GPW Impact Measurement Metadata:
Proposed New Outcome (Programmatic) Indicators & Updates to Existing Indicators

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Proposed New Outcome (Programmatic) Indicators

1. 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)

2. Does the government provide non-national 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

3. 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.

4. 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

5. 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

6. 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/

7. 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

8. Percent of countries with a national health policy oriented to PHC

Indicator	Outcome: 3.1 **PHC** approach introduced or strengthened Percent of countries with a national health policy oriented to PHC
Rationale	The development of sound national and subnational health policies and strategies (NHPS) 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 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 oriented to PHC and UHC based on the following standards: • Has been developed/revised within the past five years • Sets out clear priorities, goals, policies, objectives, interventions that are oriented towards PHC and the achievement of UHC and the health SDGs • Based on sound evidence-based analysis of the health situation • Promotes the delivery of integrated health services with an emphasis on primary care and essential public health functions at both facility and community level • 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 as co-developers of health and social services and as self-carers • Specifies plans to improve health equity and specifies interventions for the most marginalised and vulnerable populations • Describes how resources will be deployed to achieve outcomes and improve equity, including how resources will be allocated to subnational level and non-state actors • Is developed and reviewed through a regular and transparent system of review of the strategy/plan with broad involvement of key stakeholders • There is an effective country led mechanism for governance, coordination and accountability for implementation of the national health strategy /plan
Numerator	Number of countries with a national health policy oriented to PHC
Denominator	Number of countries

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	Biannual
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. Licence: CC BY-NC-SA 3.0 IGO. 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). 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).

9. Percentage of older people receiving long-term care at a residential care facility and home

Programmatic outcome Indicator	Percentage of older people receiving long-term care at a residential care facility and 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. These services typically involve care and assistance 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 both unpaid caregivers (typically family but also volunteers) and paid care staff.
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

10. 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

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/

11. Postnatal Care Coverage (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

12. Postnatal Care Coverage (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

13. 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

14. 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

15. 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

16. 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	

17. 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	

18. 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

19. 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/

20. 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)

21. 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 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
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 or legumes) • 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	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/

22. 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 collagues (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.*
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, Florescu S, de Girolamo G, Gureje O, Haro JM, He Y, Hinkov H, Karam E, Kawakami N, Lee S, Navarro-

	Mateu F, Piazza M, Posada-Villa J, de Galvis YT, Kessler RC. Undertreatment of people with major depressive disorder in 21 countries. Br J Psychiatry. 2017 Feb;210(2):119-124. doi: 10.1192/bjp.bp.116.188078. Epub 2016 Dec 1. PMID: 27908899; PMCID: PMC5288082. - Le LK, Shih S, Richards-Jones S, Chatterton ML, Engel L, Stevenson C, Lawrence D, Pepin G, Mihalopoulos C. The cost of Medicare-funded medical and pharmaceutical services for mental disorders in children and adolescents in Australia. PLoS One. 2021 Apr 9;16(4):e0249902. doi: 10.1371/journal.pone.0249902. PMID: 33836033; PMCID: PMC8034743.

23. 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	
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

24. Vector-borne disease incidence

Indicator	Vector-borne disease incidence
Rationale	Climate change affects environmental conditions, such as temperature and rainfall which are important factors in the life cycles and breeding patterns of disease vectors (eg. mosquitoes). Climate change also affects human behavior, behavioral changes that might increase risks.
Mandate (WHA resolution, SDG)	
Definition	This indicator measures the variations in the incidence and geographical spread of various vector-borne diseases (eg. malaria, dengue, etc.). This should be put in relation to changes in climate.
g. Numerator	Number of confirmed cases (eg. malaria, dengue, etc.)
Denominator	Population at risk
Preferred data sources	Routine HMIS, population survey
Other data sources	
Disaggregation	Age: >5, 5-14,15 and above, Geography: country, district, lower if possible
Frequency of data collection	Annual
Limitations	Not enough retrospective data
Data type	
Related links	

25. Proportion of GPW outcome indicators with data disaggregation, weighted by the proportion of countries with data available

Indicator	Proportion of GPW outcome indicators with data disaggregation, weighted by the proportion of countries with data available
Rationale	To deliver on the SDG commitment to leave to one behind, it is important to monitor inequalities across the 14th GPW. A cross-GPW approach to this comprises monitoring inequalities in health determinants, inequalities in exposure and vulnerability to risk factors, inequalities in access to and effective coverage with health services, inequalities in health outcomes, and inequalities in consequences of illness and service usage (e.g., impoverishment), including in – to the extent possible – health emergency situations. Through its baseline and target, the indicator assesses the current state of data disaggregation in relation to the domains covered by the SDGs while also fomenting/calling for scaling up in data disaggregation and health inequality monitoring capacity over time, as called for by the SDGs.
Mandate (WHA resolution, SDG)	The importance of data disaggregation and health inequality monitoring has been highlighted in World Health Assembly resolution 62.14 (2009) on reducing health inequities through action on the social determinants of health, resolution WHA 65.8 (2012) that endorsed the Rio Political Declaration on Social Determinants of Health, and resolution WHA 74.16 (2021) on the Social Determinants of Health. SDG target Target 17.18 also explicitly calls for greater availability of disaggregated data: *By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts.* The need for health inequality monitoring has also been emphasized in both the 2019 and 2023 UN General Assembly-endorsed Political Declarations of the High-level Meeting on Universal Health Coverage, the latter of which explicitly highlighted that reporting only averages of global, regional and national progress on universal health coverage may mask inequalities. For operationalization of primary health care oriented health systems strengthening, disaggregated data has a critical role, as emphasized in the PHC measurement framework.
Definition	The indicator "proportion of GPW outcome indicators with data disaggregation, weighted by the proportion of countries with data available" is defined as the percentage of the eligible GPW 14 outcome indicators weighted by the proportion of countries with data disaggregation by inequality dimensions for each outcome indicator. Inequality dimensions refer to globally comparable dimensions like age, sex, place of residence, education, economic status. • Baseline – TBC (when all the outcome indicators are defined) • Target – 10% increase over baseline

Numerator	Sum of eligible GPW 14 outcome indicators with data disaggregation weighted by proportion of countries with data availability for relevant dimensions.
Denominator	Total number of eligible GPW 14 outcome indicators
Preferred data sources	Health Inequality Data Repository
Other data sources	N/A – As all GPW outcome indicators with data disaggregation will be included in the Health Inequality Data Repository.
Disaggregation	The indicator will be reported by Promote, Provide and Protect separately as well as overall.
Frequency of data collection	Annual.
Limitations	Where WHO official estimates are not available, other publicly available data from the Health Inequality Data Repository will be considered.
Data type	Data is provided by the Division of Data, Analytics and Delivery for Impact at WHO. The information is updated annually and collects data from WHO and other externally published sources.
Related links	https://www.who.int/data/inequality-monitor/data

26. Proportion of countries that feature data disaggregation in their national health statistics reports

Indicator	Proportion of countries that feature data disaggregation in their national health statistics reports
Rationale	GPW 14 proposed outcome 3.3 specifically calls for health information systems to be strengthened & digital transformation implemented, with due attention to health equity and gender equality facilitated by the use of enhanced availability of data disaggregation. This indicator monitors the extent to which countries are using data disaggregation in their national health reports, self-reported through SCORE. SCORE is a technical package of essential interventions, recommended actions, tools and resources that aim to support countries in addressing challenges in meeting health information systems needs. This indicator correlates to the WHO GPW 14 results framework at "impact level" by: (a) identifying Member States that are not featuring data disaggregation in their reports and could benefit from further WHO technical assistance on data disaggregation and health inequality monitoring; and (b) show improvements over time in terms of the impact of such technical assistance. The indicator also links the Organization's technical assistance functions and its Delivery for Impact approach to SDG SDG Target 17.18 (see below).
Mandate (WHA resolution, SDG)	The importance of data disaggregation and health inequality monitoring has been highlighted in World Health Assembly resolution 62.14 (2009) on reducing health inequities through action on the social determinants of health, resolution WHA 65.8 (2012) that endorsed the Rio Political Declaration on Social Determinants of Health, and resolution WHA 74.16 (2021) on the Social Determinants of Health. SDG Target 17.18 also explicitly calls for greater availability of disaggregated data: *By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts.* The need for health inequality monitoring has also been emphasized in both the 2019 and 2023 UN General Assembly-endorsed Political Declarations of the High-level Meeting on Universal Health Coverage. For operationalization of primary health care oriented health systems strengthening, disaggregated data has a critical role, as emphasized in the PHC measurement framework.
Definition	The indicator "proportion of countries that feature data disaggregation in their national health statistics reports" is defined as the percentage of countries which completed the SCORE survey that include disaggregated data in their national health statistics reports. Baseline – 2024 baseline TBC*. Target – 10% increase (2028) * The 49% baseline (2019) was calculated using different questions than the upcoming questionnaire (2024).
Numerator	Countries which completed the SCORE survey that include data disaggregation in their national health statistics reports

Denominator	All countries which completed the SCORE survey
Preferred data sources	SCORE Survey
Other data sources	N/A.
Disaggregation	N/A
Frequency of data collection	Every four years
Limitations	Indicator excludes any country which did not complete the SCORE Survey. Results from the SCORE Survey 2024 may not be available by the end of 2024.
Data type	WHO administered survey.
Related links	SCORE data collection tool - WHO https://www.who.int/data/data-collection-tools/score

27. Number of datasets available in the WHO Health Inequality Data Repository

Indicator	Number of datasets available in the WHO Health Inequality Data Repository
Rationale	The WHO Health Inequality Data Repository is a large repository for datasets of disaggregated data. As of 2023, the Health Inequality Data Repository covers over 2000 indicators and 22 dimensions of inequality. All datasets are publicly available and are accessible through the Health Equity Assessment Toolkit (HEAT), a software that facilitates interactive data exploration, analysis and reporting. GPW 14 proposed outcome 3.3 specifically calls for health information systems to be strengthened & digital transformation implemented, with due attention to health equity and gender equality facilitated by enhanced availability of data disaggregation. The above indicator monitors the extent to which there is enhanced availability of disaggregated data for use in health inequality monitoring, specifically through increases in the total number of globally available, multi-country surveys that include inequality dimensions and feature such data in the public domain. It is an important link in the GPW 14 theory of change and results framework, in that it demonstrates enhanced availability of disaggregated data as called for by SDG Target 17.18 (see below), specifically in relation to health.
Mandate (WHA resolution, SDG)	The importance of data disaggregation and health inequality monitoring has been highlighted in World Health Assembly resolution 62.14 (2009) on reducing health inequities through action on the social determinants of health, resolution WHA 65.8 (2012) that endorsed the Rio Political Declaration on Social Determinants of Health, and resolution WHA 74.16 (2021) on the Social Determinants of Health. SDG Target 17.18 also explicitly calls for greater availability of disaggregated data: *By 2020, enhance capacity-building support to developing countries, including for least developed countries and small island developing States, to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts.* The need for health inequality monitoring has also been emphasized in both the 2019 and 2023 UN General Assembly-endorsed Political Declarations of the High-level Meeting on Universal Health Coverage. For operationalization of primary health care oriented health systems strengthening, disaggregated data has a critical role, as emphasized in the PHC measurement framework.
Definition	The indicator "number of datasets available in the WHO Health Inequality Data Repository" is based on the total number of datasets hosted in the Repository (https://www.who.int/data/inequality-monitor/data). Baseline – 62 (2023) Target – 80 (2028)
Numerator	N/A

Denominator	N/A
Preferred data sources	Health Inequality Data Repository
Other data sources	N/A
Disaggregation	N/A
Frequency of data collection	Annual - Updates to the Health Inequality Data Repository are done about once a year.
Limitations	Data included in the Repository come from WHO and other public data sources; therefore, these are not all WHO official estimates.
Data type	Data is provided by the Division of Data, Analytics and Delivery for Impact at WHO. The information is updated annually and collects data from WHO and other externally published sources.
Related links	Health Inequality Data Repository https://www.who.int/data/inequality-monitor/data

28. Whether or not legal frameworks are in place to promote, enforce and monitor health-related equality and non-discrimination, on the basis of sex

Indicator	Whether or not legal frameworks are in place to promote, enforce and monitor health-related equality and non-discrimination, on the basis of sex
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, ending gender related discrimination 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). The existence of legal frameworks to promote, enforce and monitor health-related equality and discrimination on the basis of sex, forms the essential basis of ensuring that the health sector is enabled to ensure and promote gender equality, as well as constituting an accountability framework for ending gender-related discrimination in health.
Mandate (WHA resolution, SDG)	SDG 5.1.1
Definition	This indicator measures the percentage of countries with legal frameworks in place that promote, enforce, and monitor gender equality of relevance to access to health and within the health sector
Numerator	Number of countries with legal frameworks in place that fully promote, enforce and monitor health-related equality and nondiscrimination, on the basis of sex (according to SIGI scoring methodology)
Denominator	Total number of countries for which data is available (currently 179)
Preferred data sources	Subset of data from the Social Institutions and Gender Index (SIGI) Legal Survey (OECD dataset used for monitoring relevant dimensions of SDG 5.1.1)
Other data sources	N/A
Disaggregation	N/A
Frequency of data collection	Every two years (2023; 2025; 2027; 2029)
Limitations	a. Access to OECD data sets (in process of negotiation); b. Requires WHO additional analysis of existing OECD data set; c. Requires assessment of separate score for the data subset
Data type	Survey data

Related links	**SIGI 2023 Legal Survey** 2023 SURVEY QUESTIONS SCORING METHODOLOGY

29. 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	d. 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; e. Poor/irregular data disaggregation and/or poor data quality
Data type	
Related links	Gender relevant SDG indicators

Proposed New Impact Indicator

30. Healthy-life expectancy at age 60

IMPACT Indicator	Healthy-life expectancy at age 60
Rationale	Over the past 100 years, life expectancy has increased dramatically in nearly all nations. Yet, these extra years of life gained have not all been healthy, particularly for older people aged 60 years and over. In 2020, the World Health Organization (WHO) and United Nations (UN) member states embraced a sweeping 10-year global plan of action to ensure all older people can live long and healthy lives, formally known as the UN Decade of Healthy Ageing (2021-2030). With the adoption of the UN Decade of Healthy Ageing resolution, countries are committed to implementing collaborative actions to improve the lives of older people, their families and the communities in which they reside. WHO's Technical Advisory Group for Measurement of Healthy Aging (TAG4MHA) recommends using healthy life expectancy at age 60 disaggregated by sex to assess the impact of the four actions on the ageing population across the globe, at both regional and national levels.
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	The average number of years in full health a person (at age 60) can expect to live based on current rates of ill health and mortality.
Numerator	Not applicable
Denominator	Not applicable
Preferred data sources	WHO Global Health Estimates
Other data sources	None
Disaggregation	Sex
Frequency of data collection	Every five years
Limitations	Healthy life expectancy metric is strongly dependent on morbidities resulting from chronic diseases. However, conceptually, health and healthy ageing are defined by WHO as not merely the presence or absence of diseases. Therefore, heterogeneity in health state commonly observed among older persons is not captured by HALE.
Data type	Statistic
Related links	Data for the indicator can be found here on the WHO platform: https://www.who.int/data/maternal-newborn-child-adolescent-ageing/indicator-explorer-new/mca/healthy-life-expectancy-at-age-60

Proposed Update to Metadata for Existing Outcome Indicators

31. Prevalence of overweight in 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

32. Prevalence of stunting in 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

33. Prevalence of wasting in 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