data production: Since 1995, only some 40 countries have conducted more than one survey on violence against women. Obtaining data on violence against women is a costly and time-consuming exercise, whether they are obtained through stand-alone dedicated surveys or through modules in other surveys. Feasibility: Psychological partner violence—which may be conceptualised differently across cultures and in different contexts—is still a Tear III sub-indicator. Since it is not yet feasible to report on psychological partner violence, this indicator currently reports on *physical and/or sexual intimate partner violence* only. Efforts are underway, led by WHO, to develop a global standard for measuring and reporting on psychological intimate partner violence. Similarly, this indicator calls for global reporting of violence experienced by ever-partnered women aged 15 years and above. However, most data come from DHS, which typically sample only women aged 15-49, and there is a lack of consistency in the age range of sample populations across other country surveys. For those surveys that interview a sample of women from a different age group, the prevalence for the 15-49 age group is often published or can be calculated from available data. The global indicator therefore currently reports violence experienced by ever-partnered women and girls 15-49 years of age. Efforts are underway to address this issue and to better understand and measure partner violence against women aged 50 and above.

Data type	Percentage
Related links	http://evaw-global-database.unwomen.org/en data.unicef.org http://unstats.un.org/unsd/gender/default.html

3.43. WHA 67.15 Proportion of health facilities that provide comprehensive post-rape care as per WHO guidelines

Indicator	Proportion of health facilities that provide comprehensive post-rape care as per WHO guidelines
Rationale	Coverage of post-rape care is being collected in the UNAIDS National Commitments and Policy Index indicator every 2 years. Question 137 and 137.1 of the NCPI includes 6 sub-questions that ask how many elements of comprehensive post-rape care are provided by the country and the % of health facilities provided each of the five elements of care. Hence there is an established methodology/survey for collecting this output indicator. The indicator is linked directly to WHO recommendations and provides a way of tracking the implementation of WHO recommendations for sexual violence.
Mandate (WHA resolution, SDG)	There are several WHA resolutions that mandate MS to address sexual assault. This includes resolution 67.15 and 69.5, the latter accompanying the global plan of action on strengthening health systems in addressing violence against women and girls and against children. The global plan of action progress is to be reported to WHA in 2026 and 2030 and one of the indicators is coverage of post-rape care as per WHO guidelines. Hence, WHO is already mandated to report on this to WHA.
Definition	Percentage of health facilities that provide at least four out of five elements of comprehensive post-rape care as per WHO guidelines
Numerator	Number of health facilities that provide at least four of the following five elements of post-rape care as per WHO guidelines: first line support/psychological first aid or psychosocial support; emergency contraception; STI treatment or prophylaxis; HIV PEP; and safe abortion to the full extent of the law
Denominator	Total number of health facilities in the country
Preferred data sources	UNAIDS NCPI, Questions 137 and 137.1 Global AIDS Monitoring Questionnaire 2023.
Other data sources	HERAMS and Service Availability Mapping (SAMs)
Disaggregation	Not applicable
Frequency of data collection	Every 2 years
Limitations	This is a service coverage indicator; it does not indicate access to services by rape survivors. It is also a self-reported indicator asking countries to rate their coverage according to following categories < 50% of health facilities; 50-80%; > 80% and not provided in any health

	facility. It does not allow for reporting of the exact % of health facilities or verification of the report.
Data type	Service coverage/programmatic indicator
Related links	https://lawsandpolicies.unaids.org/

3.44. SDG 3.2.1 Under-five mortality rate

Indicator	Under-five mortality rate
Rationale	Under-5 mortality rate is a key measure of child survival and national support for maternal, newborn and child health outcomes. Under-5 mortality rate is a UN Sustainable Development Goal (SDG) indicator under the SDG 3.0, Ensure healthy lives and promote well-being for all at all ages. This indicator is known as SDG 3.2.1, reducing child mortality, and ending preventable child deaths and has a target of "at least as low as 25 deaths per 1, 000 live births for every country by 2030.
Mandate (WHA resolution, SDG)	SDG 3.2.1
Definition	**The under-5 years mortality rate (U5MR) is** the probability of a child born in a specific year or period dying before reaching the age of five, if subject to the age-specific mortality rates of that period, expressed per 1000 live births. It is, strictly speaking, not a rate (i.e. the number of deaths divided by the number of population at risk during a certain period of time) but a probability of death derived from a life table and expressed as rate per 1000 live births. **Live birth** refers to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born. The UN Inter-agency Group for Child Mortality Estimation (UN IGME) estimates are derived from national data from censuses, surveys or vital registration systems. The UN IGME does not use any covariates to derive its estimates. It only applies a curve fitting method to good-quality empirical data to derive trend estimates after data quality assessment. In most cases, the UN IGME estimates are close to the underlying data. The UN IGME aims to minimize the errors for each estimate, harmonize trends over time and produce up-to-date and properly assessed estimates. The UN IGME applies the Bayesian B-splines bias-reduction model to empirical data to derive trend estimates of under-five mortality for all countries. See references for details. For the underlying data mentioned above, the most frequently used methods are as follows: Civil registration: The under-five mortality rate can be derived from a standard period abridged life table using the age-specific deaths and mid-year population counts from civil

	registration data to calculate death rates, which are then converted into age-specific probabilities of dying. Census and surveys: An indirect method is used based on a summary birth history, a series of questions asked of each woman of reproductive age as to how many children she has ever given birth to and how many are still alive. The Brass method and model life tables are then used to obtain an estimate of under-five and infant mortality rates. Censuses often include questions on household deaths in the last 12 months, which can be used to calculate mortality estimates. Surveys: A direct method is used based on a full birth history, a series of detailed questions on each child a woman has given birth to during her lifetime. Neonatal, post-neonatal, infant, child and under-five mortality estimates can be derived from full birth history module.
Numerator	Total number of deaths among children aged 0-4 years (the total number is actually the probability of death derived from a life table)
Denominator	Total number of live births
Preferred data sources	Civil registration and vital statistics,
Other data sources	censuses; and household surveys.
Disaggregation	By sex, place of residence, wealth quintile and mother's education
Frequency of data collection	Annual updates from the UN-IGME revisions
Limitations	The preferred source of data is a civil registration system that records births and deaths on a continuous basis. If registration is complete and the system functions efficiently, the resulting estimates will be accurate and timely. However, many countries do not have well-functioning vital registration systems. In such cases, household surveys, such as the UNICEF-supported Multiple Indicator Cluster Surveys (MICS), the USAID-supported Demographic and Health Surveys (DHS) and periodic population censuses have become the primary sources of data on under-five mortality. These surveys ask women about the survival of their children, and it is these reports that provide the basis of child mortality estimates for a majority of low- and middle- income countries. These data, however, are often subject to sampling or non-sampling errors (such as misreporting of age and survivor selection bias; underreporting of child deaths is also common) These under-five mortality rates have been estimated by applying methods to the available data from all Member States to ensure comparability across countries and time; hence they are not necessarily the same as the official national data.
Data type	Mortality estimate: probability of death derived from a life table and expressed as rate per 1000 live births.
Related links	WHO: http://apps.who.int/gho/data/node.wrapper.imr?x-id=1; http://www.who.int/whosis/whostat2006InfantAndUnder5MortalityRate.pdf?ua=1; http://apps.who.int/gho/data/node.wrapper.imr?x-id=4717 UNICEF: https://www.unicef.org/infobycountry/stats_popup1.html

3.45. SDG 3.2.2 Neonatal mortality rate

Indicator	Neonatal mortality rate
Rationale	Neonatal mortality rate is a key measure of newborn survival and a strong indicator for quality of care before and during birth. Neonatal mortality rate is a UN Sustainable Development Goal (SDG) indicator under the SDG 3.0, Ensure healthy lives and promote well-being for all at all ages. This indicator is known as SDG 3.2.2, reducing neonatal mortality, and ending preventable newborn deaths and has a target of "at least as low as 12 deaths per 1, 000 live births for every country by 2030".
Mandate (WHA resolution, SDG)	SDG 3.2.2
Definition	Probability that a child born in a specific year or period will die in the first 28 days of life (0-27 days), if subject to the age-specific mortality rates of that period, expressed per 1000 live births. Neonatal deaths (deaths among live births during the first 28 days of life) The UN Inter-Agency Group for Child Mortality Estimation (UN IGME) estimates are derived from national data from censuses, surveys or vital registration systems. The UN IGME does not use any covariates to derive its estimates. It only applies a curve fitting method to good-quality empirical data to derive trend estimates after data quality assessment. In most cases, the UN IGME estimates are close to the underlying data. The UN IGME aims to minimize the errors for each estimate, harmonize trends over time and produce up-to-date and properly assessed estimates. The UN IGME produces neonatal mortality rate estimates with a Bayesian spline regression model which models the ratio of neonatal mortality rate / (under-five mortality rate - neonatal mortality rate). Estimates of NMR are obtained by recombining the estimates of the ratio with UN IGME-estimated under-five mortality rate. See the references for details. For the underlying data mentioned above, the most frequently used methods are as follows: Civil registration: Number of children who died during the first 28 days of life and the number of births used to calculate neonatal mortality rates. Census and surveys: Census often includes questions on household deaths in the last 12 months, which can be used to calculate mortality estimates. Surveys: A direct method is used based on a full birth history, a series of detailed questions on each child a woman has given birth to during her lifetime. Neonatal, post-neonatal, infant, child and under-five mortality estimates can be derived from full birth history module.
Numerator	Number of children who died in the first 28 days (0-27) of life (the total number is actually the probability of death derived from a life table)
Denominator	Number of live births
Preferred data sources	Data from civil registration and vital statistics.

Other data sources	Censuses and household surveys.
Disaggregation	By sex, place of residence, wealth quintile and mother's education
Frequency of data collection	Annual updates from the UN-IGME revisions
Limitations	The preferred source of data is a civil registration system that records births and deaths on a continuous basis. If registration is complete and the system functions efficiently, the resulting estimates will be accurate and timely. However, many countries do not have well-functioning vital registration systems. In such cases, household surveys, such as the UNICEF-supported Multiple Indicator Cluster Surveys (MICS), the USAID-supported Demographic and Health Surveys (DHS) and periodic population censuses have become the primary sources of data on under-five mortality. These surveys ask women about the survival of their children, and it is these reports that provide the basis of child mortality estimates for a majority of low- and middle- income countries. These data, however, are often subject to sampling or non-sampling errors (such as misreporting of age and survivor selection bias; underreporting of child deaths is also common) These under-five mortality rates have been estimated by applying methods to the available data from all Member States to ensure comparability across countries and time; hence they are not necessarily the same as the official national data.
Data type	Mortality estimate: probability of death derived from a life table and expressed as rate per 1000 live births.
Related links	WHO: http://apps.who.int/gho/data/node.wrapper.imr?x-id=1; http://www.who.int/whosis/whostat2006InfantAndUnder5MortalityRate.pdf?ua=1; http://apps.who.int/gho/data/node.wrapper.imr?x-id=4717 UNICEF: https://www.unicef.org/infobycountry/stats_popup1.html

3.46. WHA 67.10 Stillbirth rate (per 1000 total births)

Indicator	Stillbirth rate (per 1000 total births)
Rationale	Stillbirth is one of the most common adverse pregnancy outcomes worldwide. A stillbirth or fetal death is defined as a baby who was born with no signs of life (e.g. did not cry, move, breathe, or have a heartbeat) either before (antepartum) or during (intrapartum) delivery. For international comparison, WHO defines a stillbirth or fetal death at ≥ 28 completed weeks gestation ,or if missing, Birthweight ≥1000g, or if missing; body length ≥ 35cm according to the International Classification of Diseases and Related Health Problems, 11th Revision (ICD-11). Stillbirth rates in many settings reflect the quality of antenatal care and the timeliness and quality of intrapartum monitoring and care.

	The proportion of babies that die in intrapartum is therefore an essential indicator of quality of intrapartum care. Better access to quality maternal care, especially during labour, should reduce stillbirth rates dramatically.
Mandate (WHA resolution, SDG)	This indicator is also embedded in the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). An operational plan to take forward the implementation of this Global Strategy was adopted by the World Health Assembly in May 2016 (A69/16). In addition it is part of the Every Newborn Action Plan (Resolution WHA 67.10).
Definition	The number of fetuses born per year with no sign of life and born at or after 28 weeks' gestation, or with birthweight of 1000 g, or 35 cm or more body length is expressed as a rate per 1000 births (live and stillbirths)
Numerator	Number of fetuses born per year with no sign of life and born ≥ 28 completed weeks gestation, or if missing, Birthweight ≥1000g, or if missing; body length ≥ 35cm.
Denominator	Total number of births (per 1000) in a specified time period.
Preferred data sources	The three main data sources for this indicator are: a. Civil registration and vital statistics (CRVS) systems b. Routinely collected administrative data c. Population-based household surveys
Other data sources	Routinely collected administrative data and population-based household surveys
Disaggregation	By timing/type of fetal death or stillbirth (antepartum or intrapartum; fresh1 or macerated2), gestational age in weeks and days, birthweight, sex, place of birth, place of residence (e.g. urban, rural), and type of reporting source (e.g. health facility, community).
Frequency of data collection	Within CRVS, this indicator is generally monitored at a national or subnational level on an annual basis. The data can be compiled and aggregated subnationally to provide national-level data. Estimates are done annually through UNIGME using CRVS and/or any routine data or population based data.
Limitations	Under-reporting: The number of stillbirths continues to be high and there is a lack of usable data in countries and regions in which most stillbirths occur, with under-reporting being a major challenge. Inconsistent definitions: The different criteria used to define stillbirth remain an issue globally. For international comparison, WHO uses the ICD-11 definitions of late fetal deaths with a cut-off of 28 weeks gestation). However, in some high-income settings, stillbirth data are collected and reported from 20 weeks gestation. In many low- and middle-income countries, gestational age is based on the last menstrual period, which women may not remember or may not have any records. Self-report and recall bias: In surveys, which are the main source of data for low- and middle-income countries, stillbirths are documented based on self-report from mothers and is subject to recall and misclassification bias. Lack of reporting requirements: Absence of global goals and reporting mechanisms continue to restrict the visibility of stillbirth rates, especially in countries with the greatest disease burden.
Data type	Impact

Related links	The stillbirth rate per 1000 births by country is monitored and tracked And can be found in the WHO Global Health Observatory (GHO) and the MNCAAH data portal and ENAP EPMM dashboard. https://www.who.int/data/gho/data/indicators/indicator-details/GHO/stillbirth-rate-(per-1000-total-births) https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/mca/stillbirth-rate-(per-1000-total-births) https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/ENAP-EPMM-dashboard

3.47. Obstetric and gynaecological admissions owing to abortion

Indicator	Obstetric and gynaecological admissions owing to abortion
Rationale	Complications of unsafe abortion are a leading cause of maternal death and morbidity, and are almost entirely preventable. Obstetric and gynaecological admissions owing to complications of unsafe abortion demonstrate health system need to invest in simple and safe solutions to prevent unsafe abortion and associated maternal mortality and morbidity (SDG3.1), as well as to promote good health, well-being (SDG3), and gender equality (SDG5).
Mandate (WHA resolution, SDG)	SDG Target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births. SDG Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. SDG Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences WHO Global Reproductive Health Strategy: elimination of unsafe abortion identified as priority mandate United Nations Global Strategy for Women's, Children's and Adolescents' Health: evidence-based interventions for abortion and post-abortion care included as an effective way to help individuals thrive and communities transform WHO Global Reference List of 100 Core Health Indicators: "Obstetric and gynaecological admissions owing to abortion" is included in the set of core indicators prioritized by the global community to provide concise information on health situations and trends, including responses at national and global levels.

Definition	Percentage of admissions for (spontaneous or induced) abortion-related complications to service delivery points providing inpatient obstetric and gynaecological services, among all admissions (except those for planned termination of pregnancy).
Numerator	Admissions for abortion-related complications
Denominator	All obstetric and gynaecological admissions, except those for planned termination of pregnancy
Preferred data sources	Routine health information system reports from hospital registers
Other data sources	Special studies
Disaggregation	By region/health facility, age, severity of complication
Frequency of data collection	Annual
Limitations	1. Underreporting: Sensitivities around abortion are associated with the risk that the link with abortion is underreported of misreported; 2. Treatment of abortion complications may be performed in different locations - gyneco-logical ward, emergency room or operating room; data collection for numerator should therefore include admissions from all locations.
Data type	Ratio
Related links	WHO Global Reference List of 100 Core Health Indicators 100_Core_Health_Indicators_2018.pdf (who.int) WHO Global Reproductive Health Strategy Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets (who.int) United Nations Global Strategy for Women's, Children's and Adolescents' Health https://data.unicef.org/resources/global-strategy-womens-childrens-adolescents-health/

3.48. SDG 3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods

Indicator	Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods
Rationale	
Mandate (WHA resolution, SDG)	
Definition	The percentage of women of reproductive age (15-49 years) who desire either to have no (additional) children or to postpone the next child and who are currently using a modern contraceptive method.

Numerator	Percentage of women of reproductive age (15-49 years old) who are currently using, or whose sexual partner is currently using, at least one modern contraceptive method.
Denominator	Total demand for family planning (the sum of contraceptive prevalence (any method) and the unmet need for family planning).
Preferred data sources	This indicator is calculated from nationally-representative household survey data. Multi-country survey programmes that include relevant data for this indicator are: Contraceptive Prevalence Surveys (CPS), Demographic and Health Surveys (DHS), Fertility and Family Surveys (FFS), Reproductive Health Surveys (RHS), Multiple Indicator Cluster Surveys (MICS), Performance Monitoring and Accountability 2020 surveys (PMA), World Fertility Surveys (WFS), other international survey programmes and national surveys.
Other data sources	
Disaggregation	Age, geographic location, marital status, socioeconomic status and other categories, depending on the data source and number of observations.
Frequency of data collection	Annual
Limitations	Differences in the survey design and implementation, as well as differences in the way survey questionnaires are formulated and administered can affect the comparability of the data. The most common differences relate to the range of contraceptive methods included and the characteristics (age, sex, marital or union status) of the persons for whom contraceptive prevalence is estimated (base population). The time frame used to assess contraceptive prevalence can also vary. In most surveys, there is no definition of what is meant by "currently using" a method of contraception. In some surveys, the lack of probing questions, asked to ensure that the respondent understands the meaning of the different contraceptive methods, can result in an underestimation of contraceptive prevalence, for traditional methods. Sampling variability can also be an issue, especially when contraceptive prevalence is measured for a specific subgroup (according to method, age-group, level of educational attainment, place of residence, etc.) or when analyzing trends over time.
Data type	Percentage
Related links	https://www.un.org/en/development/desa/population/publications/pdf/family/ContraceptiveUseByMethodDataBooklet2019.pdf https://www.un.org/en/development/desa/population/publications/pdf/popfacts/PopFacts_2019-3.pdf

3.49. SDG 3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group

Indicator	Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group.

Rationale	Reducing adolescent fertility and addressing the multiple factors underlying it are essential for improving sexual and reproductive health and the social and economic well-being of adolescents. There is substantial agreement in the literature that women who become pregnant and give birth very early in their reproductive lives are subject to higher risks of complications or even death during pregnancy and birth and their children are also more vulnerable. Therefore, preventing births very early in a woman's life is an important measure to improve maternal health and reduce infant mortality. Furthermore, women having children at an early age experience reduced opportunities for socio-economic advancement, particularly because young mothers are less likely to complete their education and, if they need to work, may find it especially difficult to combine family and work responsibilities. The adolescent birth rate also provides indirect evidence on access to pertinent health services since young people, and in particular unmarried adolescent women, often experience difficulties in access to sexual and reproductive health services.
Mandate (WHA resolution, SDG)	Adolescent Birth Rate is an SDG indicator (3.7.2) for the SDG Target 3.7 (By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes). This target and indicator are also embedded in the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). An operational plan to take forward the implementation of this Global Strategy was adopted by the World Health Assembly in May 2016 (A69/16).
Definition	Annual number of births to females aged 10-14 / 15-19 years per 1,000 females in the respective age group.
Numerator	Number of live births to women aged 10-14 / 15-19 years.
Denominator	Estimate of exposure to childbearing by women aged 10-14 / 15-19 years.
Preferred data sources	Civil registration is the preferred data source.
Other data sources	Census and household survey are alternate sources when there is no reliable civil registration.
Disaggregation	
Frequency of data collection	Annual.
Limitations	The numerator and the denominator are calculated differently for civil registration, survey and census data. Computation formula: Adolescent Birth Rate (10-14) = (number of births to women ages 10-14/mid-year population of women ages 10-14) * 1,000 Adolescent Birth Rate (15-19) = (number of births to women ages 15-19/mid-year population of women ages 15-19) * 1,000 In the case of civil registration data, the numerator is the registered number of live births born to women aged 10-14 / 15-19 years during a given year, and the denominator is the estimated

	or enumerated population of women aged 10-14 / 15-19 years. In the case of survey data, the numerator is the number of live births obtained from retrospective birth histories of the interviewed women who were 10-14 / 15-19 years of age at the time of the births during a reference period before the interview, and the denominator is person-years lived between the ages of 10-14 / 15-19 years by the interviewed women during the same reference period. The reported observation year corresponds to the middle of the reference period. For some surveys without data on retrospective birth histories, computation of the adolescent birth rate is based on the date of last birth or the number of births in the 12 months preceding the survey. With census data, the adolescent birth rate is computed on the basis of the date of last birth or the number of births in the 12 months preceding the enumeration. The census provides both the numerator and the denominator for the rates. In some cases, the rates based on censuses are adjusted for under registration based on indirect methods of estimation. For some countries with no other reliable data, the own-children method of indirect estimation provides estimates of the adolescent birth rate for a number of years before the census.
Data type	Ratio.
Related links	For a thorough treatment of the different methods of computation, see Handbook on the Collection of Fertility and Mortality Data, United Nations Publication, Sales No. E.03.XVII.11, (https://unstats.un.org/unsd/demographic/standmeth/handbooks/Handbook_Fertility_Mortality.pdf). In direct methods of estimation are analyzed in Manual X: Indirect Techniques for Demographic Estimation, United Nations Publication, Sales No. E.83.XIII.2. (https://www.un.org/en/development/desa/population/publications/pdf/mortality/Manual_X.pdf)

3.50. SDG 3.b.1 Proportion of the target population covered by all vaccines included in their national programme

Indicator	Proportion of the target population covered by all vaccines included in their national programme
Rationale	
Mandate (WHA resolution, SDG)	
Definition	This indicator aims to measure access to vaccines, including the newly available or underutilized vaccines, at the national level Coverage of DTP containing vaccine (3rd dose): Percentage of surviving infants who received the 3 doses of diphtheria and tetanus toxoid with pertussis containing vaccine in a given year. Coverage of Measles containing vaccine (2nd dose): Percentage of children who received two dose of measles containing vaccine according to nationally recommended schedule through routine immunization services in a given year.

	Coverage of Pneumococcal conjugate vaccine (last dose in the schedule): Percentage of surviving infants who received the nationally recommended doses of pneumococcal conjugate vaccine in a given year. Coverage of HPV vaccine (last dose in the schedule): Percentage of 15 years old girls received the recommended doses of HPV vaccine. WHO and UNICEF jointly developed a methodology to estimate national immunization coverage from selected vaccines in 2000. The methodology has been refined and reviewed by expert committees over time. The methodology was published and reference is available under web site. Estimates time series for WHO recommended vaccines produced and published annually since 2001. The methodology uses data reported by national authorities from countries administrative systems as well as data from immunization or multi indicator household surveys.
Numerator	Number of children vaccinated in the target group. (12-23 months or other age group depending on recommended national immunization schedule).
Denominator	Number of 2 years old children globally
Preferred data sources	National Health Information Systems or National Immunization systems National immunization registries
Other data sources	High quality household surveys with immunization module (e.g. DHS, MICS, national in-country surveys)
Disaggregation	Geographical location, i.e. regional and national and potentially subnational estimates
Frequency of data collection	Annual data collection Annual data collection March-May each year. Country consultation June each year Data release: 15 July each year for time series 1980 – release year -1. (in July 2018 estimates from 1980-2017) 15 July each year for time series 1980 – release year -1. (in July 2017 estimates from 1980-2016)
Limitations	Time series of coverage are subject to change when new data becomes available.
Data type	Percentage
Related links	WHO: http://www.who.int/immunization/monitoring_surveillance/routine/coverage/en/index4.html

3.51. SDG 4.2.1 Proportion of children aged 24–59 months who are developmentally on track in health, learning, and psychosocial well-being, by sex

Indicator	Proportion of children under 5 who are developmentally on track in health, learning and psychosocial well-being, by sex
Rationale	Early childhood development is multidimensional, encompassing several aspects of a child's well-being: physical, social, emotional and mental. In 2015, early childhood development became part of the Sustainable Development Goals (SDGs). These global goals include a

	commitment to ensure that, by the year 2030, all children will have equitable access to quality early childhood development and early learning opportunities
Mandate (WHA resolution, SDG)	SDG 4.2.1
Definition	Proportion of children under 5 years of age who are developmentally on track in health, learning, and psychosocial wellbeing is currently being measured by the percentage of children aged 24–59 months who are developmentally on track in at least 3 of the following 4 domains: literacy-numeracy, physical, socio-emotional, and learning.
Numerator	The number of children under the age of five who are developmentally on track in health, learning and psychosocial well-being multiplied by 100
Denominator	Total number of children under the age of five in the population
Preferred data sources	The UNICEF-supported MICS surveys have been collecting data on this indicator and converting it into the Early Childhood Development Index or ECDI in selected low- and middle-income countries since 2010. Many of the individual items included in the ECDI are collected through other mechanisms in high-income (OECD) countries as well.
Other data sources	
Disaggregation	Age, sex, place of residence, wealth, geographic location, caregiver education and other background characteristics.
Frequency of data collection	Annual
Limitations	Comparable data are available for 58 low- and middle-income countries since 2010
Data type	Percentage
Related links	UNICEF: https://data.unicef.org/topic/early-childhood-development/development-status/

3.52. SDG 5.6.2 Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education

Indicator	SDG indicator 5.6.2: Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information and education
Rationale	SDG 5.6.2 seeks to provide the first comprehensive global assessment of legal and regulatory frameworks in line with the 1994 International Conference on Population and Development (ICPD) Programme of Action (PoA), the Beijing Platform for Action, and international human rights standards. The indicator measures the legal and regulatory environment across four thematic sections, defined as the key parameters of sexual and reproductive health care, information and education according to these international consensus documents and human rights standards: • Maternity care • Contraception services • Sexuality education • HIV and HPV

Mandate (WHA resolution, SDG)	SDG 5.6.2 monitors progress toward the target of universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population.
Definition	SDG 5.6.2 seeks to measure the extent to which countries have national laws and regulations that guarantee full and equal access to women and men aged 15 years and older to sexual and reproductive health care, information, and education. The indicator is a percentage (%) scale of 0 to 100 (national laws and regulations exist to guarantee full and equal access), indicating a country's status and progress in the existence of such National laws and regulations.
Numerator Denominator	The indicator measures specific legal enablers and barriers for 13 SRHR components in 4 thematic areas. The calculation of the indicator requires data for all 13 components. The value for Indicator 5.6.2 is calculated as the arithmetic mean of the 13-component data. Similarly, the value for each section is calculated as the arithmetic mean of its constituent component data. $C_i = \frac{e_i}{E_i}(1 - \frac{b_i}{B_i}) \times 100$ where: C_i is the data for component i E_i is the total number of enablers in component i e_i is the number of enablers that exist in component i B_i is the total number of barriers in component i b_i is the number of barriers that exist in component i See metadata: https://unstats.un.org/sdgs/metadata/files/Metadata-05-06-02.pdf
Preferred data sources	SDG 5.6.2 is calculated based on official government responses collected through the *United Nations Inquiry among Governments on Population and Development*. The Inquiry has been conducted since 1963. All questions required for indicator 5.6.2 are integrated into Module II on fertility, family planning, and reproductive health of the Inquiry.
Other data sources	
Disaggregation	
Frequency of data collection	Every 4 years
Limitations	SDG 5.6.2 measures only the existence of laws and regulations; it does not measure their implementation.
Data type	Percent
Related links	SDG 5.6.2 indicator metadata https://unstats.un.org/sdgs/metadata/files/Metadata-05-06-02.pdf SDG 5.6.2 report: https://www.unfpa.org/resources/legal-commitments-sexual-and-reproductive-health-and-reproductive-rights-all

3.53. Treatment of acutely malnourished children

Indicator	Treatment of acutely malnourished children
Rationale	Over 13.7 million infants and children under 5 years of age experience wasting each year. These children are at high risk of mortality if not treated immediately. In 2023, WHO published updated guidelines on the prevention and management of wasting and nutritional oedema (acute malnutrition) in infants and children under 5 years.[10] These guidelines update and expand upon earlier WHO recommendations focused on management of severe acute malnutrition.[11] WHO has called for better integration of essential nutrition actions[12] (including management of child wasting) as an important component for achieving quality universal health coverage (UHC).[13]
Mandate (WHA resolution, SDG)	SDG 2.2.2: Prevalence of malnutrition among children under 5 years of age. The United Nations (UN) Secretary-General Global Action Plan for Child Wasting (2019)[14] established improved treatment of children with wasting as a key outcome.
Definition	Percentage of severely wasted children under 5 years of age that have been admitted for treatment nationally.
Numerator	Number of children 6-59 months with severe acute malnutrition newly admitted for treatment nationally.
Denominator	Number of children under 5 years of age with severe wasting (weight-for-height <-3 SD). The number reflecting prevalence at a single point in time is converted to incidence of new cases of wasting across the year using a k-factor or 2.6.
Preferred data sources	Numerator: UNICEF annual Nutridash survey[15] Denominator: WHO/UNICEF/World Bank Joint child malnutrition estimates. [16]
Other data sources	n/a
Disaggregation	Not currently available for numerator
Frequency of data collection	Annual for both numerator and denominator

[10] WHO guideline on the prevention and management of wasting and nutritional oedema (acute malnutrition) in infants and children under 5 years. Geneva: World Health Organization; 2023. https://app.magicapp.org/#/guideline/noPQkE

[11] WHO Guideline: updates on the management of severe acute malnutrition in infants and children. Geneva: World Health Organization; 2013. https://www.who.int/publications/i/item/9789241506328

[12] Essential nutrition actions: mainstreaming nutrition through the life-course. Geneva: World Health Organization; 2019. https://www.who.int/publications/i/item/9789241515856.

[13] Nutrition in universal health coverage. Geneva: World Health Organization; 2019. https://www.who.int/publications/i/item/WHO-NMH-NHD-19.24.

[14] United Nations Children's Fund, UN Food and Agriculture Organization, United Nations High Commissioner for Refugees, World Food Programme and the World Health Organization, Global Action Plan on Child Wasting: a framework for action to accelerate progress in preventing and managing child wasting and the achievement of the Sustainable Development Goals, New York 2021. https://www.childwasting.org/_files/ugd/2b7a06_643a6617b6a54190933d860b7b2c769b.pdf.

[15] UNICEF. Nutridash. 2021. https://www.unicef.org/nutrition/nutridash.

[16] UNICEF/WHO/The World Bank: Joint child malnutrition estimates (JME). https://www.who.int/teams/nutrition-and-food-safety/monitoring-nutritional-status-and-food-safety-and-events/joint-child-malnutrition-estimates.

Limitations	The numerator includes treatment of cases of kwashiorkor while the denominator does not, although these are generally a small number compared to the number of wasted children. The numerator excludes infants <6 months of age since such children are typically breastfed and are not admitted for treatment. The k-factor used in the denominator to convert prevalence to incidence is a commonly used estimate but may not be equally accurate in all countries.
Data type	Primary Data for numerator. Denominator is modelled for countries without recent nationally representative surveys.
Related links	https://www.unicef.org/nutrition/nutridash. https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-jme-wasting-prevalence

3.54. WHA 73 (12) Percentage of older people receiving long-term care in residential care facilities or at home

Programmatic outcome Indicator	Percentage of older people receiving long-term care in residential care facilities or at home
Rationale	With the global population ageing rapidly, there has been a significant shift in demographic patterns. The demographic transition, characterised by a decline in fertility rates and an increase in life expectancy, has led to a significant increase in people aged 60 years and over. As people live longer, there is an increased risk for age-related illnesses and declines in intrinsic capacity and functional ability, leading to a greater need for long-term care services. However, there is a considerable inequality in the unmet care needs among older persons within and across countries. The United Nations Decade of Healthy Ageing 2021-2030, a global action plan, aims to promote health and well-being among older persons. Recognizing the growing need for long-term care services, the UN has designated access to long-term care as one of the four action areas under this Decade. The endorsement of providing access to long-term care as a key action by Member States in the World Health Assembly and the UN General Assembly in 2020 underscores the importance and recognition of this issue on a global scale. UN resolution 2020 urges WHO to track the Member States' progress in ensuring access to long-term care and report back to the General Assembly in 2026 and 2029. WHO's Technical Advisory Group for Measurement of Healthy Aging (TAG4MHA) recommends tracking the percentage of older people receiving long-term care in residential care facilities and at home to monitor countries' progress in implementing long-term care action.
Mandate (WHA resolution, SDG)	• UN Resolution adopted by the General Assembly on 14 December 2020 https://documents-dds-ny.un.org/doc/UNDOC/GEN/N20/363/87/PDF/N2036387.pdf?OpenElement • WHA73(12) Decade of Healthy Ageing https://cdn.who.int/media/docs/default-source/decade-of-healthy-ageing/decade-proposal-final-apr2020-en.pdf?sfvrsn=b4b75ebc_28&download=true

Definition	Long-term care (health and social) consists of services to ensure that people with or at risk of significant loss of physical and mental capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity. Long-term care aims to prevent, reduce, or rehabilitate functional decline and it can be provided in different settings, such as home, community, hospitals, residential care facilities, or hospice. These services typically involve care and support with everyday tasks (including dressing, bathing, shopping, cooking and cleaning), support with social participation, and management of advanced chronic conditions through community nursing, rehabilitation and end-of-life care. Services are provided by family members, friends or other community members (also called informal or unpaid carers) or by paid care workers.
Numerator	Number of older persons 65 years and older receiving long-term care
Denominator	Total number of older persons aged 65 years and over
Preferred data sources	OECD Health Statistics, Population surveys on ageing
Other data sources	Administrative data
Disaggregation	Age, sex, income and place (facility and at home)
Frequency of data collection	Periodic, every three years
Limitations	The definitions and eligibility criteria for long-term care services vary by country, making global comparisons challenging. Also, the coverage of data, particularly from low and middle-income countries is limited. However, the WHO Ageing and Health Unit is working with ILO and OECD to expand global databases on long-term care and data from more countries will be added in coming years.
Data type	Statistic
Related links	Data for the indicator can be found here on the WHO platform: https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/mca/percentage-of-older-people-receiving-long-term-care-at-a-residential-care-facility-and-at-home

3.55. SDG 5.3.2 Proportion of girls and women aged 15 – 49 who have undergone female genital mutilation

Indicator	Proportion of girls and women aged 15 – 49 who have undergone female genital mutilation
Rationale	FGM is a harmful practice that is associated with health consequences in the short- and long-term costing health systems millions of dollars each year. It is a violation of the rights of women and girls and an extreme manifestation of gender inequality. WHO is supporting high prevalence countries to develop and implement health plans to promote FGM prevention and care services based on a set of resources developed by WHO, including guidelines, a clinical handbook, a global strategy against medicalization, training materials on person-centred communication for FGM prevention and other training and advocacy tools. These plans are structured around four pillars of action: building political will, strengthening capacity of health workers, implementing

	legal and policy frameworks to ensure accountability of health workers to not perform FGM and ensuring monitoring and evaluation frameworks. Multi-sectoral efforts are needed to abandon the practice, and the health sector must play a prominent role, particularly at the primary care level given the positionality of primary care health workers, including community health workers, in reaching at-risk communities.
Mandate (WHA resolution, SDG)	SDG 5.3b calls for the abandonment of female genital mutilation and World Health Assembly 61.16 calls for all member states to take actions to abandon this harmful practice and ensure high quality treatment and care to women and girls affected. The Global Strategy to Stop Health-care Providers from Performing Female Genital Mutilation provides a framework of action for countries to stop the medicalization of FGM.
Definition	Proportion of girls and women aged 15 – 49 who have undergone any type of female genital mutilation
Numerator	Number of girls and women aged 15 – 49 who have undergone any type of female genital mutilation
Denominator	Total number of girls and women aged 15 – 49 in the population
Preferred data sources	National representative population-based surveys, such as the DHS and MICS with modules on female genital mutilation
Other data sources	Other household surveys
Disaggregation	By age: 15 – 19 years old, 20 years old and above; by FGM type; by FGM medicalization status (by health worker or other)
Frequency of data collection	Every five years
Limitations	(1) Data on FGM type is based on self-report and while these data are reliable for overall prevalence estimates, the reporting of FGM types may be less accurate. (2) Medicalized FGM is measured based on the self-report responses of who performed FGM on children between the ages of 0 – 14 years old, and some reports of FGM medicalization may also include individuals perceived to be part of the formal health system although without training or qualification. (3) Prevalence estimates capturing lifetime exposure to FGM will not be sensitive to recent changes, therefore disaggregation by age to report prevalence among 15 – 19 year-olds will be critical.
Data type	Proportion
Related links	https://data.unicef.org/topic/child-protection/female-genital-mutilation/#data

3.56. Incidence of catastrophic out-of-pocket health spending (SDG indicator 3.8.2 and regional definitions where available) (SDG indicator 3.8.2)

Indicator	Incidence of catastrophic out-of-pocket health spending (SDG indicator 3.8.2 and regional indicators where available)
Rationale	Target 3.8 is about universal health coverage (UHC) and is defined as “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”. The concern is with all people and communities receiving the quality health services they need (including medicines and other health products) without financial hardship. Financial hardship is

	a key consequence of inadequate financial risk protection mechanisms and can be experienced in any country, regardless of the income level and type of health system. Paying out of pocket for health may mean a household can no longer afford to meet other basic needs (for example, food, housing and heating). To identify those spending on health out-of-pocket beyond their ability to pay, the incidence of catastrophic out-of-pocket health spending needs to be monitored.
Mandate (WHA resolution, SDG)	At the global level and across all regions, WHO support for monitoring financial protection is underpinned by a World Health Assembly resolution on sustainable health financing, universal coverage and social health insurance: Microsoft Word - A58_R1_R&D-en.doc (who.int). At the regional level, there are additional resolutions. For example, in the WHO European region, European Programme of Work 2020-2025 ("United Action for Better Health in Europe"); Resolution EUR/RC65/13 on priorities for health systems strengthening in the WHO European Region 2015–2020 Sustainable Development Goals and The Tallinn Charter all call for tracking the incidence of catastrophic out-of-pocket health spending.
Definition	The incidence of catastrophic out-of-pocket health spending is defined as the number of people or households with out-of-pocket health spending exceeding ability to pay. Within the sustainable development goals, SDG 3.8.2 indicator counts the number of people with out-of-pocket health spending exceeding 10% and 25% of household total consumption or income as a percentage of the total population. Regional definitions also exist. For example, in the WHO European region, the incidence of catastrophic out-of-pocket health spending is defined as the number of households with out-of-pocket health payments exceeding 40% of basic spending on food, housing and utilities.
Numerator	Household expenditure on health is defined as any expenditure incurred at the time of service use to get any type of care (promotive, preventive, curative, rehabilitative, palliative or long-term care), including all medicines, vaccines and other pharmaceutical preparations, as well as all health products, from any type of provider and for all members of the household. These health expenditures are characterized by direct payments that are financed by a household's income (including remittances), savings or loans but do not include any third-party payer reimbursement. They are labelled Out-Of-Pocket (OOP) payments in the classification of health care financing schemes (HF) of the International Classification for Health Accounts (ICHA). They are the most inequitable source of funding for the health system as they are solely based on the willingness and ability to pay of the household; they only grant access to the health services and health products individuals can pay for, without any solidarity between the healthy and the sick beyond the household1 , the rich and the poor; they represent a barrier to access for those people who are unable to find the economic resources need to pay out of their own pocket. The components of household expenditure on health should be consistent with division 06 on the health of the UN Classification of Individual Consumption According to Purpose (COICOP) on medicines and medical products (06.1), outpatient care services (06.2), inpatient care services (06.3) and other health services (06.4)2. Further information on definitions and classifications of health expenditures should be consistent with the International Classification for Health Accounts (ICHA) and its family of classifications (for example, by type of provider).
Denominator	Out-of-pocket health payments are catastrophic when they exceed a given fraction of ability to pay. Ability to pay can be defined in different ways. The simplest approach uses household total consumption (preferred) or income as a proxy for the resources available to pay for health care. This is the approach followed for SDG 3.8.2 as it can be applied everywhere. But this approach is

	likely to over-estimate the purchasing power of the poorest and under-estimate the purchasing power of the richer. Another approach uses consumption net of spending on basic needs. The definition of basic needs may vary across countries and regions. In the WHO European region capacity to pay for health care is defined as per adult equivalent total household consumption minus a standard amount to cover food, housing (rent) and utilities (water, electricity and fuel used for cooking and heating).
Preferred data sources	The recommended data sources to track the incidence of catastrophic out-of-pocket health spending (SDG indicator 3.8.2 and regional indicators where available) are household surveys with information on both household consumption expenditure on health and total household consumption expenditures, which are routinely conducted by national statistical offices. Household budget surveys (HBS) and household income and expenditure surveys (HIES) typically collect these as they are primarily undertaken to provide inputs to the calculation of consumer price indices or the compilation of national accounts. Another potential source of information is socio-economic or living standards surveys; however, some of these surveys may not collect information on total household consumption expenditures – for example, when a country measures poverty using income as the welfare indicator. The most important criterion is the availability of both household consumption expenditure on health and total household consumption expenditures. Country level estimates are available for 165 countries or territories covering all WHO regions (see related links). In addition, numbers for countries in the WHO European region are available from UHC watch.
Other data sources	Note: data on catastrophic health spending should be complemented by data on unmet need for health care and service coverage (SDG 3.8.1 indicator)
Disaggregation	The following disaggregation is possible in so far as the survey has been designed to provide representative estimates and/or there are enough observations collected at such level: • Residence area type • Sex of the head of the household (male/female) • Age and sex of the head of the household (below 60 years old/ 60 years or older; male/female) • Age composition of the household based on the following grouping: “Adults only (20-59 years old)” - households that consist of members aged between 20 and 59 years old; “Adults with children and adolescents (below 60 years old members)” - households that consist of members aged below 60 only as follows: at least one member below 20 years old AND at least one member aged between 20 and 59 years old; “Multigenerational households (all ages)” - households that include at least one person below 20 years old AND at least one person aged between 20 and 59 years old AND at least one person >= 60 years old; “Adults with older persons (from 20 years old)” - households that consist of members aged >=20 only as follows: at least one person aged between 20 and 59 years old AND at least one person >= 60 years old; “Only older adults (>=60 years old)” - households that consist of members aged >=60 years old only; “Only members below 20 years old” - households that consist of members aged below 20 years old only • Residence area type • household quintiles by consumption per person or using OECD equivalence scales where relevant Other possible disaggregation are possible such as by occupational status
Frequency of data collection	The primary data inputs are anonymized micro-data from household surveys. Each country determines access and permission conditions. The World Health Organization (WHO) contact

	Ministries of Health and/or National statistical offices for two purposes: a) request access to the household survey microdata in order to produce SDG indicator 3.8.2; b) request estimates produced by the country itself. A) WHO obtains access to the household survey microdata from national statistical offices through its regional offices or country offices. The access request is often part of technical assistance programs on health financing issues. B) Estimates produced by each country are requested through a country consultation conducted by the World Health Organization every two years.
Limitations	See Annex 8 on page 107 of the 2023 WHO/World Bank global monitoring report on UHC for a summary of the advantages and disadvantages of different ways of catastrophic out-of-pocket health spending and Annex 7 on page 106 on the difference between catastrophic and impoverishing out-of-pocket health spending. Section 4.b "Comments and limitations" on pages 5-7 and Section "Comparability /deviation from international standards" on pages 11-12 in the SDG 3.8.2 metadata description See Box 1 on page 7 of WHO/Europe's most recent regional report on financial protection for a summary of the limitations of using household budget survey data to monitor financial protection.
Data type	Percent
Related links	https://unstats.un.org/sdgs/metadata/files/Metadata-03-08-02.pdf Estimates at global, regional and country levels are available from 4 different databases: https://www.who.int/data/gho/data/themes/topics/financial-protection https://data.who.int/indicators/i/A65146D https://data.who.int/indicators/i/4934B28 http://datatopics.worldbank.org/universal-health-coverage/ https://unstats.un.org/sdgs/dataportal In addition, estimates for the WHO-European region are available from UHC watch – an interactive platform tracking progress on affordable access to health care in Europe and central Asia – for data on financial hardship, unmet need and health spending, up to date information on health coverage policy and WHO/Europe resources on financial protection and health financing policy. Methodology: ○ Chapter 2 on Financial protection in "Tracking universal health coverage: 2017 global monitoring report", World Health Organization and International Bank for Reconstruction and Development/ The World Bank; 2017; ○ Wagstaff, A., Flores, G., Hsu J., Smitz, M-F., Chepynoga, K., Buisman, L.R., van Wilgenburg, K. and Eozenou, P., (2018), "Progress on catastrophic health spending in 133 countries: a retrospective observational study", the Lancet Global Health, volume 6, issue 2, e169-e179. http://dx.doi.org/10.1016/S2214-109X(17)30429-1 ○ Chapter 18 of "Analyzing health equity using household survey data". Washington, DC: World Bank Group; 2008, ○ Cylus J, Thomson S, Evetovits T (2018). Catastrophic health spending in Europe: equity and policy implications of different calculation methods. Bull World Health Organ. 96:599–609.

	○ WHO Regional Office for Europe (2019). Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: WHO Regional Office for Europe. ○ WHO Regional Office for Europe (2019). Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: WHO Regional Office for Europe. ○ Thomson S, Cylus J, Al Tayara L, Gallardo Martínez M, García-Ramírez J, Cerezo J, Karanikolos M, Evetovits T (2024). Monitoring progress towards universal health coverage in Europe: a descriptive analysis of financial protection in 40 countries. Lancet Regional Health Europe 37(2): https://doi.org/10.1016/j.lanepe.2023.100826.

3.57. Impoverishing out-of-pocket health spending (related to SDG indicator 1.1.1 and regional definitions where available)

Indicator	Incidence of impoverishing out-of-pocket health spending (pushed and further pushed below a poverty line)
Rationale	This indicator is used to assess the extent to out-of-pocket health spending contributes to exacerbating poverty. The rationale is that out-of-pocket health spending diverts household spending away from non-medical budget items such as food and shelter to such an extent that, in some cases, a household's position in relation to a pre-defined poverty line before and after spending out of pocket on health changes to go deeper into poverty by either a) crossing the poverty line or b) going further below the poverty line.
Mandate (WHA resolution, SDG)	Related to SDG 1, namely end poverty in all its forms everywhere. WHO support for monitoring financial protection is underpinned by a World Health Assembly resolution on sustainable health financing, universal coverage and social health insurance: Microsoft Word - A58_R1_R&D-en.doc (who.int). At the regional level, there are additional resolutions. For example, in the WHO European, European Programme of Work 2020-2025 ("United Action for Better Health in Europe"), Resolution EUR/RC65/13 on priorities for health systems strengthening in the WHO European Region 2015–2020 and The Tallinn Charter.
Definition	The incidence of impoverishing out-of-pocket health payment includes a) those who are impoverished – pushed below a poverty line by out-of-pocket health spending (%) and b) those who are further impoverished, i.e. pushed further below a poverty line by out-of-pocket health spending (%). At global level, for international cross-country comparison, the international poverty line of $2.15 a day in 2017 purchasing power parity (PPP) is used (shown as $2.15-a-day). With this line it is possible to demonstrate the interdependency between SDG target 1.1, the eradication of extreme poverty and SDG target 3.8 (Universal Health Coverage). But this line is the most relevant for low and lower-middle income countries. It is too low for upper-middle- and high-income countries. A relative poverty line defined as defined as 60% of the median daily per capita consumption or income in each country is used to demonstrate the interdependence between poverty eradication and UHC in all countries at all income levels. There are other ways to define country specific lines for cross-country comparability. For example, in the WHO European region, is a country-specific relative poverty line (basic needs line) based on household spending to meet basic needs (food, housing and utilities).
Numerator	
Denominator	

Preferred data sources	Household budget surveys; Household income and expenditure surveys; Household socioeconomic and living standards surveys. Same as for SDG 3.8.2. Country level estimates are available for 157 countries or territories covering all WHO regions (see related links)
Other data sources	Note: data on impoverishing health spending should be complemented by data on catastrophic out-of-pocket payments, unmet need for health care and service coverage (SDG 3.8.1)
Disaggregation	Same as the incidence of catastrophic out-of-pocket health payments.
Frequency of data collection	Same as for the incidence of catastrophic out-of-pocket health payments.
Limitations	On the difference between catastrophic and impoverishing out-of-pocket health spending, see also Annex 7 on page 106 of the 2023 WHO/World Bank global monitoring report on UHC and related online FAQ. See Box 1 on page 7 of WHO/Europe's most recent regional report on financial protection for a summary of the limitations of using household budget survey data to monitor financial protection.
Data type	Percent
Related links	Estimates at global, regional and country levels are available at: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-pushed-below-a-relative-poverty-line-by-household-health-expenditures-(60-of-median-daily-per-capita-consumption-or-income) https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-pushed-further-below-a-relative-poverty-line-by-household-health-expenditures-60-of-median-daily-per-capita-consumption-or-income https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-pushed-below-the-2.15-a-day-poverty-line-by-household-health-expenditures-(percent--national--rural--urban) https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-pushed-further-below-the-2.15-a-day-poverty-line-by-household-health-expenditures-(percent--national--rural--urban) https://www.who.int/data/gho/data/themes/topics/financial-protection; http://datatopics.worldbank.org/universal-health-coverage/ In addition, for the WHO European region, see UHC watch – an interactive platform tracking progress on affordable access to health care in Europe and central Asia – for data on financial hardship, unmet need and health spending, up to date information on health coverage policy and WHO/Europe resources on financial protection and health financing policy. Methodology: • Wagstaff A, Flores G, Smitz M-F, Hsu J, Chepynoga K, Eozenou P (2017). Progress on impoverishing health spending: results for 122 countries. A retrospective observational study. Lancet Global Health.

	• Chapter 19 in "Analyzing health equity using household survey data". Washington, DC: World Bank Group; 2008 • WHO Regional Office for Europe (2019). Can people afford to pay for health care? New evidence on financial protection in Europe. Copenhagen: WHO Regional Office for Europe. Thomson S, Cylus J, Al Tayara L, Gallardo Martínez M, García-Ramírez J, Cerezo J, Karanikolos M, Evetovits T (2024). Monitoring progress towards universal health coverage in Europe: a descriptive analysis of financial protection in 40 countries. Lancet Regional Health Europe 37(2): https://doi.org/10.1016/j.lanepe.2023.100826.

3.58. WHA64.9 Out-of-pocket payments as a share of current spending on health

Indicator	Out-of-pocket payment as a share of current health expenditure (OOP%CHE).
Rationale	This is a system level indicator that reflects the extent to which a country relies on out-of-pocket payment to finance its health system. In general, a higher share of OOP in total health spending is associated to reduced access to services and increased financial hardship for household when use the services.
Mandate (WHA resolution, SDG)	A64 (WHA64.9) 'Sustainable health financing structures and universal coverage" Microsoft Word - A64_R1_COV+PRELIMS-en.docx (who.int)
Definition	Out of Pocket Expenditure (OOP) divided by Current Health Expenditure (CHE)
Numerator	Out of Pocket Expenditure (OOP)
Denominator	Current Health Expenditure (CHE)
Preferred data sources	WHO Global Health Expenditure Database
Other data sources	
Disaggregation	NA
Frequency of data collection	Annual data collection
Limitations	Data reporting with 2-year time lag and very few countries reporting t-1 data.
Data type	Percentage (%)
Related links	https://apps.who.int/nha/database/Home/Index/en

4. PROTECT HEALTH

Table 3. Overview of 10 outcome indicators

SDG / WHA	Outcome Indicators
	Vaccine coverage of at-risk groups for high-threat epidemic/pandemic pathogens: yellow fever , cholera , meningitis, polio, and measles
	Number of cases of poliomyelitis caused by wild poliovirus
	Probability of spillover of zoonotic diseases
	Coverage of WASH in communities and healthcare facilities
	National health emergency preparedness
	Trust in government
SDG 3.d.1	International Health Regulations (IHR) capacity and health emergency preparedness
	Timeliness of detection, notification & response of IHR notifiable events
	Composite indicator comprising three tracer indicators for essential health services among population in settings with humanitarian response plan (HRP)
	Proportion of vulnerable people in fragile settings provided with essential health services (%)

4.1. Vaccine coverage of at-risk groups for high-threat epidemic/pandemic pathogens: yellow fever , cholera , meningitis, polio, and measles

Indicator	Prevent – vaccination
Rationale	Vaccination is a key public health intervention which can prevent and contain outbreaks of infectious diseases
Mandate (WHA resolution, SDG)	
Definition	The Infectious Hazards Management (IHM) department in the Health Emergencies Programme has identified certain countries as at-risk for yellow fever, cholera, and meningococcal meningitis prevention and control. Sixty-six countries are considered at-risk for at least one of these pathogens. An immunization coverage estimate for routine (yellow fever; meningococcal meningitis) and campaign coverage (yellow fever; meningococcal meningitis; cholera) will be generated for each category of country presented, weighted by the relative sizes of the target populations for routine immunization and vaccination campaigns. Because not all Member States are not at-risk for these diseases, routine immunization estimates for first dose measles-containing vaccine (MCV1) will be used in order to develop estimates for all Member States, and to highlight the importance of a functioning immunizations program for disease prevention. Coverage for all antigens will be weighted equally. An immunization coverage estimate for routine (yellow fever; meningococcal meningitis) and campaign coverage (yellow fever; meningococcal meningitis; cholera) will be generated for each category of country presented, weighted by the relative sizes of the target populations for routine immunization and vaccination campaigns. Because not all Member States are not at-risk for these diseases, routine immunization estimates for first dose measles-containing vaccine (MCV1) will be used in order to develop estimates for all Member States, and to highlight the importance of a functioning immunizations program for disease prevention. Coverage for all antigens will be weighted equally. The indicator is a weighted average of routine and campaign vaccinations for diseases linked with epidemics and pandemics. The indicator will include only the priority infection hazards relevant to each country. The indicator can be adapted to include other mass-vaccination campaigns that are needed (e.g. pandemic influenza, Ebola virus disease). Current vaccinations used in the prevent indicator are: ○ priority infectious hazards: yellow fever, meningococcal meningitis A and cholera – when relevant ○ measles, polio – to emphasize the importance of routine coverage. The indicator is calculated as the population-weighted average of routine and campaign vaccine coverages for the applicable diseases: i.e. measles and polio for all Member States, and yellow fever and/or cholera and/or meningitis where there is a risk. $$\text{Emergency prevent indicator} = \frac{\sum_v \text{Coverage}_v \times \text{relevant population}_v}{\sum_v \text{relevant population}_v}$$

	where v represents the relevant vaccines for the country and year of estimation. The coverage estimates are each weighted by the relevant population. For routine vaccination, this is the total population of surviving infants. For campaigns, this is the target population. The rolling/cumulative vaccinated population is used during emergencies or any supplementary campaigns. There are 66 Member States currently considered at risk by the WHO Health Emergencies Programme for at least one of yellow fever, cholera, and meningitis A. Because not all Member States that are at high risk for, or affected by, yellow fever, cholera, and meningitis made or had requests approved by the ICG or conducted other vaccination campaigns, the mean campaign coverage estimate is calculated using the antigen data available (i.e., non-missing). The estimate for cholera is the average of campaign coverage (when available), weighted by the relative sizes of the target population for the specific campaign(s). There is no cholera vaccination currently recommended as part of the routine vaccination schedule. Where target population data are not available for a specific campaign, the number of doses shipped by the ICG or GTFCC will be used as a proxy for target population size.
Numerator	Polio (Pol3): %coverage*population (surviving infants 1yr) Measles (MCV1): %coverage*population (surviving infants 1yr) Cholera (OCV1): vaccinated Meningitis (MenA): %coverage*population (surviving infants 1yr) Yellow fever (routine): %coverage*population *New* Polio (campaigns): vaccinated *New* Measles *(*MCV2): vaccinated
Denominator	Polio (Pol3): surviving infants 1yr Measles (MCV1): surviving infants 1yr Cholera (OCV1): target population Meningitis (MenA): surviving infants 1yr Yellow fever: population *New* Polio (campaigns): target population *New* Measles *(*MCV2): target population
Preferred data sources	Coverage estimates for routine vaccination (yellow fever, measles, polio) from WHO/UNICEF estimate of immunization coverage (WUENIC) for MCV1 and YF routine immunization estimates; WHO/UNICEF Joint Reporting Form (JRF) for administrative coverage estimates of meningococcal meningitis routine immunization coverage; emergency immunization coverage for cholera, meningococcal meningitis and yellow fever using the International Coordinating Group (ICG) on Vaccine Provision; mass preventive oral cholera vaccination campaign coverage data from the Global Task Force on Cholera Control (GTFCC); polio immunization campaign data from WHO/Global Polio Eradication; additional meningitis, polio and yellow fever immunization campaign coverage estimates from the WHO/UNICEF JRF.
Other data sources	Global Health Observatory; pandemic influenza vaccination campaign data in targeted countries, where applicable
Disaggregation	Country; antigen
Frequency of data collection	Annual (routine immunizations); periodic (vaccination campaigns), updated annually

Limitations	Routine immunization data for meningococcal meningitis are not available from WUENIC and are only available (self-reported administrative coverage) from the JRF. Emergency vaccination campaign coverage estimates might require the use of administrative estimates, which could bias (overestimate) campaign coverage as measured using a population-based survey. Because cholera is not part of routine immunization programs, relatively small cholera campaigns can have a disproportionate influence on the mean coverage estimate. The indicator is an absolute estimate, meaning that countries can demonstrate progress by incremental improvement independently of other countries' performance. Ultimately, all countries should have coverage estimates of >90%. The weighting scheme places a high weight on routine vaccination, emphasizing the value of routine coverage for many diseases. A potential limitation of this approach is that small, targeted campaigns will have only a small impact on the indicator. Other weighting schemes were also considered (e.g., equal weighting for all antigens – in which small campaigns (e.g., for cholera) had an oversized effect on the mean).
Data type	Percent
Related links	

4.2. Number of cases of poliomyelitis caused by wild poliovirus

Indicator	Number of cases of poliomyelitis caused by wild poliovirus (WPV)
Rationale	
Mandate (WHA resolution, SDG)	
Definition	Reported cases of laboratory-confirmed polio cases. A polio case is confirmed if wild poliovirus is isolated from stool specimens collected from an Acute flaccid paralysis (AFP) case. Sum of reported cases.
Numerator	
Denominator	
Preferred data sources	Surveillance systems
Other data sources	
Disaggregation	
Frequency of data collection	Weekly
Limitations	
Data type	Count, absolute number of cases

Related links	WHO: http://www.who.int/immunization/monitoring_surveillance/en/;

4.3. Probability of spillover of zoonotic diseases

Indicator	Prevent – zoonotic spillover
Rationale	Mitigating the risk of spillover of zoonotic pathogens from animals to humans is crucial as this is the predominant cause of emerging infectious diseases and recent pandemics
Mandate (WHA resolution, SDG)	
Definition	Probability of spillover of zoonotic diseases
Numerator	Number of people potentially exposed to spillover of zoonotic diseases (EVD, CCHF, Lassa Fever, MVD)
Denominator	Total population
Preferred data sources	Dynamic Preparedness Metric (DPM)
Other data sources	Prediction distribution of zoonotic niche: Pigott *et al.* 2017[17] Population density: GHS population grid multitemporal (1975-2030). European Commission, Joint Research Centre (JRC)
Disaggregation	National, subnational, disease specific
Frequency of data collection	Yearly (only for population)
Limitations	Numerator is static
Data type	Percent
Related links	https://extranet.who.int/sph/dpm-dashboard

4.4. Coverage of WASH in communities and healthcare facilities

Indicator	Prevent – water, sanitation, and hygiene (WASH)
Rationale	WASH is a highly effective way to protect communities and healthcare workers from health emergencies
Mandate (WHA resolution, SDG)	WHA72.27 and A/78/L.14 on health care facilities SDG 6.1 and 6.2 relating to WASH in communities
Definition	Coverage of WASH in communities and healthcare facilities
Numerator	1. Communities: People practicing open defecation, People with basic handwashing facilities including soap and water, People using at least basic sanitation services, People using at least basic drinking water services 2. Healthcare facilities: Water, sanitation, hand hygiene, health care waste management, and environmental cleaning basic services in health care facilities
Denominator	1. Total population 2. Number of healthcare facilities

[17] Pigott DM, Deshpande A, Letourneau I, et al. Local, national, and regional viral haemorrhagic fever pandemic potential in Africa: a multistage analysis. Lancet. 2017;390(10113):2662-2672. doi:10.1016/S0140-6736(17)32092-5

Preferred data sources	WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply, Sanitation and Hygiene
Other data sources	
Disaggregation	National, rural/urban
Frequency of data collection	Yearly
Limitations	Data availability regarding WASH in healthcare facilities
Data type	Percent
Related links	https://washdata.org/; https://www.washinhcf.org/

4.5. Trust in government

Indicator	Prevent – trust in government
Rationale	The level of trust a community has in government affects the effectiveness of preparedness and response measures
Mandate (WHA resolution, SDG)	
Definition	Trust in government
Numerator	Trust in government
Denominator	Total population
Preferred data sources	OECD
Other data sources	Wellcome Global Monitor: Covid-19
Disaggregation	National
Frequency of data collection	OECD: yearly (2021) Wellcome Global Monitor: one-off
Limitations	Limited global coverage of trust in government indicators
Data type	Percent
Related links	

4.6. National health emergency preparedness

Indicator	Prepare – National health emergency preparedness
Rationale	Assessing and strengthening core health emergency preparedness capacities is essential to ensuring health security at all levels
Mandate (WHA resolution, SDG)	Articles 5 and 12 and Annex 1A of the International Health Regulations (IHR) (2005) SDG Indicator 3.d.1: IHR (2005) capacity and health emergency preparedness
Definition	IHR States Parties Self-Assessment Annual Report (SPAR) total capacity score adjusted based on the recent completion of functional reviews/simulation exercises and funding level of national emergency investment plans
Numerator	Sum of scores for all 15 core capacity, with potential weighted factors based on indicators relating to additional areas and functions

Denominator	Number of core capacities (15)
Preferred data sources	SPAR data is reported by Member States and disseminated by WHO at https://extranet.who.int/e-spar/ Completion of functional reviews, simulation exercises, and national emergency plans available at Strategic Partnership for Health Security and Emergency Preparedness (SPH) Portal https://extranet.who.int/sph/
Other data sources	
Disaggregation	National, Regional, Core capacity
Frequency of data collection	Annual
Limitations	Self-reported assessment Some variability in reporting each year (range 182 to 194 countries report each year) Completion of functional reviews, simulation exercises, and national emergency plans currently available, funding level of national plans will need to be collected
Data type	Quantitative score (0-100)
Related links	Health Security and Emergency Preparedness (SPH) Portal https://extranet.who.int/sph/; Global Health Observatory https://www.who.int/data/gho

4.7. SDG 3.d.1 International Health Regulations (IHR) capacity and health emergency preparedness

Indicator	International Health Regulations (IHR) capacity and health emergency preparedness
Rationale	
Mandate (WHA resolution, SDG)	
Definition	Percentage of attributes of 13 core capacities that have been attained at a specific point in time. The 13 core capacities are: (1) National legislation, policy and financing; (2) Coordination and National Focal Point communications; (3) Surveillance; (4) Response; (5) Preparedness; (6) Risk communication; (7) Human resources; (8) Laboratory; (9) Points of entry; (10) Zoonotic events; (11) Food safety; (12) Chemical events; (13) Radionuclear emergencies. *IHR (2005) Capacity Level (Annual)* = $\frac{Sum\ of\ Self-Reported\ IHR\ Capacity\ Averages}{13}$
Numerator	State Party self-reported average of 13 IHR (2005) capacities, as measured by the SPAR.
Denominator	Total number of reported capacities (i.e., 13).
Preferred data sources	SPAR reports (available on the Global Health Observatory); Strategic Partnership for International Health Regulations (2005) and Health Security (https://extranet.who.int/sph/)
Other data sources	Joint external evaluation (JEE; available at https://extranet.who.int/sph/); Current Health Expenditure (CHE; available on Global Health Observatory); previous years' IHR (2005) self-assessment annual reporting data (available on Global Health Observatory).
Disaggregation	Country; capacity.

Frequency of data collection	Annual
Limitations	Data are self-reported from Member States; analysis of self-report of capacities using the SPAR (2018) identified that there was a strong correlation between self-reported capacities and externally evaluated capacities. Although self-assessment annual reporting is mandated under IHR (2005), it is possible that not all Member States will submit a report in time for calculating the baseline. In this event, which is anticipated to be rare, previous years' annual reporting data, validated against other existing IHR (2005) monitoring and evaluation framework components, will be used to estimate a baseline value.
Data type	Self-reported assessment data, using a standardized tool. Average value (0–100) of indicator capacity levels, each expressed as an integer value from 0–5.
Related links	Global Health Observatory: http://www.who.int/gho/ihr/en/; SPH: https://extranet.who.int/sph/

4.8. Timeliness of detection, notification & response of IHR notifiable events

Indicator	Detect, notify, and respond (DNR)
Rationale	Timely and effective detection, notification, and response is the cornerstone to every response to an acute public health event
Mandate (WHA resolution, SDG)	
Definition	Average time (in days) between event onset and initial response
Numerator	Time (in days) between event onset and initial response for all events
Denominator	Number of IHR-reportable events
Preferred data sources	Event information site (EIS)
Other data sources	*New* Event management system (EMS) and regional databases
Disaggregation	National, Event type
Frequency of data collection	Yearly (minimum)
Limitations	Expanding the number and type of events measured is planned to increase the quality and usefulness of the timeliness indicator Integrating timeliness targets (7-1-1-28) is also planned to better identify challenges in acute response and improve performance
Data type	Number of days (converted into levels and percent)
Related links	

4.9. Composite indicator comprising three tracer indicators for essential health services among population in settings with humanitarian response plan (HRP)

Indicator	Sustain – essential health services during emergencies
Rationale	Delivery of essential health services to people in need in protracted crises/humanitarian settings is vital to protecting health and livelihoods.
Mandate	

(WHA resolution, SDG)	
Definition	Composite indicator comprising three tracer indicators for essential health services among population in settings with humanitarian response plan (HRP)[18] (outpatient consultations, deliveries, and vaccination coverage)
Numerator	1. Total number outpatient department (OPD) consultations 2. Number of deliveries in a health institution 3. Number of people vaccinated against measles (*alternate*: PENTA)
Denominator	1. Population 2. Number of deliveries 3. Target population
Preferred data sources	District Health Information System 2 (DHIS2) Inter-sectoral multi-sector needs assessment (MSNA)
Other data sources	Health Needs Assessment (HNA) Global Health Cluster survey
Disaggregation	Subnational, Age, Gender
Frequency of data collection	Yearly
Limitations	Tracer indicators do not cover full spectrum or specific health services needed in each setting with an HRP
Data type	1. Rate 2. Percent 3. Percent
Related links	

4.10. Proportion of vulnerable people in fragile settings provided with essential health services (%)

Indicator	Proportion of vulnerable people in fragile settings provided with essential health services
Rationale	
Mandate (WHA resolution, SDG)	
Definition	The indicator will provide the overall number of functioning health facilities at primary and secondary and tertiary care levels that provide the minimum services packages against the population size. The minimum services package is defined by the country/event context. Fragile, conflict, and vulnerable (FCV) countries are identified by WHO based on criteria including the existing protracted grade, existing acute grade but likely to convert to protracted grade, having a humanitarian response plan (HRP) or other relevant response plans, an INFORM index of at least 4.4, or countries with "risk of very high concern" or "high concern" in the IASC EWEAR. This list is updated periodically by WHO, in consultation with the Regional Emergency Directors. As of January 2019, there were 29 FCV countries.

[18] https://humanitarianaction.info/document/global-humanitarian-overview-2024/article/response-plans-overview-2024

	The Health Resources and Services Availability Monitoring System (HeRAMS) aims to guide the standardized, systematic and continuous collection, collation, analysis and dissemination of data on the availability of essential health resources and services in highly constrained, low-resourced and fast changing environments. HeRAMS is a data collection system with standard and country-defined indicators, which is updated on a near-real time basis by service providers. Data on the functioning of health facilities and the availability of context-specific minimum service packages are collected and shared using an online platform. The indicator can be measured using the numerator and denominator described below.
Numerator	Number of fragile, conflict, or vulnerable settings with an average attainment of the Sphere indicators for availability of delivery of a minimum services package at primary and secondary/tertiary levels (i.e., per 50,000 for primary care health facilities; per 250,000 for secondary and tertiary care health facilities).
Denominator	Total number of fragile, conflict, or vulnerable settings.
Preferred data sources	HeRAMS
Other data sources	Population-based survey data, where available, can be used to assess access to services among affected populations.
Disaggregation	By health facility type; by country/setting
Frequency of data collection	Data are collected on a near-real time basis. Estimates will be updated annually, the average monthly mid-point.
Limitations	HeRAMS has not yet been rolled-out in all FCV settings. Data quality is difficult to verify given the challenging nature of these environments. Availability of essential health resources and services is a proxy for access to essential health resources and services, which is measurable only by population-based surveys.
Data type	Percentage
Related links	http://www.who.int/hac/herams/en/